Kevin Harrington Associates Limited

CHILD O

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

TABLE OF CONTENTS

1. INTRODUCTION

1.1 A young person took her own life in January 2014, shortly before her 17th birthday. She had been very troubled for several years and had continuing contact with health and social care services. With the agreement of her family she had been admitted to the care of their local authority, the London Borough of Haringey, and placed in a therapeutic residential setting in Wiltshire. It was near here that she died after lying under a train.

1.2 These events were considered by the Haringey Local Safeguarding Children Board (HSCB), mindful of the government's guidance[1] that
"when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children".
The guidance requires that a Serious Case Review (SCR) should be carried out to provide that analysis and identify the necessary service improvements when a child has died and abuse or neglect are known or suspected, or more generally when it is believed that lessons can be learned from what has happened. The HSCB decided that the circumstances of Child O's death were such that it was necessary to conduct an SCR and this is the Overview Report from that review.

1.3 The death of this young person has been the subject of considerable publicity in which she has been identified. Her parents have been clear that they do not wish her identity to be disguised in any way in this review. This was accepted by the author of this report, and in earlier drafts she was referred to by her given name.

1.4 However, when this issue was considered by the Panel steering this review, it was decided that this would not be appropriate because of, with reference to the child's wider family,
"the Board's duty of care to protect information about individuals who could be identified and who have not given permission for that information to be shared",
and because
"the Board should not set any precedent[2] in relation to SCRs that deviates from their duty of care, or from standard best practice".
The subject of this SCR is therefore referred to as Child O.

1.5 Child O was, for whatever reasons, a very damaged and vulnerable girl. That could hardly have been more clear. It is notable, in considering what the various agencies have said about their involvement with her, that there was

[1] Working Together to Safeguard Children (2015) – referred to in this report as "Working Together" – is the government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004.

[2] There are national precedents – Daniel Pelka, for example, in Coventry - but HSCB has not previously identified a child at the centre of an SCR.

never a time in the period under review when any professional who knew her did not have profound concerns for her.

1.6 Her distress manifested itself most often in self-harm. People who harm themselves do not generally go on to kill themselves but, at the same time, self harm carries a significant risk of subsequent suicide[3]. At the very first contact with a professional in the period under review, a presentation to a GP in 2010 when Child O was thirteen years old, she spoke of having already tried to kill herself. A month later she was assessed at UCLH as being "at high risk of suicide". The possibility of suicide remained consistent.

1.7 However, in the hours immediately before her death there was no indication that Child O might choose that time to end her life. Those around her at the time have reflected that
"something quite overwhelming had taken hold of her on (that) evening".
Her suicide on that particular night could not have been anticipated.

1.8 This review has identified very serious weaknesses across the services which should have helped Child O and her family, stemming from an overall failure to use safeguarding arrangements and risk assessments effectively. But there was also clearly a significant, avoidable delay in taking a key action – agreeing to her and her family's request that she be admitted to the public care, to live separately from her family in a therapeutic placement - which probably had the best chance of achieving enduring, positive change.

1.9 The author of this report has been involved in one previous[4] SCR in Haringey. It is of concern that a number of issues raised in that review, which considered events in 2010 / 2011, re-appear in this review, across the agencies involved. These include inadequate assessments, failure to use child protection arrangements appropriately and a lack of effective management oversight.

1.10 In May 2015 the HSCB published another SCR report[5]. The circumstances of the children and family under review were very different to those considered here. However a number of the "critical failings" identified in that review echo some of the findings of this report.

[3] NICE Guidance 2014.pdf
[4] Child T Overview Report
[5] Child CH Overview_Report

2. FAMILY BACKGROUND

2.1 Child O was the youngest of five children. Although in the care of the local authority when she died, she continued to spend a lot of time at home with her family, as she had done previously during long periods as an in-patient receiving psychiatric hospital care.

2.2 The family composition is as follows:

Father (1958)	[Parents, married]	Mother (1956)

Sister (1984)	Brother (1985)	Sister (1988)	Brother (1995)	Child O (1997)

2.3 Both parents are from the USA, but all the children were born in the UK. Child O's father was one of three children and Child O's mother one of seven. There is a large extended family in the USA. The family, including Child O except when she was unwell in 2012, travelled to the USA every year or more often than that.

3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

3.1 This SCR was formally initiated by the then Chair of the HSCB, Graham Badman CBE, in January 2014. Graham Badman's term of office terminated in March 2014 and HSCB appointed a new Chair, Sir Paul Ennals, in May 2014.

3.2 Graham Badman had convened a panel of senior representatives (the Panel) from relevant agencies to lead the SCR and had personally chaired that Panel. Sir Paul Ennals initially also chaired the Panel before handing that responsibility over to Karen Baggaley. Ms Baggaley, the Vice-Chair of the HSCB, is the Assistant Director for Safeguarding and the Designated Nurse for Child Protection for the NHS Haringey Clinical Commissioning Group.

3.3 The HSCB appointed an experienced independent person – Kevin Harrington[6] - to act as Lead Reviewer and to write this report.

3.4 This review has taken an unusually long time to complete. One of the reasons for that is the large number of agencies required to contribute. Many agencies and professionals, from a number of different localities, had been involved. All agencies were required to submit an Individual Management Review (IMR), either containing a narrative and an analysis of their involvement where that had been substantial, or a narrative account of events where involvement had been less significant. Those agencies are detailed in the table below, and are subsequently referred to by the acronyms / abbreviated forms provided.

AGENCY	NATURE OF INVOLVEMENT
London Borough of Haringey, Children and Young Person's Services (CYPS)	Child O was known to this local authority from the summer of 2011, and was in care to this local authority when she died.
Tumblewood Community School (Tumblewood)	The therapeutic residential home where Child O was living at the time of her death
School B, a state school in central London	This was the last school Child O attended
NHS Islington Clinical Commissioning Group (ICCG)	The commissioners of Child O's health care from April 2013 when they replaced their predecessor body, the Islington Primary Care Trust (IPCT)
The Whittington Hospital NHS Trust (The Whittington)	This Trust directly provided a range of health services to Child O - accident and emergency, community and in-patient child mental health services.
The Priory Hospital North London (The Priory)	This private hospital provided "overflow" In-patient child mental health services, when NHS provision

[6] Appendix A of this report contains brief autobiographical details,

	was unavailable or inappropriate
Metropolitan Police Service (MPS)	Police in London were Involved in investigations and child protection processes during the period under review
Keys Childcare Group (Crisis Care)	Providers of short-term residential care prior to Child O's admission to Tumblewood
General Practitioners (London)	Family GP services in London
General Practitioners (Wiltshire)	GP services to Child O in Wiltshire
NHS Haringey Clinical Commissioning Group (HCCG)	This agency has provided an overview of all health services contributing to this report
The Cassel Hospital	This hospital provided advice about managing Child O's situation.
University College London Hospitals NHS Foundation Trust (UCLH)	Child O was briefly admitted to UCLH after self-harming, at the beginning of the period under review
North Middlesex University Hospital NHS Trust (NMUHT)	Child O was briefly admitted to NMUHT after self-harming
Barnet and Chase Farm Hospital NHS Trust (BCFH)	Child O was twice treated at BCFH after self-harming
Royal Free London NHS Foundation Trust (Royal Free)	Child O attended the Royal Free twice to discuss surgery to conceal scarring caused by self harm
British Transport Police (BTP)	This force was Involved in the investigations into the circumstances of Child O's death
Central London Community Healthcare NHS Trust	Provided a school nursing service while Child O was at mainstream school
London Ambulance Service NHS Trust	Transported Child O to hospital on two occasions
The Tavistock and Portman NHS Foundation Trust (Tavistock)	This Trust had one routine contact when Child O became a "looked after" child.
London Borough of Hackney, Children's Social Care services (CSC)	The family previously lived in Hackney and CSC had been involved in assessing their situation

3.5 The Coroner's inquest into Child O's death concluded in October 2014. The Coroner wrote to the Chief Executive of the London Borough of Haringey, and to the Metropolitan Police Service raising concerns and seeking comments about a number of issues (which are addressed in this report). It was agreed with the Coroner that this review should be completed, to inform

the agencies' response, and those agencies have now corresponded directly with the Coroner in relation to the matters raised.

4. TERMS OF REFERENCE

4.1 The Terms of Reference for the review are at Appendix B. They are drawn from Working Together, amended to reflect issues specific to the circumstances of this case.

4.2 Agencies were initially asked to review their involvement with the family from January 2007, but the scope was subsequently revised to focus on the events from the summer of 2010, when Child O was first referred to therapeutic services, until her death in January 2014.

5. METHODOLOGY USED TO DRAW UP THIS REPORT

5.1 This report is based principally on the IMRs, background information submitted and subsequent Panel discussions and dialogue with IMR authors and other staff. Child O's parents were also been keen to contribute and their views and comments are reflected in section 7 of this report.

5.2 This report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their submissions to the review.
- Identification and analysis of key issues arising from the review.
- Conclusions and recommendations.

5.3 The conduct of the review has not been determined by any particular theoretical model but it has been carried out in accordance with the underlying principles of the statutory guidance, set out in Working Together: The review

- *"recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight[7];*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings".*

5.4 The government has introduced arrangements for the publication of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published. That has been discussed with Child O's parents, who have no objection to publication and indeed have acknowledged the potential wider benefits of doing so.

[7] This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

6. KEY EVENTS

6.1 Introduction

6.1.1 This section of the report briefly describes the key events during the period under review and the background to those events. Further detail is then provided throughout the report.

6.1.2 The following table summarises Child O's whereabouts during the period under review. It does not include brief hospital admissions or short periods spent at home.

Dates	**Child O's whereabouts**
December 2010 to January 2011	The Priory
January 2011 to July 2011	Simmons House
July 2011 to September 2011	Home, including time in the USA
September 2011 to February 2012	The Priory
February 2012 to April 2012	Simmons House
April 2012 to mid June 2012	Home
June 2012 to March 2013	The Priory
March 2013 to June 2013	Crisis Care
June 2013 to July 2013	Tumblewood
July 2013 to September 2013	Home, including time in the USA
September 2013 to January 2014	Tumblewood

6.2 2010

6.2.1 The first evidence of cause for concern in the period under review was in the summer of 2010 when Child O, aged 13, was briefly admitted to the Whittington with alcohol intoxication. Then in October 2010 Child O's mother took her daughter to the GP. Child O had taken a mixture of painkillers before school, then called her mother. The GP spent a long time with them, together and separately. Child O said she had "tried to kill herself" a number of times previously and spoke of "personal problems". She had talked about this with a friend but did not wish to say anything further though she agreed to see a counsellor. She spoke of using alcohol and cannabis, and denied any sexual activity. She did not want her mother to be made aware of these matters but she said that "home and school were OK".

6.2.2 The GP made an immediate referral to Child and Adolescent Mental Health Services (CAMHS) and a home visit was made from their Adolescent Outreach Team (AOT). Child O repeated what she had told her GP and also spoke of being angry with her parents. She talked of a friend who had tried to kill herself. Child O's mother reported concerns that Child O and her friend were involved in self-harming behaviour. CAMHS offered to see Child O every week and placed the family on a waiting list to be seen together should individual appointments not resolve the problems.

6.2.3 The family decided, in the first instance, that Child O should see a psychologist at school, rather than being seen at CAMHS. However a month later Child O and her parents went to UCLH. She was said not to have eaten for 5 days, was unable to sleep, was cutting her arms and now said that she had been having suicidal thoughts for a year. She indicated that something bad had happened a year ago but would not disclose what this was. She said the problems were at school and in her local area. She did not always get on with her parents but that was not the main problem.

6.2.4 Child O was found to be physically well but significantly depressed and at high risk of self-harm or suicide. She was admitted to UCLH and from there was transferred to the Priory, a private psychiatric hospital in North London with an adolescent unit, as no NHS beds were available. Before transfer a referral was made to the London Borough of Hackney Children's Social Care services (CSC).

6.2.5 The admission to the Priory was funded, as a short-term arrangement, by the former Islington Primary Care Trust (ICPT). This was because the family had a GP in the London Borough of Islington, though their home was in the neighbouring borough of Hackney. The AOT remained involved in planning and working with Child O and it was judged likely that she would need to transfer to longer term NHS provision at Simmons House, again a specialist adolescent hospital in north London. IPCT had a standing arrangement – the "Tier 4[8] Panel" - for reviewing these funding and care arrangements.

6.2.6 Child O's care was now to be managed under the Care Programme Approach[9] (CPA). The first assessment made by the Priory was that she had an affective disorder – that is, that her mood was disordered - with some paranoid component. Her reluctance to discuss her problems made it difficult to judge whether she had indeed experienced a traumatic life event or the extent to which she did have paranoid ideas or delusions.

6.3 2011

6.3.1 At the end of January Child O transferred to Simmons House. This admission was for assessment and was expected to continue for some months. In February the Tier 4 Panel confirmed continuing funding for this arrangement and decided there should be a further referral to Hackney CSC. This was because of the safeguarding implications of Child O's situation – she was so vulnerable that agencies needed to be satisfied that all aspects of her situation had been thoroughly assessed.

6.3.2 By the end of March the admission to Simmons House had been confirmed as a continuing arrangement rather than an assessment, but Child

[8] Child and adolescent mental health services nationally are planned, commissioned and delivered in line with a four-tier strategic framework, in which Tier 4 addresses the most complex needs, often by in-patient provision.
[9] The CPA is the national arrangement for planning and reviewing the mental health needs of individuals.

O had become more unsettled. She briefly absconded once and then refused food for five days, leading to an admission to UCLH where she was fed by naso-gastric tube. Her behaviour on the ward was judged unpredictable and risky so that a nurse remained with her at all times. She was in UCLH for about a week until she could return to Simmons House in April.

6.3.3 During this time Hackney CSC conducted a Core Assessment[10] and decided that there was no need for their involvement in the continuing care arrangements for Child O. The assessment found no concerns about her parents' ability to care for and protect Child O, though Child O herself refused to see the assessing social worker. The parents were judged to have taken protective action when she became unwell and, in view of the considerable input from health services, it was decided that there was no need for further input from the local authority at that time.

6.3.4 In May the Tier 4 Panel confirmed continuing funding for the placement until late July. The team at Simmons House was now exploring plans for Child O's longer term care. She was self-harming daily and refusing to participate in meetings with her parents. At times she had to be reported as a missing person to police. She spoke of hating her father, and of fears that she would be assaulted by other men if she were to return to live at home, an option which she refused to consider.

6.3.5 By mid-June Child O's attitude had changed and she was spending more time at home. In early July her mother contacted police as Child O had facial injuries said by her to have been caused by a man in an incident on a bus. Child O's mother was concerned that her daughter was being mistreated by someone but Child O would not confirm this. Police enquiries could not corroborate the report.

6.3.6 Soon after this Simmons House made a further referral to Hackney CSC after an incident where Child O returned to her home, badly bruised, saying she had been attacked in a park. Hackney CSC have reported that they agreed with Simmons House that they should refer the matter to Haringey CSC as the family were imminently moving to Haringey. They remained registered with their GP in Islington.

6.3.7 Child O went to America with her family for several weeks in the summer of 2011 and there was a planned discharge from Simmons House, where staff had expressed concern about this long period away from hospital. The discharge letter to her GP referred, for the first time, to a diagnosis of post traumatic stress disorder (PTSD).

6.3.8 A referral was now made, in early August, by Simmons House to Children's and Young People's Services (CYPS) in Haringey. This reported that Child O had spoken of having a miscarriage when she was twelve and

[10] A Core Assessment (Framework for the Assessment of Children in Need, HMSO 2000) was a detailed assessment, undertaken by CSC over a period of weeks, when it was suspected that a child was suffering, or likely to suffer, significant harm.

subsequently being assaulted by the putative father. These reports were never substantiated.

6.3.9 At the end of September Child O was re-admitted to the Priory. There was said to be an increased suicide risk and her behaviour had become more challenging. She was cutting herself daily, banging her head and using ligatures to stop her flow of blood. She was aggressive to both of her parents, feeling overwhelmed academically, having returned part-time to school, and said she was stressed by moving house. She had spoken of auditory and visual hallucinations.

6.3.10 A Haringey social worker now became involved, as a result of the referral in early August, liaising with various agencies. Child O continued to self-harm in a number of ways (though these incidents were not all recorded by the hospital and shared appropriately between agencies). On one occasion in early November she cut her head and tried to strangle herself and required treatment at A&E (BCFH).

6.3.11 The following day the Tier 4 Panel received a report that CYPS felt she did not meet the threshold for their involvement. However some two weeks later Child O's case was allocated to a social worker for an Initial Assessment. CYPS had also made a referral to the MPS Sapphire Team, an MPS specialist unit responsible for the investigation of rape and serious sexual assault. The referral had been prompted by comments made by Child O's mother at a meeting at the Priory. She had expressed concerns about her daughter being in a relationship with an older man and about Child O saying that she had previously been pregnant. A Sapphire officer advised that there was insufficient information for them to become involved. They asked CYPS to make further enquiries and re-refer as necessary.

6.3.12 A week later CYPS recorded that their Initial Assessment had been completed and there was no need for the local authority's continuing involvement. Child O had refused to see the social worker during the assessment.

6.3.13 The Tier 4 Panel met just before Christmas and decided to seek a meeting of the agencies involved, to include CYPS. They also discussed whether it would be possible for the child/family to register with a GP in Haringey. Child O remained at the Priory.

6.4 2012

6.4.1 On New Year's Day Child O told staff at the Priory that her mother had hit her. This was notified to police and CYPS under child protection arrangements but Child O would not give any further details. It was agreed that CYPS would follow up but on 17/1/12 CYPS wrote to her mother to advise that no further action would be taken. The letter contains a confusing reference to Child O moving into residential care but the local authority no longer being involved. A Tier 4 Panel in mid-January noted "*difficulty*" in

working with the local authority and again discussed the idea of a change of GP.

6.4.2 Later that month Child O was again taken by ambulance to hospital and admitted self-harming - ingestion of batteries, screws, washers and cleaning fluid. She was to stay in hospital for 2 days. The notes on admission refer to "*severe sexual abuse in the past*" though this is not clarified or evidenced further.

6.4.3 A few days later the Priory wrote to the local authority asking that they assist with the plan for Child O to move to
"a therapeutic residential placement that could predominantly meet her educational needs while maintaining her safety, and offering low intensity non-directive therapy until such time as she wants to access more structured therapy".
Child O and her family were said to be in agreement with this. At the same time there was a decision that she did not need in-patient psychiatric care but would attend Simmons House as a day patient while arrangements for residential care were made. This arrangement continued until the end of April when she no longer wished to attend Simmons House and was discharged, to be followed up in the community by CAMHS.

6.4.4 During the first weeks of March CYPS had carried out a Core Assessment, in the course of which professionals increasingly took a view that Child O had been raped or sexually assaulted by men in the Finsbury Park area when she was 12 years old. That assessment concluded that there should be continuing involvement by CYPS and that Child O should be seen as a "child in need[11]".

6.4.5 The Haringey Complex Care Panel – a Panel organised by the local authority to consider care arrangements which might require inter-agency funding – now met and started to consider Child O's case, recommending initially that there be a meeting involving key professionals and Child O's parents. In April a doctor at Simmons House noted that there had been a very useful meeting, and that there would be further discussions between the local authority and the NHS. Then Simmons House received a letter from the Chair of the Complex Care Panel, stating that
"the panel accepts that Child O needs to be given the opportunity to live outside the family home. As agreed with yourselves, there may be a number of provisions that could meet her needs. We are, therefore, going to explore a range of options and will be ready to present a decision to you during the week commencing 11 June 2012."

6.4.6 Child O was an in-patient at the Whittington for a week at the end of May after swallowing razors, hair pins, broken glass and batteries. Two weeks later she was re-admitted. She said that she had had consensual sex with an adult male and then to have drunk vodka before shooting herself in the chest

[11] Section 17 of the Children Act 1989 defines a child as being in need if he or she is unlikely to achieve or maintain, or to have the opportunity to achieve or maintain, a reasonable standard of health or development without provision of services from the local authority.

with a pellet gun. She said she wanted to kill herself. Doctors considered whether she might be made subject to detention under the Mental Health Act ("sectioned") but decided this was not appropriate. She was transferred to the Priory in mid-June.

6.4.7 In response to the matters described in the previous paragraph CYPS convened a Strategy Meeting under child protection arrangements and again invited the Sapphire Unit but not the local police Child Abuse Investigation Team. Sapphire officers attended and advised that they would not become involved because there was no specific disclosure or corroborative evidence of a sexual offence.

6.4.8 In July the local authority advised that Child O's situation did not meet their criteria for admitting her to care, or otherwise making any financial contribution to the costs of any placement made. The local authority had also now suggested that Child O be assessed by an educational psychologist to assist in determining how her needs might best be met. Meanwhile Child O continued frequently to self harm and talk of suicide.

6.4.9 Child O stayed in the Priory during the summer while the family went to the USA. Her mother had considered cancelling her trip to the USA but did eventually go for two weeks. One of Child O's siblings visited her during this time.

6.4.10 In August the ICCG wrote to CYPS outlining the continuing concerns of clinicians about sexual exploitation/sexual grooming of Child O. It was further said that her self-harming behaviour was extreme and could place her life at risk. The letter stated that she did not need to be a psychiatric in-patient but that it was unsafe for her to live at home or in the local area.

6.4.11 There was now a further change of position by the local authority with renewed references in correspondence to the development of a joint funding arrangement. However they were still conducting the Core Assessment initiated in March, which was not completed until August. One of the conclusions of that assessment was that there should be a further psychiatric assessment, as there were judged to be conflicting diagnoses and the local authority had concerns about Child O's capacity for engaging with a therapeutic placement. The Cassel Hospital had been approached by the local authority to conduct this assessment.

6.4.12 October was marked by unusually positive reports from the Priory. A psychologist reported that Child O was the happiest she had been since admission. She was participating in most activities, when previously she had stayed in her room most of the time. Child O was also co-operating with medical investigations into surgery to reverse scarring caused by cutting herself.

6.4.13 However agencies were openly in dispute about the decision to seek an assessment from the Cassel Hospital. The local authority advises that

"the Cassel Hospital had been asked to undertake the review given their specialist experience and knowledge in residential therapeutic treatment of severely disturbed young people".
However this request had been made without reference to clinicians at Simmons House or the Priory, who felt that their diagnoses had been consistent throughout. Those clinicians explicitly queried whether the local authority did not have confidence in their opinions and advice. Health agencies requested that the referral to the Cassel be withdrawn or deferred but the local authority argued that they were right to request a separate clinical overview if it felt this was necessary to inform care planning.

6.4.14 The local authority also raised the issue of Child O's education, suggesting that she might need assessment for a Statement of Special Educational Needs. Health care professionals asked that this request be formalised and its purpose clarified but in fact the issue was not pursued by the local authority. It was eventually agreed that the re-assessment by the Cassel Hospital could be based on a review of records and discussions with some staff but would not involve Child O and her family directly.

6.4.15 In late October CYPS contacted Barnet CAIT regarding an allegation that Child O had been inappropriately touched by another patient. The CAIT advised CYPS to report the incident to local police as it did not fall within the CAIT remit. There is no evidence of any further action being taken in this matter.

6.4.16 In mid-November Child O again cut herself several times and required treatment in A&E at North Middlesex Hospital. A further meeting was held towards the end of November. All relevant agencies, including the Cassel Hospital, were represented. The Cassel Hospital recommended that the "*status quo was maintained*" and they should continue to carry out a full assessment. This proposal was not agreed.

6.4.17 The ICCG agreed to fund an assessment of Child O in a residential placement. Just before Christmas CYPS indicated that they were in agreement with the proposal that Child O move to a jointly funded residential care placement. Clinicians felt that Child O could be discharged home from the Priory while these matters were followed up. In fact she remained an in-patient until March 2013.

6.5 2013

6.5.1 During January and February there were discussions with a potential placement. Health agencies were satisfied with this plan and were working towards a move in March, although the local authority was still exploring alternative placements, against the possibility that the first option might not be successful. At the same time the proposed establishment was itself considering a possible risk assessment by a mental health agency before committing to taking Child O. It was decided that Child O could go to an "intermediate" placement, where such an assessment could be carried out. This would be funded by the local authority.

6.5.2 In March Child O left the Priory to go to this placement – Crisis Care in Shropshire. A few days later she was formally admitted to local authority care under section 20, Children Act, 1989 – that is, she was in care with the agreement of her parents who retained parental responsibility for her. This was what her parents had originally proposed in January 2012.

6.5.3 The focus of enquiries was shifting and the placement of choice was now the Tumblewood Community, a residential resource for adolescent girls in Wiltshire. However it was not until mid-May that Child O had her first direct contact with Tumblewood. After being shown around and meeting some young people she was judged to have been positive and cheerful. Crisis Care subsequently confirmed that she was very positive about the placement.

6.5.4 It was a month later, in mid-June, that Child O moved to a long-term placement at Tumblewood. All reports indicate that she settled well and co-operated in discussions about her education, health and social needs. She had a new social worker from CYPS, who visited soon after her admission to attend a meeting which agreed the objectives of the placement. The plan set out her daily routine in detail, including her education programme. It confirmed that she would have an allocated female worker alongside her for support, and a key worker. She would be expected to participate in a structured group work programme and would attend a weekly “Art plus” group. Community Meetings were held twice daily, before and after school and she would have regular oversight from a psychiatrist.

6.5.5 The plan to go to America for the summer was discussed with social workers & the IRO in mid-June when setting up the statutory Looked After Child (LAC) review for the end of July, and it was agreed that the family would go to the USA immediately after the review. In fact the social worker argued that they should do so, in line with Child O’s wishes, even though Child O’s mother had suggested delaying departure to allow the family to attend an event at Tumblewood.

6.5.6 In a routine monthly report at the end of June Child O is recorded as saying she had
“finally found somewhere where she thought she could live comfortably.”
The report states that she was proving a valuable addition to the group, attended community meetings regularly and showed maturity in her interactions with both young people and adults.

6.5.7 Child O spent a weekend at home in July, reporting on return that it had gone well. The report at the end of July was again positive with staff comments similar to those made in the previous report. Her own written contribution is also positive about her time at Tumblewood. The LAC Review at the end of July was attended by Child O and her mother, and was generally encouraging, envisaging that Child O would be living at Tumblewood for the next two years.

6.5.8 Immediately after the LAC Review Child O returned to the family for the planned holiday in America. She had been in placement for seven weeks. Around the same time an Ofsted inspection of Tumblewood as a registered children's home downgraded Tumblewood from its former "Good" rating to "Inadequate". The formal notice to Tumblewood details the following concerns:

- *"The home's safeguarding policy is inadequate. This policy had not been submitted to the Local Authority Designated Officer for Child Protection (LADO) for consideration and comment.*
- *2 allegations made by young people against members of staff have not been reported to the LADO or to Ofsted under Regulation 30, Schedule 5.*
- *Prompt action is not always taken to minimise the risk of young people going missing from the home. There is delay in reporting some missing young people to the police to secure a swift and safe return to the home.*
- *The home has not informed placing authorities of all missing episodes.*
- *Regulation 33 and Regulation 34 monitoring processes are ineffective in identifying shortfalls in care and recording practices and improving outcomes for young people.*
- *The risk reduction measures in place within the home lead to an institutional feel"*

6.5.9 When CYPS were routinely informed of this, senior managers decided, without reference to the family or any other agency, that Child O should not return to Tumblewood when the family came back from holiday. The placement is described in records as "*terminated*". A Team Manager within CYPS raised concerns because
"alternative plans do not seem to have been considered and (because of) the impact on Child O and her family".
These concerns were not accepted by senior managers. The family was contacted by email to advise them of the decision.

6.5.10 A week later a CYPS manager decided that, in any event, Child O had already been removed from local authority care by her family, by virtue of taking her on holiday for six weeks. This was despite the local authority's involvement in agreeing these holiday arrangements in mid-June.

6.5.11 A senior manager then queried
"whether Child O did in fact need a specialised placement given her extended leave with family and having regular weekends at home."
The local authority proposed that there should be a "*re-assessment*", which should take account of the Ofsted findings about Tumblewood. The Independent Reviewing Officer[12] (IRO) who had chaired the LAC Review

[12] This is a statutory post, established in the Children Act 1989 and strengthened in subsequent legislation. The IRO is appointed to monitor the performance by the local authority of their functions in relation to the child's case, participate in any review of the child's case and ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the appropriate authority
IRO guidance

complained that she had not been consulted about any of the decisions being taken by senior managers.

6.5.12 A social worker wrote to the family advising that, because of the Ofsted judgment, the placement had been "*suspended*" and
"a reassessment would need to be undertaken before we would consider placing Child O back at Tumblewood or anywhere else".

6.5.13 The local authority made direct contact with the family when they returned to the UK and confirmed that they would not support Child O's return to Tumblewood. ICCG and CAMHS expressed concerns as they had not been consulted about this, despite the joint funding arrangements. Then, despite the local authority's decision that Child O was no longer "in care", a LAC review was held at the end of August. Child O attended and was clear that she wished to return to Tumblewood. The IRO represented this to senior managers at CYPS, indicating that she also felt Child O should return.

6.5.14 The ICCG wrote formally to the local authority stating that they did not support the decision to refuse a return to Tumblewood because of

- the lack of consideration of clinical risk attached to the decision
- the lack of any alternative arrangements in place
- strong and clear objections from the local clinical team

CYPS responded in detail, confirming that any resumption of the placement would be subject to a re-assessment of Child O and consideration of the problems at Tumblewood. In the meantime the local authority had offered the family "*daily support (9-5)*" which had been declined.

6.5.15 This situation continued for another three weeks until mid-September when Tumblewood was re-inspected and judged "adequate". Initially there was further confusion as a CYPS manager was concerned that the grading was "adequate" rather than "good", and that this might mean Child O should not be re-admitted. However a few days later it was agreed by CYPS that Child O could return and she did so. She was noted to be happy and settle quickly.

6.5.16 Child O's mother approached ICCG in October asking if they would fund periodic reviews of her daughter by the psychiatrist who had managed her care in the Priory. This request was refused as she was now under the care of the psychiatrist at Tumblewood. That psychiatrist subsequently sought to liaise with the clinicians previously managing Child O's care but received no response until after Child O's death.

6.5.17 During the first weeks of October Child O complained of a number of minor illnesses and her attendance at school declined significantly, but she was otherwise normally involved in the life of the establishment. She spent time at home during the half-term break and was noted to be more unsettled on her return, declining to join in group activities. On one occasion she was found in a trance-like state, muttering under her breath "*someone is going to hurt me*." There was evidence of self-harm – marks on her hand. She spoke to staff of hearing "*noises in my head*" and referred to herself as "*mental*", but

responded well to expressions of concern and encouragement from staff. There was mounting evidence that she was unsettled in male company and staffing arrangements were adjusted to take this into account. The monthly overview report for October noted that she had "*struggled*" since returning to Tumblewood.

6.5.18 Child O had seen the Consultant Child Psychiatrist at Tumblewood twice before the summer break and then attended fortnightly sessions with him from early November until a week before her death. She also started psychotherapy sessions in mid November and continued to attend weekly, save for oversleeping once and going home at Christmas.

6.5.19 The psychiatrist was contacted by Child O's mother in November, unhappy that she had not been involved in discussions about her daughter's treatment. She repeated these concerns to Tumblewood staff after a new incident of self-harm, and told them that Child O had rung her saying she felt near to needing admission to psychiatric hospital.

6.5.20 Child O then had to be taken to A&E, complaining of chest pains, and was diagnosed with an inflammation of the chest. Following this her risk assessment at Tumblewood was updated with clear instructions on how to respond to various presentations.

6.5.21 Early in December Child O was involved in a fight with another young woman at Tumblewood. She was told to remain on the premises but refused to do so. She was away for some hours before returning, still angry. Over the next day she would not leave her room or co-operate with staff. The situation settled but, nine days later, she was seen with a deep scratch to her face, believed to be self-inflicted. While a member of staff was assisting with these injuries Child O disclosed that when she had left the site after the fight she had gone to the railway tracks nearby. She wanted to jump under a train but did not do so because it was her brother's birthday and she did not want her family to be angry with her.

6.5.22 A week before Christmas a review of Child O's education was held, attended by her mother, her social worker and Tumblewood staff. The meeting did not go well and Child O left angrily complaining that she was being criticised for unsatisfactory educational progress. She then went home for Christmas.

6.6 2014

6.6.1 Child O returned early in the New Year, telling staff she was glad to be back. However, on return, she saw the psychiatrist and referred to having "*PTSD episodes*" related to intrusive thoughts. She would not be more specific, commenting that this might lead to her detention under the Mental Health Act. The next day staff attempted to resolve the issue of the fight in

December. Child O became very agitated and distressed and tried to choke herself with a scarf which staff had to cut from her throat.

6.6.2 A LAC Review was held a few days later. Child O and her mother attended and Child O was pleased with decisions made which amended her education programme so that she was required to attend fewer classes. Overall it was agreed that the emphasis in working with Child O should be on developing life skills to help her when she left Tumblewood at age 18.

6.6.3 In mid-January Child O's mother contacted Tumblewood. She said that there were media reports of the inquest into the suicide of a friend of Child O. She wanted to tell Child O about this so that she did not learn of it from the media and she spoke to Child O later that day. The following day Child O spoke to a member of staff saying that her friend had committed suicide, by jumping in front of a train at King's Cross, because she was bullied. Child O's manner did not give any cause for concern.

6.6.4 However she left the site that evening and staff found messages indicating that she intended to commit suicide. This was reported to police who followed up without delay but she was found to have indeed taken her own life by lying in front of an express train.

7. THE FAMILY

7.1 Child O

7.1.1 Child O was an unusually troubled young person, even by the standards of the specialist agencies that worked with her throughout the period under review. A letter from one of her treating psychiatrists in 2013 described *"significant risk to her personal safety, ongoing suicidal ideation…and a number of significant attempts while in the community …she was at risk of being drawn into abusive situations which often can happen as a re-enactment of previous trauma. She also was experiencing frequent nightmares, flashbacks, dissociative experiences and visual and auditory hallucinations – often resulting in self harming episodes".*

7.1.2 It is similarly unusual that we still have so little firm evidence of the matters contributing to that disorder and distress. However Child O was resolute in her determination not to reveal information about herself. She would not speak to social workers trying to assess her situation. She expressed concern that her family would access her medical records and she insisted that only limited notes be kept of meetings she attended. Tumblewood found that
"The longer Child O was in residence the more she presented herself and was experienced as not just cautiously private but…highly guarded, secretive, often untrusting … and fiercely resistant to opening up about her feelings preoccupations and fears".

7.1.3 Despite the time she spent there the reports from the Priory and Simmons House do not give a helpful picture of Child O herself. Engagement with staff at Simmons House was inconsistent and there is only one member of staff (at the Priory) judged to have had any real success in engaging with her. The attempts by CYPS to understand Child O and form a positive relationship with her were also generally unsuccessful. The CYPS IMR finds that
"conversations with Child O did not reflect sufficiently on her views, wishes and feelings about what it was like to be her, what was important to her, what she was worried about, where she felt safe…and there was limited exploration and self-reflection about her behaviour".

7.1.4 Child O's education was hugely disturbed by her ill health and her recurring admissions to hospital. It is clear that she also actively sought to avoid some of the requirements of being educated and that this was linked in part to her lack of confidence. She spoke to teaching staff at Simmons House about her reluctance to get involved in any assessments
"as she felt that she would score '0'."

7.1.5 Staff at Crisis Care did succeed, perhaps more than any other agency, in engaging with Child O, respecting her antipathy to any involvement with male staff and working around a difficulty they had identified in her capacity to adjust to disruptions in patterns of activity. As discussed below this was the

only time that Child O spent an extended period away from her family and her life in London.

7.1.6 Child O absolutely refused to permit or participate in any assessment process at Tumblewood - physical, psychological, educational or social. She also used the programme of “planning for independence” as another tool to distance herself from others. Some staff were defeated by this and could not engage with her but the IMR judges that the staff most regularly involved with Child O were not daunted. They saw dealing with her determined guardedness as part of the "work in progress".

7.1.7 The Tumblewood IMR seeks to understand this presentation as more than just a truculent refusal to co-operate. It suggests a fear of being judged and a fear that if she opened up about what she felt and what had happened to her, she would be exposed as damaged and vulnerable. She might be forced to see and accept herself in the way that she believed others saw her.

7.1.8 Child O struggled to accept that others found positive and admirable qualities in her. She needed close continuing contact from staff but at the same time she resisted that contact. At Tumblewood, despite the short and interrupted time she spent there, we see evidence of Child O as forceful and strong in demanding “independence”, and intelligent (while rejecting most educational “offers”). She could display mature thought and insight, warmth, generosity, a capacity for ordinary adolescent fun and an innate sense of justice and fairness.

7.1.9 The IMR from Tumblewood describes her as displaying the following characteristics:

- thoughtful and caring concern for others
- ability to make her own decisions and choices
- academic brightness and ability
- a readiness to participate and make a positive contribution
- love of animals
- respect for her living environment and surroundings

7.1.10 Child O’s time at Tumblewood is discussed further below and presents a mixed picture of progress and setback. But it is notable that there definitely was some purposeful activity and achievement: there was evidence there and at Crisis Care that Child O could enjoy the “ordinary” aspects of life as a young person.

7.2 Child O’s parents’ views of the services provided

7.2.1 Child O’s parents have been keen to participate in this review and have met the author of this report to share their views and experiences. Only one sibling now lives at home, a young person who remains deeply distressed by Child O’s death and has not been involved in this review.

7.2.2 Child O’s parents have been generous in their comments about individual members of staff, but forceful in describing their despair at the

succession of organisational barriers they faced in seeking ways to help their daughter. They believe that it was only ultimately because they instructed solicitors and involved their MP that the situation was unblocked. They are articulate professionals and are very aware that other parents might not have the contacts and the confidence on which they drew to pursue their case.

7.2.3 Child O's parents firmly believe that their daughter was sexually exploited when she was 11 or 12 and this was the root of her problems. Her father did not believe for some time that this had happened but now feels that it is definitely true. They report a number of comments made by Child O to her mother, especially in the summer of 2012, which support that view. They described aspects of Child O's personality – a girl who could be vain, a "smart aleck" – which they felt left her vulnerable to exploitation. They are frustrated that police consistently advised that no further criminal investigations could be pursued. They are aware that agencies' understanding of and responses to concerns about child sexual exploitation have changed significantly in recent years.

7.2.4 Frequent changes of personnel, especially at CYPS, were a source of frustration. Similarly they were repeatedly disappointed when the local authority responded slowly and repeatedly failed to provide any written explanation for their decisions and actions. These are significant weaknesses in basic service standards and are reflected in the recommendations from this report.

7.2.5 In their view Child O's time at the Priory was more useful than her admissions to Simmons House – they thought that the Priory was more structured and provided a security that Child O responded to. Crisis Care turned out to be a very good experience for Child O – she achieved things and enjoyed her time there. She grew to like being outdoors and the contact with animals, there and elsewhere, was always very important to her.

7.2.6 Child O's parents said they knew that Child O respected and had confidence in some of the staff at Tumblewood. They judged that some of the work done with Child O, especially in the early stages of the placement, was very positive, although securing Child O's trust was always a challenge. They feel strongly that the hiatus caused by Haringey's decision to withdraw funding and disrupt the placement significantly affected the stability of those arrangements.

7.3 Working with the family

7.3.1 Subsequent sections of this report will describe how each of the agencies approached their work with the family. Agencies are criticised for deficiencies in that work but it is right to put those concerns in context. There were aspects of the family's interactions with the agencies which made that work more challenging.

7.3.2 Child O's mother's professional background was a complicating factor. She is a health professional whose duties involve working with young people.

Inevitably she will have brought some of her experience and knowledge into her discussions with those caring for Child O. Her presentation can be forceful and some staff will have found the situation unusual and intimidating. They may have had unrealistic expectations of her. Some staff in the London services knew her both professionally and personally. It will have been equally challenging for Child O's mother herself to see that those roles and boundaries were clear and consistent, and to contribute fully to an exposition of the family's problems with people and agencies who were at other times colleagues.

7.3.3 Tumblewood also now take the view that they did not get their working relationship with the family right. Most importantly, right at the outset, *"the "rules of engagement" for the frequency of contact between mother and daughter and the collaboration and sharing of care concerns between Tumblewood and (the mother) appear not to have been sufficiently discussed and clarified".*

7.3.4 Child O's mother came to have far more day to day contact with her daughter and with staff at Tumblewood than staff were used to. Child O had to be given the room to settle and develop in her new environment. Yet staff never challenged this level of involvement on the basis that it might conflict with their therapeutic goals. They became too "friendly" with Child O's mother. The Tumblewood IMR describes this factor sensitively – it made the *"overall "degree of difficulty" of the placement and its management that much harder".*

7.3.5 For Tumblewood
"the mother and daughter relationship becomes the near exclusive focus" because father and siblings were rarely mentioned by Child O when she was at Tumblewood. On the occasions that she did talk of her siblings, during her time at Tumblewood, she did so with warmth and affection. We know that her brother's birthday had preoccupied her when she visited the railway tracks in December. On one occasion she reacted angrily to staff having spoken to her father but she never said anything negative about him to them.

7.3.6 Agencies in London also had far more contact with Child O's mother than her father. Given her professional background, it might be expected that she would take a lead role in communicating with agencies. However those agencies then too easily allowed themselves to be deflected from engaging with the family as a whole.

7.3.7 There were complexities in the family history. Child O's mother had spoken of earlier difficulties in her own life which were never explored with her. Child O had at times spoken negatively to staff in the London agencies about some family members, as well as expressing affection. One of her siblings displayed insight when talking to a social worker about Child O's self-harm and how it might demonstrate an attempt to gain control of herself and her situation. At one time Child O expressed respect for a sibling who had overcome personal difficulties and successfully pursued a challenging professional career. Similarly there is a report of Child O supporting a sibling

through emotional difficulties before that sibling went on to notable achievements in sport, representing the UK internationally. On another occasion there was a noted difference of opinion between Child O's mother and another of Child O's siblings as to whether the family could guarantee to keep Child O safe, the sibling feeling that this would require 24 hour supervision whereas Child O's mother was more sanguine.

7.3.8 The agencies' records contain passing references to information about family members, volunteered by the family, which might have been further explored but were not. One potentially significant issue – how the family could manage successfully to take long summer breaks together when Child O seemed otherwise so out of control – was never confronted. There was no comprehensive assessment which drew together and analysed all that was known about the family background in order to inform assessments of Child O's needs, the risks to which she was exposing herself and the extent to which her family could keep her safe.

7.4 The involvement of the Local Authority Designated Officer

7.4.1 There are concerns about how and how far the fact that Child O's mother was a health professional became inappropriately part of the discussions between agencies. Those concerns are highlighted in the involvement of the Local Authority Designated Officer (LADO).

7.4.2 The LADO is a statutory role within all local authorities, responsible for considering cases where it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child.
- possibly committed a criminal offence against children, or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

The location of the employment will determine which authority is responsible for providing LADO services.

7.4.3 There were two episodes in this case, almost exactly a year apart, in which a LADO became involved. In February 2011 the LADO for the area where Child O's mother worked, Islington, was approached after a Tier 4 Panel held at Simmons House. That approach was made by a manager in Islington's children's services who had attended the panel. This officer told the LADO that the treating psychiatrist had reported to the Panel that Child O had made allegations of physical abuse against her parents.

7.4.4 This was inappropriate. The reported allegation of physical abuse should have been made directly to the London Borough of Hackney, where the family lived, by the psychiatrist as soon as she became aware of it.

7.4.5 The LADO contacted the psychiatrist, stressing the difference between a child protection referral to the area where a child lives and a referral to the LADO in the area where a professional works. The LADO advised that the

first step should be for the doctor to make a formal referral to the London Borough of Hackney, so that they could investigate Child O's allegation of physical abuse. Hackney should then advise the LADO of their conclusions so that Islington could determine whether any investigations were necessary in respect of the mother's employment.

7.4.6 It is not clear whether the psychiatrist did now make a direct referral but a Hackney social worker did carry out an assessment. Child O would not confirm to the social worker the matters raised. Consequently the case was closed by Hackney and the Islington LADO properly took no further action.

7.4.7 In February 2012 the same LADO was contacted by a Haringey social worker – by now the family had moved to Haringey - to say that Child O had complained that her mother had hit her "when she was younger". The original source of this allegation is unclear and, similarly, it remains unclear whether it refers to anything that was not part of the earlier matter.

7.4.8 The LADO again advised that the responsible authority, now Haringey, should liaise with police and conduct their investigation, which would then inform the LADO's decision as to any action she should take. Eventually there was an investigation by Haringey CYPS which found no evidence of physical abuse. Consequently there was again no need for any action by the LADO.

7.4.9 The potential need for a LADO to be involved did add to the complexity of the case, and the events suggest a lack of understanding of the role and responsibilities of the LADO by some of the staff involved. In fact, evidence submitted to the SCR indicates this may be an enduring problem. It continues into the analysis by Whittington Health which comments that
"The LADO process for the mother seems to have been protracted over a long period of time and reliant on other agency decision making rather than providing an autonomous risk assessment".

7.4.10 In fact the Islington LADO dealt with the matters brought to her swiftly and with clarity. She subsequently provided a briefing session for some staff from Islington agencies to explain the requirements of the role. There is a recommendation from this report that similar arrangements are made in Haringey.

8. THE AGENCIES

8.1 London Borough of Haringey, Children's and Young People's Services

8.1.1 The London Borough of Haringey, for the purposes of this review, was responsible for providing children's social care services after the family moved into that locality in the summer of 2011.

8.1.2 The local authority was made aware of the family in early August 2011 but it was not until the end of October that there was a management decision that this should be a "referral" – that is, a continuing piece of work, to be dealt with in line with organisational and statutory requirements and timescales. This decision should be reached within 24 hours. There is no indication of any management oversight of the case in the early period of contact. Case recording was poor throughout (which has itself hampered the ability of CYPS now to analyse and explain the weaknesses in their responses).

8.1.3 During that period in 2011 there was no direct contact with the family. Importantly this meant that there was no attempt to gain the parents' permission to talk to other agencies and gather information, a fundamental requirement which should form part of the routine response to service requests. Equally there is no evidence of staff talking to Child O about her consent to gathering and sharing information.

8.1.4 This early failure to contact the family and seek to establish a working relationship with them then features repeatedly and significantly throughout the case history. Assessments and decisions were not shared and explained. Within the failure to involve Child O's parents there was a particular weakness in respect of her father.
"There is no evidence that father (was) engaged within the assessment or was encouraged to have a view (so that)….vital information about how the family functioned was lost".
The IMR notes that a failure to involve fathers in assessments and continuing work with families has frequently been identified in SCRs and similar exercises. That may be explained to some extent when fathers are absent or not significantly involved in family life. That was not the case here.

8.1.5 Reports such as this often reflect a failure to hear the "voice of the child". Child O was a difficult person to engage but there is little evidence of any well-directed efforts to do so by CYPS. The exception is the IRO, once Child O had been admitted to care, who can be seen to have advocated for Child O when the IRO disagreed with actions taken by senior managers.

8.1.6 Assessment of a family situation should be the bedrock on which continuing agency involvement is based. National guidance on how assessments should be conducted has become less prescriptive since these events but, at the time in question, there were standard requirements for CYPS assessments, with fixed timescales and quality standards.

8.1.7 Assessments carried out by CYPS in this case did not meet those requirements. They did not properly involve her family or other agencies. They were not thorough in establishing facts and analysing them. They reached unevidenced conclusions – dismissing, for example, early disclosures by Child O of sexual exploitation on the basis that they were incredible and probably a consequence of Child O's *"mental health issues".*

8.1.8 In particular
"No consideration was given to undertaking a risk assessment of the known and perceived risk being posed to Child O".
That risk assessment should have analysed and addressed the many threats to Child O's well-being – sexual exploitation, her own mental ill health, the extent to which her parents could keep her safe within and outside the home. Risk assessment was self-evidently key to working with Child O and is discussed separately below.

8.1.9 Assessment should lead to planning, action and review. Instead there was repeatedly confusion and inactivity. The first assessment concluded in December 2011 that Child O should be seen as a "child in need", to be followed up accordingly. Just over a month later there was a decision that the case be closed. No action had been taken by CYPS in the intervening period. The case was then immediately and without explanation re-opened but without any planning for how it was to be progressed. The management of the case appears to have been in disarray.

8.1.10 The proposal that Child O be admitted to the public care was being pressed by her mother and all the other agencies involved from at least January 2012. It is clear that it was consistently resisted by the local authority but not in a consistent way that can be easily followed.

8.1.11 In April 2012 the local authority wrote to other agencies advising that they accepted that
"Child O needs to be given the opportunity to live outside the family home and they would therefore*) explore a range of options".* However by July 2012 the local authority's position was that they would not admit Child O to care and that there should be a psychological assessment. There then seems to have been a change of position to an acceptance that there should be an admission to care. But, before any placement could be made, the local authority decided to seek a further opinion, from the Cassel Hospital. That opinion would be based on a full assessment which included Child O spending time at the Cassel.

8.1.12 This was a decision taken outside the normal arrangements for care planning and funding decisions. Case recording does not reflect the decision-making process but does note that the case was removed by the local authority from the agenda of the "Complex Cases" Panel. The rationale for the decision to approach the Cassel is questionable. It would produce at least a third opinion as the proposal for admission to care and a therapeutic placement was already supported by the psychiatrists at both the Priory and

at Simmons House, if not a fourth, as it was also supported by the commissioners, ICCG.

8.1.13 Child O and her family were caught in the middle of the dispute between the agencies as to whether and how this review by the Cassel should proceed. They were distrustful of the local authority's motives but reluctant to commit to any course of action which would cause further delay.

8.1.14 Eventually the clinician tasked with carrying out the review received *"a clear message (from the local authority) that the review had to proceed without the planned clinical assessment at the Cassel, or any direct contact between the patient and myself".*
The Cassel therefore produced a report based only on some information provided by CYPS, and discussions with the social worker and the Consultant Psychiatrists at the Priory and Simmons House.

8.1.15 That report offers some speculative insights into Child O's situation but concludes that
"I am unable to give a clinical opinion with any degree of confidence, as to whether this young woman is currently able to make use of a therapeutic environment, possibly away from London. I may well be able to get a clearer clinical picture of her, if I could see her for a consultation, although given the degree of difference of opinions, this is by no means certain".
The report therefore suggests that the "status quo" is maintained while the various agencies involved were persuaded to work together to support the Cassell's review. That suggestion was not accepted by the agencies.

8.1.16 At this point - it was now November 2012 - it appears that the local authority decided no longer to contest the views of the other agencies. The family say that by this time they had mobilised the support of their MP and local politicians and that it was in the face of these pressures that the local authority agreed to proceed with a residential placement.

8.1.17 It is hard to escape the conclusion that this succession of delays was at least in part fuelled by the financial implications for the local authority of an admission to a very specialised, very expensive placement. Of course it is right that the local authority and its officers should be diligent about expenditure, which in these circumstances would be considerable, and that any concerns about the effectiveness of such a placement should be fully explored.

8.1.18 But the evidence in this case suggests something more than that. The need for Child O to be admitted to the public care was demonstrable from early in 2012. The family and all the other agencies involved felt that this was appropriate at that time. Child O herself may have welcomed and certainly did not resist the proposal. This is not to say that such a step would ultimately have successfully addressed her problems, or prevented the tragic events leading to this review. But, even in situations where officers are genuinely doubtful that admission to care will be a successful step, it is still sometimes a

step that has to be taken, because there is no better alternative. This was such a situation.

8.1.19 Child O was eventually accommodated under s.20 Children Act 1989 in March 2013, some fifteen months after her family and other agencies had started to press for this. However some disorganisation in the management of the case persisted. The IRO felt it necessary to use formal processes to challenge drift and delay in organising a statutory review of the case.

8.1.20 The unsatisfactory management of the case continued when, in 2013, CYPS decided to terminate or suspend the placement at Tumblewood, firstly in response to the Ofsted findings and then because Child O was away from the placement for an extended period on holiday with her family. Attempts were made, unsuccessfully, by CYPS to speak directly to the family on holiday to inform them of the decisions but they were decisions that had already been taken, without reference to the family or any other agency, including the ICCG which was jointly funding the placement.

8.1.21 Clearly the local authority did need to respond to the Ofsted findings and consider its position. The consequences of their subsequent decisions, and the way they were managed, need to be contextualised and seen in perspective. The impact on Child O's engagement with therapeutic processes should not be exaggerated – the strength of that engagement had been a cause for concern from an early point in the placement. In effect she ended up spending only three extra weeks away from the placement after returning from the long family holiday.

8.1.22 However the local authority's actions are certainly likely to have further unsettled Child O and compounded her dissociation from the placement. The failure to identify and tackle that dissociation had already been evidenced in the time she was allowed to spend away from Tumblewood and her partial engagement, on her terms, with the placement's programme.

8.1.23 The local authority's decisions and the way they were executed displayed a lack of good judgment, achieving nothing positive. They upset Child O and her family, creating an immediately difficult and uncertain situation for them, as well as displaying a disregard of the requirement to work co-operatively with the other agencies. There was no reason why these decisions had to be taken while the family was away on holiday. There was no indication of immediate risk of harm to Child O if she were to return to Tumblewood. Indeed the local authority was in breach of statutory responsibilities in taking this action before consulting the family. Once they did meet the family Child O was insistent that she wanted to return.

8.1.24 There was at the time, and this is still the case, no formal policy in Haringey that a residential placement must have an Ofsted rating of "good" or better, at point of placement or thereafter. Even if this was an "unwritten" policy there is a distinction between not making a placement and disrupting a placement that had already been made. In the circumstances of this case one would expect that Child O would return to placement and there would be an

immediate statutory review to consider the changed situation, assess risk and plan accordingly, with the involvement of the family and all funding partners. Local authority managers did not have to take the position they adopted. They were guided by organisational and/or financial imperatives, not the best interests of this child.

8.1.25 Equally the local authority failed to consult with the IRO who, once made aware of the decision, registered her concerns. However the IRO did not formally challenge the decision using the statutory powers[13] available to her. It would have been appropriate at least to initiate a formal "local dispute resolution process" which would have sought to resolve the problem within 20 days. In these circumstances, which were serious, it may have been appropriate for the IRO to exercise her power to refer the matter to CAFCASS. It would also have been right to ensure that Child O was fully informed of her rights – to seek separate legal advice and to have access to an advocate. The IRO's response to these circumstances was well-intentioned but not sufficiently thorough and there is consequently a recommendation from this report.

8.1.26 Under its own procedures the local authority should also have organised a "disruption meeting". Those procedures require that *"Disruption Meetings should be convened in relation to children whose placement in a children's home or foster care has ended abruptly or on an unplanned basis".*
This placement had certainly been brought to an abrupt ending. There is also no evidence that the administrative requirements arising from the decision were satisfied. Even if the placement were "suspended" rather than terminated, Child O's status as a Looked After Child could not be "suspended". This should have sparked a number of procedures and notifications but this did not happen.

8.1.27 There is no evidence of the authority initiating any sort of re-assessment or taking any action to identify an alternative placement. Their proposal of organising a "day carer" was predictably rejected both by Child O and her family.

8.1.28 There was a continuing lack of thoroughness or consistency when the local authority decided that Child O should return to Tumblewood. If she had, "technically" or otherwise, spent a period when she was not in the care of the local authority then there should be evidence of all the formal requirements of a re-admission to care, including placement planning arrangements and the associated statutory documentation. There is no such evidence and Child O was simply allowed to return to Tumblewood.

8.1.29 Negotiations now took place for this to be a "39 week placement" – that is, a placement which broadly coincides with school terms, rather than being a 52 week commitment for the funding agencies. This was not resisted by Child O's family. They could hardly do so when she was spending so much time at

[13] https://www.gov.uk/government/publications/independent-reviewing-officers-handbook

home and away with them throughout the summer. However it is not an unusual arrangement and should have been considered when Child O initially went to Tumblewood. This is further evidence of the need for more thorough inter-agency arrangements for tackling situations such as this.

8.1.30 The report from CYPS to this review advises that, following the initiation of this SCR, their service was inspected by Ofsted. Ofsted judged that the Department "requires improvement", concluding that there were:
"…no widespread or serious failures that create or leave children being harmed or at risk of harm (but)… the authority is not yet delivering good protection and help and care for children, young people and families[14]*"*

8.1.31 CYPS has now put in place an Improvement Action Plan, which is part of the Council's wider improvement work, currently being delivered as part of a transformation programme known as "Haringey 54,000". The IMR advises that significant organisational changes are already underway.

8.1.32 The IMR also advises that one of the cornerstones of the improvement programme is an aim to
"ensure earlier support and better outcomes for families to prevent the need for more costly services later in a young person's life".
That is an aim with which no-one would disagree. However there are some young people who will always need these "*costly services*". CYPS were slow and reluctant to identify Child O as one such person. The local authority needs to ensure that its improvement programme does not repeat or compound the failures evidenced in this review.

8.2 Tumblewood

8.2.1 Tumblewood is a residential therapeutic service for girls, aged 11 to 18, who have serious emotional and psychological problems affecting their development and life chances. It seeks to offer these young people an integrated programme of care, education and therapy, aiming to equip them to reintegrate safely into their local communities and society. It was Child O's placement from June 2013 until her death.

8.2.2 Tumblewood recognised and did not under-estimate the level of Child O's unhappiness and disturbance, and the complexity of her troubled relationship with her family. As with every other agency
"she determinedly refused at all times to provide any details of… information that would have assisted the investigation of her allegations and her protection".
At the same time, following on from her positive time at Crisis Care, it is the information from Tumblewood that presents the best picture from any agency of Child O, including her positive qualities, her thoughtful and caring side.

8.2.3 Four key objectives for this placement were identified:

[14] Single Inspection of LA children's services & review of the LSCB Ofsted 2014.pdf

- *“to give her the experience of living and being looked after as a child not a patient {Care]*
- *to support her to develop trust in and trusting relationships with others and to communicate and explore her feelings with those she comes to trust [Mental Health]*
- *to enable her to achieve her potential and progress as a student [Education]*
- *To help her both to acquire the necessary skills for living independently and to develop her capacity to manage herself safely and without fear when she returns home and to her local community [Independence]”.*

8.2.4 These are sensible and comprehensive aims but the IMR notes how, over time, tensions emerged between those objectives, and in relation to how they were balanced and prioritised.
“The … needs of Child O for that experience of care as a looked after child and for clear attention to strengthening her mental and emotional health often were overtaken in priority by the education and independence objectives”.

8.2.5 Child O was at Tumblewood for about seven weeks in June/July 2013 before going on holiday to America for the summer. During that initial period there is evidence that she settled, enjoyed aspects of the placement and largely responded well to the expectations that Tumblewood had of her.
“Numerous comments are recorded highlighting her high level of engagement in her individual, educational and group experiences in the programme”.
The response to educational input is encouraging after so long away from any educational provision.

8.2.6 However there were also early signs of a less positive engagement. Child O started a pattern of long walks on her own without complying with arrangements made for her to return by a certain time. On her return from her first weekend at home, some four weeks after placement, she took to her bed, saying that she was unwell, and missing four days at school. This marks the start of another pattern, of her saying that she was unwell in advance of and following a period at home. There was also a
“resistance to any kind of “examination” – physical, educational, psychological, social care or, in her view, therapeutic – (which) will loom prominently across the whole period of her placement”.
There was also some evidence now of resistance to communal living and she insisted on changing the date of a formal review so that she effectively avoided a significant communal event.

8.2.7 Soon after she went on holiday to America Tumblewood had the Ofsted inspection which resulted in Child O not returning as planned. This meant that after spending seven reasonably successful weeks at Tumblewood, she was away for an extended period. The time Child O actually spent overall at Tumblewood was too brief and was frequently disrupted by weekends and long holidays. She only spent around half of the seven months of her placement actually in residence at Tumblewood:

" She missed many important experiences, like planned project activities, Community celebrations, regular weekend routines and the spontaneous informal interactions between and amongst staff and young people. These latter occasions contribute so much to the culture of group living and to the internalisation of that culture by newer residents".

8.2.8 The absences also served to undermine the attempts to address Child O's self-harming behaviour. The National Institute for Clinical Excellence[15] recommends a long term approach of developing
"trusting, supportive and engaging relationships"
working with the young person to develop strategies to avoid such behaviour. This approach was very difficult to establish when her time at Tumblewood was so frequently interrupted.

8.2.9 At first Child O was positive about returning to Tumblewood after the summer but staff soon noted that her enthusiasm had waned. There were long periods when she reported that she was unwell but refused to see a doctor, and times when she said she was unable to participate in education and other activities but chose to take part in activities that she enjoyed. The IMR judges that her re-integration into that community could have been better planned and executed.

8.2.10 In October Child O had an argument with her house mate who, she said, had eaten some of her food. Child O's unhappiness about this incident dragged on for some months, despite the attempts of staff to resolve it. She and the other girl stopped sharing accommodation but staff noted her determination not to let the matter rest, or be resolved.

8.2.11 A difficulty arose in relation to the psychiatric input into the management of Child O's care. She had started seeing a psychiatrist at Tumblewood but both she and her mother asked if she could also continue to see the previous psychiatrist at the Priory. The psychiatrist from the Priory refused advising that this would be neither practical nor desirable, as psychiatric input needed to be part of the overall "package" at Tumblewood. It is disappointing to learn that the attempts of the Tumblewood psychiatrist to discuss the case with the previous psychiatrist met with no response from the Priory.

8.2.12 Later in October there was an incident in which Child O went into what she herself called "meltdown" – she became very disorientated, distressed and fearful, in a "trance-like" state, for no apparent immediate reason. Staff struggled to reassure her and "bring her back". Child O could offer no explanation for what might have caused this. This was to happen on a number of subsequent occasions, accompanied by self-harming behaviour.

8.2.13 Despite this the psychiatrist reports evidence of Child O engaging positively and trying to explain her difficulties to him, albeit in her characteristically guarded way. From the beginning of November they met

[15] NICE guidance

each fortnight, the last occasion being a week before her death. She also separately began weekly individual psychotherapy.

8.2.14 Unfortunately her overall situation was complicated when she developed a painful medical condition, an inflammation of the cartilage joining the ribs. This led to a presentation at A&E and required continuing management. The IMR comments that there is
"no doubt that Child O was regularly unwell physically …(but) the real issue is whether there was a deeper source to her illnesses that often made her feel so frail".
This comment captures both how unwell this girl was, and how, even now, we have very little understanding of the causation of that ill health.

8.2.15 In December the difficulties with her previous house-mate resurfaced and culminated in Child O assaulting her. Staff at Tumblewood thought she was bullying the other girl. Child O would accept no responsibility for the incident, entirely blaming the other girl. This dispute remained an unresolved issue until the day of her death and the IMR judges that it would have been preferable to find a way of bringing it to a conclusion:
"managers could have said to her that …while in their judgement her behaviour was clearly unacceptable, it was equally clear that she was neither prepared nor able to acknowledge this. Therefore they would leave the matter "on file" until some time in the future when she was likely to be more able to consider the more difficult parts of herself".

8.2.16 It was after the assault in December that Child O went to sit by railway tracks. She disclosed this nine days later after a self-harming incident. That self-harm – a deep, bloody scratch to her face - distracted staff attention from the previous events, including the disclosure, and the more immediate concerns became their focus.

8.2.17 Consequently that episode of going to the railway tracks was never discussed with Child O and it was not taken into account when risk assessments were reviewed. Nor was it flagged up in the establishment's routine arrangements for staff feedback and briefings. Child O may not have responded to overtures from staff about the incident but it was a missed opportunity to try to engage with her. The incident of course now takes on a particular significance in the light of the circumstances of her death.

8.2.18 Over the following weeks Child O presented essentially the same mixed picture. She contributed enthusiastically to some activities but on her own terms – so that there were many community expectations with which she consistently refused to comply. She would not participate in educational activities and completely refused to allow psychological testing, a fundamental part of the programme at Tumblewood. She cut herself repeatedly and generally refused to allow staff to see or help her in treating the wounds. Yet her psychiatrist felt that there was evidence of her trying to understand and tackle her condition. Staff also found other examples of her "opening up" and talking about her emotions.

8.2.19 There were continuing indications that Child O's health was precarious. She took to a salad-only diet and was found to be purchasing "slimming pills" via the internet (which Tumblewood intercepted). She spoke to the psychiatrist about intrusive thoughts but refused to give any details, saying this would lead to her being detained under the Mental Health Act. Her mother also wondered, in conversation with staff, whether she might need to be in hospital.

8.2.20 The psychiatrist and staff at Tumblewood considered this and decided that there were enough positive factors for them to continue to try to work with her in the residential setting. She was co-operating with some aspects of the programme, was building strong relationships with some staff and was deeply hostile to the idea of re-admission to hospital.

8.2.21 That position was endorsed at a statutory Looked After Child review, where she was also pleased with decisions to attempt a different educational programme, with an emphasis on vocational training and animal care. The IMR judges that this decision about her education might have been taken sooner as the pressure to achieve academically was difficult for Child O to manage. However records from those days before and after that last LAC review describe her as relaxed and happy with occasional short-lived difficulties.

8.2.22 On the day of her death Child O did not behave unusually and in the evening, as she often did, she remained in her room rather than joining in any activities. However, during the evening, staff discovered that, during a 90 minute period when she was on her own, she had gone out leaving a note that she intended to take her own life. The note stated that she loved her family very much, they should not blame themselves but should carry on with their lives and be happy. She attributed her actions to the "*bastards*", unidentified, who had harmed her.

8.2.23 Some broad themes emerge from the analysis of her stay at Tumblewood in the IMR, which is detailed and thoughtful. The extent of time she spent away from the placement and her consequent marginalisation from the overall approach at Tumblewood is emphasised:
"Such a setting designed intentionally to embed participants in the whole experience of living and learning together, especially when the resident has been …assessed as too unwell to make use of family or community based services. The costs of the absences from the community and… the visits home were too great".

8.2.24 Looking at the way in which the placement was set up and launched, the IMR finds that the overall goals set may have been too imprecise and that there was then a
"lack of a robust process for the production and testing of desired and agreed placement objectives".
Staff were sometimes tentative about challenging Child O who, from the outset, was very selective in the activities to which she would commit herself. She was allowed from a very early stage to develop the habit of taking long,

solitary walks, without reference to the overall strategy for promoting her independence. The IMR recommends a detailed review of the establishment's Independence Programme to clarify its structure and implementation and how these are negotiated in detail between staff and young people.

8.2.25 The IMR also comments on the way in which the home worked with Child O's mother who was in very frequent contact with them. This degree of contact from a parent was unusual and staff, apart from the Directors of the establishment, had little experience of working with parents who actively sought to be involved. As discussed above, her mother's own professional background may also have affected these relationships, so that the line between her as a parent and her as a professional became blurred at times.

8.2.26 The nature and extent of her mother's involvement, which developed rather than being agreed, along with the amount of time Child O spent away from the placement, will all have inhibited the development of the supportive, trusting relationship Tumblewood sought to establish. Overall the population of residents has changed – prior to 2013 it was rare for any girl to have close contact with their family. The service accepts that it has not kept pace with this and needs to redesign aspects of their work accordingly. It is clear that there has been a rigorous self-examination of the practices at the home.

8.2.27 Staff feel that they were slowly making progress with Child O. The independent IMR author felt also that several key members of staff did grasp the complexity of Child O's condition and needs, and that she was starting to trust them. This achievement with such a deeply troubled, conflicted and suspicious young person should not be underestimated.

8.2.28 There are now very few therapeutic residential care homes which would consider looking after a child whose health and well-being were as precarious as Child O's. One other similar service considered whether it could help Child O and decided that it could not. While it is now, with hindsight, clearer that a different, perhaps more controlling, approach might have been used, the decision to place Child O at Tumblewood was appropriate.

8.3 NHS Islington Clinical Commissioning Group

8.3.1 ICCG was the part of the NHS responsible for commissioning health services for Child O from April 2013. This was because Child O had a GP in the London Borough of Islington although the family now lived in the neighbouring borough of Haringey. Before April 2013 her health care was the responsibility of a predecessor organisation, Islington Primary Care Trust (IPCT). The staff actually dealing with the situation were unchanged throughout. This section of this report addresses the involvement of both ICCG and ICPT

8.3.2 IPCT started commissioning and funding specialist care for Child O from December 2010, when she was admitted, first to the Priory, and then to Simmons House. She was to remain technically an in-patient, apart from a few days at home in June, until the summer of 2011, when the family went on

holiday to America. Soon after their return she was readmitted to hospital. This marked the beginning of the chain of “negotiations” between health services, in both Islington and Haringey, and local authority services in Haringey about her placement needs and how they would be funded.

8.3.3 The IMR describes in detail the many meetings and discussions which took place between early 2012 and June 2013 when Child O moved to Tumblewood. The principal cause of this long delay was the position taken by the local authority which has been discussed above. A lesser but also troubling factor was the extent to which the NHS and local authorities struggled to accommodate the consequences of the family living in Haringey but having a GP in Islington.

8.3.4 The IMR explains the bureaucracies involved, which are too dense to set out in this report. Various Panels and decision-making processes became involved without adequate and sensible reference to each other. This “cross-borough” issue became a significant obstacle to planning and delivering the care that Child O needed. There were even discussions between health commissioners and practitioners about asking the family to transfer to a Haringey GP, so that Islington commissioners would no longer be involved. Some staff pointed out at the time that to suggest a change of GP merely to fall into line with the bureaucracy of funding arrangements would be quite wrong.

8.3.5 In 2012, in a different part of London, a teenage boy took his own life. This led to a SCR, in which the Overview Report[16] was written by the author of this report. That report commented on the fact that the family was unable to access the most convenient and appropriate mental health services, despite the best efforts of their GP, because, again, there was a local authority boundary between them and their GP. There may be ways round this, and the IMR makes an appropriate recommendation, but it appears to be a problem which could recur elsewhere. There is consequently a broader recommendation from this report.

8.3.6 Overall the ICCG staff displayed a strong commitment to achieving the best solution for this family. As the IMR comments
“both the senior commissioning manager and the commissioning manager continually chased and followed areas of concern. They took those concerns to the appropriate people and were aware of and took seriously their responsibilities. They demonstrated a clear focus upon the needs and best interests of Child O throughout”.

8.3.7 However the IMR, which is thorough, points out that formal arrangements for the escalation of cases to increasingly senior levels were not used. This is a frequent finding in SCRs, and so significant in this case that it is discussed separately below.

[16] Sutton Local Safeguarding Children Board Child Be Executive Summary of a Serious Case Review

8.4 The Priory Hospital North London Adolescent Unit

8.4.1 This is a Tier 4 service in which places are commissioned by NHS England specialist commissioning teams. The Unit accommodates up to 18 young people between 12 and 18 years of age as inpatients, and can facilitate day services where clinically appropriate. The unit is mixed gender and accepts young people both on an informal basis and when detained under the Mental Health Act. It was where Child O went when her mental health first required a hospital admission.

8.4.2 Child O was admitted to the Priory on three occasions:

- December 2010 to January 2011
- September 2011 to February 2012
- June 2012 to March 2013

Child O would normally have been admitted to Simmons House, a local NHS in-patient facility. The Priory was used as an "overspill" provision and, on her first two admissions, she was recalled to Simmons House when a bed became available there. On the third occasion Child O refused to be admitted to Simmons House and it was agreed at the outset that she would remain at the Priory until she could be discharged.

8.4.3 The IMR stresses that these overspill arrangements are fundamentally unsatisfactory for such vulnerable young people. Knowing that they are likely to be moved back from the Priory to NHS provision possibly
"compounds …negative feelings, low confidence, low self-esteem and lack of stability".
The fact that Child O refused re-admission to Simmons House in June 2012 might be evidence of that. At the same time the determination of how far such a specialist resource can be immediately available must be a challenge for commissioners. The rationale for a "back up" arrangement is understandable.

8.4.4 There is evidence of incomplete recording of events and analysis by the Priory:
"there are no detailed handovers regarding the family or family relationship. There are limited notes relating to Child O …it remains difficult to ascertain in any great detail an understanding of this family".
The IMR suggests that this may be because information was not shared by other agencies or by the family, though it also arises from unsatisfactory practice at the hospital. That is supported by a subsequent comment in the report that
"there is no significant information known about Child O's parents and her other family members. There is no detailed account of the family background (when)… I would expect all patients to have a comprehensive assessment … available to inform interventions, therapies or treatment, but more importantly to understand the view of the child and where they are coming from. This information is not evident in the documents reviewed".

8.4.5 In any event this means that our understanding of the care offered by the Priory is incomplete. There is little useful information about the hospital's

use of the Care Programme Approach (CPA), the statutory arrangement across agencies for planning the care of someone with mental health needs. It is recorded that CPA meetings took place but it is not clear that these meetings contributed to a clear and well understood approach to working with Child O.

8.4.6 It is well documented that Child O consistently failed to engage with services offered, both individually and in group settings, although many therapeutic interventions were attempted. That lack of engagement was compounded by the extent to which Child O was not actually on the wards. She spent long periods at home and otherwise away from the hospital. This lack of engagement continued and escalated throughout her time at the Priory (and, as we have seen, beyond that).

8.4.7 The IMR reports that
"there are clear records of risk assessments and management plans which reflect Child O's individual needs…The risk assessment process demonstrably informed the management of risk, and enabled the nursing and medical team to maintain Child O's safety. Child O was heavily involved in her care plans".
In fact the most well evidenced finding is of Child O's determination not to engage with the services offered. This was despite having spent in total over a year at the Priory, a range of interventions being attempted and the clearly evidenced commitment of the Consultant Psychiatrist leading the attempts to help her.

8.4.8 One of the interventions offered at the Priory was a programme of family therapy. Child O refused to participate, as did her only sibling still living at home. They had similarly declined when family therapy was suggested at Simmons House. Her parents had attended meetings at Simmons House but felt they had not been useful and that there was no point in going through this again at the Priory.

8.5 Whittington Health

8.5.1 This IMR considers the contact Child O and her family had with services managed by Whittington Health, namely Islington CAMHS, the Whittington Hospital and, most significantly, Simmons House, where she spent the periods from February to July, 2011, and February to June 2012. Simmons House is an in-patient and day-patient psychiatric unit for young people between 13 to 17 years of age. The unit has places for a maximum of 12 young people of whom ten can be resident.

8.5.2 It was during Child O's first admission to Simmons House that information began to emerge suggesting that the causation of her disturbance might include some sort of sexual abuse or exploitation, probably dating from when she was aged 11 or 12 years old. Staff properly sought to explore whether she might have been abused within her family. She explicitly told staff that she had not, and consistently asserted this throughout the period under review.

8.5.3 Evidence that Child O was associating with people who might represent a threat to her was also confirmed during this first admission. In June 2011 police from Croydon contacted the hospital advising that a man detained in custody under the Mental Health Act wanted to speak to Child O. It is clearly significant that this fourteen year old child was apparently linked to someone, on the other side of London, who might represent a threat to her. Yet this was noted by an agency nurse without leading to any further action.

8.5.4 There was a similar cause for concern during Child O's brief admission to the Whittington Hospital in June 2012. At one point it appears that Child O spoke to a student nurse about difficult relationships with family members. Again a written record of this was made but there was no further action. This junior nurse may have not understood the potential significance of highlighting this matter.

8.5.5 Once agencies became embroiled in the long dispute about placement and funding responsibility, this became the principal focus of attention. Securing a therapeutic placement seems to have become the only solution envisaged, and there is little evidence of attempts or plans for reducing the continuing risks to Child O. Senior staff felt Child O needed to be placed elsewhere and they may have become less robust in trying to sustain better engagement in education and therapy at Simmons House.

8.5.6 The management of this case by the Whittington gives cause for concern. The IMR contains no reference to CPA arrangements. There is no documented evidence of the Named Nurse for Child Protection being approached for advice or giving any advice. In-house safeguarding supervision was provided by the Simmons House Safeguarding Lead but was not formally documented. Safeguarding supervision did not lead to an escalation of concerns to members of the Safeguarding Team outside Simmons House and, overall, was not adequate to the issues this case raised. This is particularly disappointing in such a complex case where the nature and aetiology of Child O's presentation was – and remains – unexplained.

8.5.7 An issue of concern which emerged first at Simmons House is the amount of time actually spent in placement. The apparent contradiction between Child O's need to be away from her family and the time she then spent with her family, including extended trips abroad, was not adequately challenged. From Simmons House she appears to have spent as much time at home as she wished, and there is no indication of this being actively managed. It again demonstrates how far Child O was successful in imposing her own terms and conditions on the services she received and used.

8.5.8 Child O was an in-patient in Simmons House for, in total, nearly a year yet there is little documented evidence of staff being successful in forming relationships with her. It would not have been easy to do so - she had a well developed ability to keep her distance. But it is disappointing not to see this dynamic being recognised and challenged, as the opportunity to do so was

one of the benefits offered by in-patient care. Instead, as is repeatedly the case, what emerges is a picture of Child O "calling the shots".

8.5.9 Once Child O was in local authority care Whittington Health took on additional responsibilities as they are responsible for input into monitoring and promoting the health of young people in care to Haringey. Child O refused to be seen for the statutory Initial Health Assessment and so these services also did not work well. The information gathered is fragmented and there was no clear plan for the oversight of Child O's health.

8.5.10 The IMR does helpfully pick up the issue of the use of the Strength and Difficulties Questionnaire[17] (SDQ). This is a brief and basic behavioural screening questionnaire for children and young people. It exists in several versions and aims to measure psychological well-being and screen for the risk of mental ill health. It is very widely used across the country.

8.5.11 When used here, in May 2013, it found a 'risk of developing mental health difficulties', a pointless conclusion for a child who had already had such substantial contact with mental health services. The completion of the SDQ is often built into routine procedures but, as here, it can be a waste of professional time and needs to be used in a more targeted way.

8.6 Child O's education

8.6.1 The first information received by the review about Child O's education was when she commenced in Year 9 at a school in central London in September 2010.Limited information was available to the review regarding the reason for a transfer of school other than needing a "fresh start". The new school also had limited information about her previous education history and any previous contact with support services. This would have better equipped them to respond to the problems ahead.

8.6.2 The scale of Child O's problems emerged quickly. She was on (authorised) absence for over 20% of the first term. The school sought to support her through counselling and input from the school nurse. During November Child O's mother reported feeling that progress was being made. Before Christmas 2010 however Child O's first admission to in-patient psychiatric care had taken place. Her school started to provide work for her to do in hospital but effectively her formal education was already coming to an end.

8.6.3 While in hospital during 2011 there were discussions about Child O's re-integration to school but these were generally thwarted as her difficulties persisted. In early September of that year a plan was put in place to support her return to mainstream school but her attendance lasted only a few weeks before she was re-admitted to the Priory. After that she never returned to

[17] Although identified in this IMR these arrangements are not commissioned by Whittington Health but by the local authority, and provided by the Tavistock and Portman NHS Foundation Trust).

mainstream education and she did not successfully engage with any educational provision until she went to Tumblewood.

8.6.4 Child O's engagement with School B was so limited that there is little to say about the way they approached such a troubled girl. The IMR appropriately judges that
"Potential benefits could have been achieved through a pre admission multiagency meeting to capture more detail about Child O's educational history and to inform plans to support her admission to the school".
That report also notes that there is government guidance for schools when their pupils will be away for extended periods, but that this was not referred to. As is the case throughout this review the fact that there was more than one local authority involved – the family was living in Hackney while the school was in central London – compounded the challenges faced by agencies.

8.6.5 Overall this review accepted the IMR's conclusion that
"The school provided the best opportunity they could to maximise Child O's smooth transfer into the school. However the information they had about her past educational, medical and family history was limited. Whilst this may not have had a bearing on decision making … in the longer term it could have made a difference to sustaining her engagement…".

8.6.6 There is less evidence that Child O's education was vigorously pursued while she was in the 2 hospitals in London. Education should form a key part of CPA planning, especially for a young person of statutory school attendance age. The hospitals have not demonstrated that it was given an adequate priority. This must have been a factor in Child O's subsequent struggle to comply with educational provision at Tumblewood.

8.6.7 It is reported that records of educational provision made for Child O when she was in Simmons House in 2011 were considered at weekly ward rounds but these records have not been found. There are partial, disjointed notes, some of which are inaccurate, from her time there in 2012. Those notes suggest that Child O generally rejected attempts to involve her in educational activity.

8.6.8 During Child O's time in Simmons House in 2012 there was an occasion when she was noted by teaching staff to have facial bruising which she was apparently trying to conceal with her hair. This was recorded, and it was said to have been caused by Child O banging her head but there is no evidence that it was followed up appropriately under safeguarding arrangements.

8.6.9 Similarly the Priory has provided no information on Child O's education prior to June 2012. From that point Child O was consistently uncooperative with attempts by Priory staff to provide an education. She declined consent for the staff to contact her former school. She showed some interest in art and music but her attendance level was 30-40% at best.

8.6.10 The records kept of Child O's education in hospital also presage some of the management issues that were evidenced at Tumblewood. She was

particular about the activities with which she was prepared to co-operate, and often reluctant to work co-operatively with teaching staff. Her insecurity is acutely captured in her shrewd response to staff asking what she had to lose by taking an exam - "*my last remaining shred of self-confidence*".

8.6.11 Education has already been identified as a priority by the LSCB in its work over the coming year, but the specific issue of the education of children in hospital has not previously been highlighted. This review has not received much information about how well Child O engaged with educational provision in hospital and how well any problems were addressed. However, the Coroner found that
"It is quite clear from the expert opinion evidence that I have read Child O's educational needs in particular were not being satisfied in either Simmons House or the Priory"

8.6.12 There is consequently a recommendation from this report, which also addresses the issue of compliance with child protection requirements, in respect of the facial bruising that was not followed up.

8.7 Crisis Care

8.7.1 Crisis Care is an independent sector service offering assessments and residential placements which include the use of adventurous activities and outdoor pursuits in a very rural setting. Child O stayed at Crisis Care, in Shropshire, between March and June 2013, when she moved to Tumblewood.

8.7.2 This appears to have been an unusually calm and settled period for Child O. Apart from some minor self inflicted injuries – scratches to her face and hands – there were no incidents of concern during her time there. She engaged well with staff and participated in all activities. This included the educational services provided despite some initial reluctance on her part. She had not attended a school for some two years – but she
"made significant progress in this area and achieved a number of AQA[18] short course awards"
The IMR notes that
"Child O wrote to Crisis Care once she left and spoke to staff when they were at Tumblewood with another young person. She had very positive relationships and memories of her time at Crisis Care".

8.7.3 It is striking that Child O settled well and was able to demonstrate real achievements here, with little evidence of self-harm. This was the longest period – 11 weeks – that Child O spent away from London and her family during the period under review. Crisis Care is in a very rural setting and young people are not allowed access to mobile phones, and to the internet only for educational purposes. They advise that

[18] AQA is an independent education charity and the largest provider of academic qualifications taught in schools and colleges.

"The reason for such tight controls is due to the nature of the placement being a crisis intervention placement, often young people placed have experienced multiple placement breakdowns and their care history has been chaotic and risks are elevated".
As discussed above the view at Tumblewood now is that it would have been better to insist on a similar approach, an extended period without returning to her home, when she came to them.

8.7.4 The only unsatisfactory matter raised by Crisis Care is that the local authority did not provide all the relevant and necessary documentation to accompany a young person being admitted to care, and this was not resolved before she left the placement. This is a matter of concern for the local authority as well as the receiving placement and leads to a recommendation from this report.

8.8 Metropolitan Police Service

8.8.1 The MPS had no substantial involvement in these matters but has reported on the following episodes which are significant.

8.8.2 In the summer of 2011 Child O's mother reported to police that Child O had returned home the previous evening with facial injuries. She had told her mother that a man had hit her but she did not want police to be involved. Her mother did make a report to police and the Initial Investigating Officer (IIO) made enquiries with CCTV from around the Finsbury Park area, but no assault/incident was seen, and there was no other corroborative evidence. The IIO submitted a report to the Borough Intelligence Unit, so that, should there be any other reports in the area, the relevant department would be made aware. As Child O did not allege any offences, refused to speak to police and would not disclose anything further to her family, the case was closed. Police spoke again with Child O's mother who expressed her concern that her daughter was being abused and exploited by someone living in that area. Child O's parents remain frustrated that this investigation came to nothing. They feel that there are investigative opportunities that were not fully explored but police contest this.

8.8.3 In November 2011 CYPS made a referral to the Sapphire unit of the MPS, advising that Child O's mother had spoken of her daughter being involved with an older man. CYPS had no further detail and were advised that there was no action that could be taken on the basis of this minimal information: they should make further enquiries and re-refer as necessary This advice was appropriate at that time but the police officer dealing did not, as she should have done, complete a MERLIN – the routine recording and notification to other agencies of police involvement with a young person. Police have advised that this matter has been followed up.

8.8.4 Sapphire were again involved in January 2012 when they received a further referral from CYPS. This contained a letter written by Child O to a former fellow pupil. The IMR advises that

"Within the letter she describes an incident 3 years prior where she claims to have been abducted from a street, taken into a park, beaten and raped. It further describes how she was forced to have sex with a variety of men, drink alcohol, giving birth to a child as well as experiencing numerous pregnancies and miscarriages".

8.8.5 This referral was not appropriately dealt with by the Sapphire officer who received it. He decided not to take any action, emailing CYPS to say that he *"…would need to establish if (the child) wishes police to investigate and would be willing to speak to a sexually offences trained officer and if so what her mental state of mind is at this time".*
The letter itself was not kept by police. The officer made no formal record of these matters on any MPS information systems although the content of this letter, whatever its veracity, should have led to immediate action under child protection arrangements. Police and CYPS should have had a formal, recorded strategy discussion to agree how this would be investigated and by whom.

8.8.6 This officer was unavailable during the course of the SCR, so there is no clear explanation for the action taken. It may be that the officer was unaware of formal child protection requirements, saw this solely as an unsubstantiated allegation and made a serious error of judgment.

8.8.7 However there was a further incident involving police in June 2012. Police were called to the family home after the incident where Child O had shot herself with a BB gun. While in attendance her mother repeated the concerns she had raised the previous summer, that Child O was being abused by a man or men in the Finsbury Park area.

8.8.8 Two weeks later CYPS called a Strategy Meeting under child protection procedures. Officers from the Sapphire team attended. They advised that no police action would be taken as there was no specific disclosure or evidence of a sexual offence. Again there is no police record of attendance at this strategy meeting.

8.8.9 This response from police was again inadequate especially as the meeting concluded that Child O was at risk of sexual exploitation. The weaknesses in these police responses probably have their roots in the specialist Sapphire Team being out of touch with another specialist police area, the investigation of abuse or neglect of children. Specifically, the CAIT would have been more familiar with the challenges posed when a minor is reluctant to co-operate with an investigation. This is a more complex situation than that faced by police when a competent adult makes such a decision.

8.8.10 There is also little evidence of any challenge from any other agency to the position repeatedly taken by police. None of the professionals working with Child O sought any further advice or took any further action in response to the police decisions.

8.8.11 There have subsequently been organisational changes so that the Sapphire service is now amalgamated with the Child Abuse Command. This should promote better collaboration although the IMR notes that there is no overarching system across the new service for taking referrals. The IMR has therefore identified both individual and organisational learning from these matters and makes appropriate recommendations to address these issues. This Overview Report further recommends that the MPS should demonstrate that the changes made are resulting in an improved quality of service.

8.8.12 The MPS had a number of other contacts with Child O, mostly as a result of her being missing from home or hospital, and also in situations where allegations were made that she had been hit. She consistently refused to co-operate with any police enquiries.

8.8.13 The IMR concludes that the most significant missed opportunities for the MPS lie in the insufficient responses to the parents' general concerns that Child O was being sexually exploited. Child O's parents feel this keenly, reporting to the inquest that
"Though we were able to provide times, dates, physical evidence from computers, phones and phone records and even clothing, the police were unwilling to undertake an investigation".
This specific claim is disputed by police who report that neither items of clothing nor any other exhibits were offered to them, and that there is nothing further that they could have done to progress their investigations.

8.8.14 However, for police, as is the case for many of the agencies contributing to this review, a broader understanding of CSE has developed substantially in recent years. The review heard that the police response now would certainly be more proactive and sustained, and would be managed by the specialist CSE service established by the MPS. A better informed approach from police might have contributed to a greater understanding of the worries and fears that Child O so evidently experienced.

8.9 British Transport Police

8.9.1 The BTP were responsible for the police investigations into Child O's death. Those investigations were thorough and their IMR is essentially a report about their general response to such situations. That is summarised here for information.

8.9.2 The force will actively develop Suicide Prevention Plans (SPP) when an individual attempts suicide but survives – which might be said of the incident when Child O went to the railway tracks in December. The SPP is a working document created by front line officers, aimed at monitoring and supporting the welfare of a vulnerable individual. It provides a framework to assess and reduce risk by applying certain actions and controls to individuals or locations that are considered to be high risk in relation to suicide and/or self harm.

8.9.3 The front-line officers dealing will usually start the SPP, completing the relevant information required about the particular incident. The SPP is then

passed to a specialist team assisted by NHS mental health staff, who will decide whether and how it should be followed up. The SPP records BTP's liaison with the individual as well as contact made to other agencies such as Mental Health Units, GP's or crisis teams.

8.9.4 The SPPs are reviewed on a regular basis and once it is ascertained that the risk is reduced or that no further action from BTP can or will support the individual it may be closed. It remains on file and on the intelligence system for officers' information'

8.9.5 The BTP is also actively developing more involvement in safeguarding generally. A lead officer has been appointed at Assistant Chief Constable level and further specialist staff are to be introduced. An overall strategy for the force's approach to child safeguarding is being developed. The BTP now aims to liaise directly with local authorities, or Multi Agency Safeguarding Hubs, rather than doing so via territorial police. New processes and guidance for staff have been introduced, aimed at promoting a more proactive approach and a knowledge base to inform the development of the service. There has been a substantial increase in safeguarding training for all staff.

8.10 The General Practitioners - London

8.10.1 Two GP practices in London were involved with the family during the period under review though Child O was registered only with GP1. Although the GP records are predictably substantial Child O was actually seen by her GP only six times during the review period. Of those contacts only two are significant to this review. In 2010 she was seen after taking an overdose and this contact led to the initial referral to CAMHS. In March 2012 her parents brought her to the GP as she had been unable to walk for some days. The GP judged that this condition had a psychological causation, but this presentation, which was isolated and not repeated, remains unexplained.

8.10.2 When seen in 2010 it would have been appropriate to refer Child O to hospital for a paediatric review. The IMR also judges that the GPs might have kept a "watching brief" after the initial referral to CAMHS, as there was a wait of some 2-3 weeks before Child O was seen. Finally the IMR notes that records were not updated to reflect the emerging issues of post traumatic stress disorder and sexual abuse and exploitation.

8.10.3 The overall standard of care provided by the GPs, and their compliance with professional standards and expectations during these contacts was good and appropriate referrals were made:
"On both occasions the documentation indicates that she was listened to and given time well in excess of the standard GP consultation. In addition she was seen with her parents and by herself".

8.11 The General Practitioners – Wiltshire

8.11.1 On moving to Tumblewood Child O registered with local GPs, the same GPs used by all the young people at Tumblewood. She saw the GPs

only for minor or straightforward issues and the IMR judges that they provided satisfactory care.

8.11.2 However Child O also remained registered with her GP practice in Islington. Only some paper records and no electronic records were transferred. This meant that the Wiltshire practice was unaware of her documented history with the episodes of self-harming and suicidal thoughts.

8.11.3 The IMR comments that the GPs might have been more curious, given the nature of the services provided at Tumblewood, but also notes that a number of other agencies had responsibilities in this connection. She was a child in the care of the local authority so that CYPS had a responsibility to ensure that all those professionals who might have contact with her were properly informed. The establishment itself, Tumblewood, was looking after her day to day and had a responsibility to ensure that her GPs were properly informed about her medical history.

8.11.4 There is no evidence that this lack of knowledge affected the services Child O received from these GPs but this is clearly a weakness in the systems of all these agencies. There is consequently a recommendation from this report.

8.12 NHS Haringey Clinical Commissioning Group: Health Overview Report

8.12.1 The Health Overview Report (HOR) is prepared by the NHS organisation responsible for commissioning health services in the area in which the family live. Its principal purpose is to evaluate and comment on all the health services involved in the case under review, serving also as the IMR for the commissioners of health services.

8.12.2 Key observations from the HOR largely echo the principal findings of this report in relation to NHS agencies.
“The commissioning process clearly failed in this case; taking far too long for differences to be resolved”.
and
“The escalation process was used in this case but did not result in resolution at the highest level”.

8.12.3 The HOR also comments on the fact that CAMHS professionals did not access safeguarding supervision specifically in respect of this case from the Named Nurse for Safeguarding Children. This was a case where the way in which agencies were working together and the way in which they were responding to Child O and her family had become “stuck”. Skilled supervision might have highlighted and challenged that position.

8.12.4 The recommendations from the HOR include measures to promote and increase family engagement, along with training aimed at improving staff understanding of self-harm and its treatment.

8.13 Involvement by other NHS agencies

8.13.1 A number of NHS agencies had some minor involvement. They have provided information to the review which is mentioned in the main chronology and summarised below.

8.13.2 Child O was admitted to University College Hospital London NHS Trust (UCLH) in December 2010, as described in section 6.2 above. This presentation led to her first admission to psychiatric care at the Priory. In March 2011 Child O spent a week as an in-patient at UCLH after a prolonged period of refusing food at Simmons House.

8.13.3 In 2011/ 2012 Child O was treated three times at Chase Farm Hospital for self-inflicted injuries. On the first occasion in November she was seen with injuries to her hand and wrist. Just over a month later she was brought in after attempted self-strangulation with a scarf. On the second occasion, but not the first, liaison between the two hospitals, Chase Farm and the Priory, was good. In January 2012 Child O was brought by ambulance to hospital after swallowing metal objects and cleaning fluid. On this occasion she was admitted to a children's ward overnight but refused to see a psychiatrist or talk to any CAMHS staff. She further refused to attend follow-up appointments.

8.13.4 Towards the end of 2012 Child O was seen twice by plastic surgeons at the Royal Free Hospital to discuss treatment for the extensive scarring she had caused by self-harm. She was given advice about this intervention, which would have been complicated, and she attended one follow-up appointment.

8.13.5 The Central London Community Healthcare NHS Trust (CLCH) provided a school nursing service. While Child O remained technically in mainstream education this service was routinely informed when Child O was treated at various hospitals for self-harm. There was some liaison but no need for any action by the school nursing service.

8.13.6 Child O was treated once at North Middlesex University NHS Trust (NMUH) in late 2012. She was an in-patient at the Priory at the time and had cut herself. Medical attention was appropriate and the paediatric registrar dealing liaised appropriately with the family and the Priory.

8.13.7 The London Ambulance Service NHS Trust (LAS) transported Child O to hospital on two occasions.

8.13.8 The Tavistock and Portman NHS Foundation Trust (Tavistock) conducted the Strengths and Difficulties Questionnaire, when Child O was admitted to care, as discussed above.

9. KEY ISSUES

9.1 Introduction

9.1.1 This section of the report draws out the key learning points for the agencies, and considers matters highlighted in the Terms of Reference for the review.

9.2 The failure to use child protection arrangements

9.2.1 It is striking that, in the face of such obvious cause for concern, there was never a formal child protection investigation into Child O's situation. There was evidence to suggest that she may have been sexually exploited and there is well -established guidance[19] across the London area for addressing concerns of this nature within the overall framework of child protection arrangements.

9.2.2 That guidance does not require the immediate implementation of formal child protection procedures. That may not be the best way to approach situations where children are not judged to be at risk from family members. The guidance recognises the particular delicacy of such situations and the need to tread carefully
"children concerned are often subject to significant threats, bribes and conflicted loyalties. They may feel impelled to tell their abusers what is being planned and in turn become more isolated from services. Similarly, families may be unable to promote the child's best interests".

9.2.3 However the guidance is clear that formal child protection arrangements may need to be implemented and that was certainly the case here, throughout the period before Child O's admission to local authority care. Concerns were high from the outset and there was never evidence to indicate that those concerns might be eased. Even without reference to this specialist guidance one would have expected a formal child protection response in the light of Child O's extreme behaviour and the extent to which her parents struggled to control her and protect her from the potential consequences of that behaviour.

9.2.4 Yet there is no evidence that the implementation of child protection procedures was adequately considered, either by practitioners or their managers, in any service. Agencies outside the local authority did not use formal escalation procedures to challenge this.

9.2.5 The child protection procedures are sensitive to the reality that young people, and this was particularly true of Child O, are unlikely radically to change their behaviour because they are told to do so.
"Implementing effective diversionary and safeguarding and support plans for children may require professionals to be extremely persistent in continuing to

[19] London Child Protection Procedures - Safeguarding children from sexual exploitation

offer support and services. It may be that a non-LA children's social care professional may best be able to provide a direct service".

9.2.6 In fact Child O's problems and her consequent behaviour were so deep-rooted that it is also unlikely that she would have responded to a diversionary approach, however persistent professionals were, while she remained in London with her family. But using this guidance – to which agencies in Haringey are fully signed up – would have brought a structure to the way they assessed the situation and worked together. That may have clarified the options available and eliminated some of the delay in reaching the plan that agencies eventually agreed.

9.2.7 In any case there is no point in having detailed, tailor-made procedures if they are not used. The circumstances of Child O's situation required a formal child protection response and, within that, a consideration of the specific guidance on children who are being sexually exploited. No agency identified this and pursued it. This is perhaps further evidence of the way in which the disagreement between agencies about admission to care diverted attention from the fundamental processes of assessment and review.

9.3 Child sexual exploitation

9.3.1 The Terms of Reference for this review properly required all agencies to consider the issue of child sexual exploitation (CSE), its significance here, and the extent to which the agencies were prepared to respond and did respond to this issue for Child O.

9.3.2 It has repeatedly been shown throughout this account that the underlying causes of Child O's disturbance and unhappiness have not been clearly evidenced. We have seen that agencies might have done more to explore and tackle this but it is also right to emphasise that Child O consistently displayed an absolute determination not to disclose information that could be investigated, so that agencies could form targeted plans of intervention and support.

9.3.3 As Tumblewood comments, she alleged that she had been the victim of *"serious and sustained sexual and physical assaults by men in and near her local community. However she determinedly refused at all times to provide any details of what, when and where, information that would have assisted the investigation of her allegations and her protection"*
So, at the outset, it is right to say that there is no clear, verified evidence that Child O was the subject of CSE. Having said that it is also right to recognise that, in cases of sexual abuse, the word of the child is sometimes the only evidence that can be established, and is never to be dismissed.

9.3.4 CSE is an issue which presents in various ways throughout the history. Child O herself repeatedly gave indications that she had been sexually mistreated in some way, and that this had happened, or commenced, when she was 12 years old or younger. Child O's parents are convinced that there was some CSE of their daughter and that it is key to the problems she

experienced. Certainly while in London it came to be treated by health and social care agencies as a fact.

9.3.5 In that context there is relatively little evidence of the agencies using strategies and practical approaches that might have helped Child O to "stay safe". The Health Overview report suggests that
"It might have been helpful to have conversations with Child O explaining to her that professionals understood the sorts of threats perpetrators make to keep victims quiet, that measures could be put in place to keep her and her family safe and that the perpetrators are likely to be harming other young people as well as her".
Staff at Simmons House are reported to have tried to discuss their concerns with Child O but their overtures were characteristically rejected by her.

9.3.6 It is notable that Tumblewood, in their account of their approach to working with Child O, rarely mention CSE. They clearly recognised the difficulties experienced by Child O in working with/being cared for by men, and designed their staffing arrangements around that. Otherwise, however, their work with Child O was based more on responding to what was in front of them, and what Child O did want to talk about. That was probably the most appropriate approach for this young person.

9.3.7 The exploitation of children for the sexual gratification of adults is not new but there has been a shift in societal understanding of the issue. Until relatively recently the sexual exploitation of children was still defined as child prostitution, a disturbing social evil rather than something recognised unequivocally as child abuse. Agencies' understanding of CSE and its prevalence, and the development of strategies to help exploited young people, have all undoubtedly grown and improved. It is probably uncommon to be confronted with a young person as resolutely resistant as Child O, but it is not unusual to be working with exploited young people who struggle to disclose what has happened to them, and agencies have got much better at doing so.

9.3.8 However the agencies in this review have generally not demonstrated in their reports that there was a background of adequate awareness to the issue of CSE, and an ability to respond effectively to such concerns. This is also an issue that was identified, while this review was being carried out, in an inspection by Ofsted of the work of the LSCB. That inspection reported[20] that further work was necessary to develop the local guidance and strategy on CSE, and the Board has already completed that work. Consequently there is no separate recommendation on this issue from this report.

[20] Ofsted 2014.pdf

9.4 Risk assessment and assessment under mental health legislation

9.4.1 Ofsted have specifically considered the protection of older children in their work[21] considering the outcomes of SCRs between 2007 and 2011. A headline finding was that
"Practitioners should…demonstrate that clearly risk-assessed decision-making informs all actions in relation to older children"

9.4.2 The Panel accepted that using a formal risk assessment tool can only be an adjunct to clinical judgement. However Child O's behaviour had been extremely dangerous throughout the time that agencies knew her. Most of that risk, such as her self-harming, was self-evident. Yet there were considerable variations between the agencies' approach to managing that risk, and some dangerous failures routinely to use formal risk assessments.

9.4.3 CYPS confirm that
"No consideration was given to undertaking a risk assessment of the known or perceived risk being posed".
There is also no evidence of CYPS evaluating the way risk would be managed by Child O's family or by the other agencies. At Simmons House there is no evidence of regular review of the risks to Child O.

9.4.4 At the Priory there was more emphasis on risk assessment:
"there are clear records of risk assessments and management plans which reflect Child O's individual needs …The risk assessment process demonstrably informed the management of risk, and enabled the nursing and medical team to maintain Child O's safety".

9.4.5 Risk assessment formed a fundamental part of the regime at Tumblewood. The IMR has scrutinised the assessments and their use closely, judging that
"The risk assessments were very good, well focussed, circulated to and used by staff to inform their thinking".

9.4.6 That IMR also pinpoints the one important instance when these otherwise thorough arrangements failed. There was no risk assessment in relation to the episode in December when Child O reported sitting by the railway tracks. When information about this emerged it was overshadowed by an episode of Child O self-harming and was not discussed at the next Risk Assessment meeting, the following morning. This was a
"missed opportunity to escalate levels of concern internally… and externally".

9.4.7 However the greater concerns arise from the services where no structured arrangements were used for evaluating and addressing the risks in Child O's life. The SCR Panel heard that the LSCB's risk management guidance had not been reviewed for some time. It is therefore recommended that the Board engage the key local organisations in Haringey in work to address this.

[21] Ages of Concern (Ofsted 2011)

9.4.8 There are correspondences with the assessment of Child O's mental health. Child O was never formally assessed under those provisions of mental health legislation which might have led to her compulsory admission to hospital. That is, she was never seen by an Approved Mental Health Professional and two doctors who were specifically tasked with carrying out such an assessment.

9.4.9 The reports to this review from the Whittington Hospital advise that the use of compulsory powers was always considered after incidents of self-harm. There is a record that, after the incident of self-harm with a pellet gun in 2012, doctors at the Whittington considered whether she might be formally assessed. Otherwise there is no documentation that this course of action was considered there. Similarly no other agency contributing to this review has reported considering the potential application of arrangements for such an assessment, or provided any evidence of doing so.

9.4.10 Child O was certainly aware of the issue. It would have been unlikely that someone who had spent so much time under psychiatric care would not be so aware. She specifically expressed concerns about being "sectioned" soon after her return to Tumblewood in January 2014 – not long before her death.

9.4.11 Child O was not someone who refused to co-operate with the treatment offered through mental health services, even if her co-operation may have been partial - she was undoubtedly capable of deciding what she would and would not co-operate with. Simmons House have advised that Child O, in her general level of self harm, her partial co-operation and manipulation of professionals, and her overall presentation while a patient, was not dissimilar to other patients.

9.4.12 That may be right but there is one respect in which Child O was consistently unusual – the extent of her determination not to "open up" about what she felt about her situation and how she came to be in such difficulties. There were also "flash points" – times when her self harm was particularly serious, and required hospital treatment over a period of days.

9.4.13 There may have been points at which the use of compulsory powers under mental health legislation should have been formally tested. It is reasonable to expect to see evidence that this course of action was considered and evaluated, and no such evidence has been presented to this review by any of the relevant agencies.

9.5 The joint commissioning of services

9.5.1 It is right that this report should explore any lessons which might be learned from these events about the ways in which agencies work together to commission specialised services. The Terms of Reference specifically ask *"How well did agencies work together in jointly commissioning services?"*

9.5.2 However, before doing so, it is also important to reinforce a key point already made. The failures of agencies to work well together, which led to entirely unacceptable delays in meeting this child's needs, were not rooted in difficulties in joint commissioning. They stemmed principally from the approach taken by the local authority, which recognises in its report to this review that
"Obtaining placement funding seems to have become a barrier which impacted adversely on professionals' ability to listen to Child O or keep her needs, and risks, in focus. Decisions appear to have been dominated by placement procurement and funding considerations and tended to detract from focussing on safeguarding Child O".

9.5.3 It is also right to be clear that this case does not really tell us much about the overall arrangements for the joint commissioning of services by public agencies in this locality. Joint commissioning refers to a cyclical process in which agencies work together to identify local need, specify what services should meet those needs, commission services in line with that specification and then evaluate how effective those services have been, to feed into a continuing identification of need. Joint commissioning arrangements have, nationally, been championed for some years as the most efficient way of delivering services which are relevant, effective and "joined up" (although some recent research[22] has challenged the basic hypothesis that partnerships lead to better services and outcomes).

9.5.4 Setting aside the position taken by the local authority, there were other complications. The family had lived in two other London boroughs before moving into Haringey. Their GP was in the borough of Islington which meant that any NHS funding contribution would be the responsibility of the NHS in Islington. Although there are arrangements in place between the ICCG and the London Borough of Islington to deal with such funding issues, there is no "cross locality" protocol, between, for example, the ICCG and neighbours such as the London Borough of Haringey.

9.5.5 The lack of such a protocol may be irrelevant in this case. The review has seen no evidence to suggest that the local authority would have worked in a different way had they been dealing with the equivalent NHS teams in Haringey. However the case does highlight the potential difficulties arising from the issue of locality and, as indicated above, this is not the first SCR where this has been identified as an issue. There is consequently a recommendation from this report.

9.6 Escalation

9.6.1 The review has seen the significance of the failure to come speedily to a plan to which all agencies could sign up. There are arrangements for dealing with such situations, involving increasingly senior personnel across the

[22] Eg, Joint Commissioning in Health and Social Care: An Exploration of Definitions, Processes, Services and Outcomes University of Birmingham, 2013

agencies in discussions / negotiations. Ultimately there is an arrangement in Haringey for child protection matters to be referred to the Chair of the LSCB.

9.6.2 These processes were not adequately followed. A range of senior managers became involved in a disorganised and ineffectual way and without consistent reference to the formal arrangements. Some NHS organisations even started considering applying for judicial review - a sledgehammer for a nut, when local options remained unexplored. The focus on the child was lost, except at the ICCG.

9.6.3 Escalation is not just complaining to another agency or to a more senior colleague about another agency. It is a formal process and, when discussions are being carried out as part of that process, this must be made clear. Ideally, when agencies have good working relationships, escalation should form part of a culture where constructive challenge is seen as an essential and positive element of safeguarding practice. The application of formal escalation arrangements is a learning point for all the key London agencies in this review.

9.7 The impact of organisational change

9.7.1 Organisational change in the public sector is so commonplace that SCRs always consider whether it may have affected the course of events. In this case the most evident factor is the number of changes of personnel at all levels within the local authority. In fact there have been so many changes of personnel that only three officers remain who have been able to throw light on the detail of which managers were involved, when and why.

9.7.2 This directly affected the ability of the service to deliver clear and consistent messages, explaining any rationale for the way in which the case was managed and led. It adversely affected the capacity of other organisations to work consistently with social care services. The consequences of this instability should be recognised by the most senior managers and elected representatives who lead that local authority.

9.7.3 Otherwise organisational change was accommodated well, particularly in respect of the commissioning of NHS services. Within the NHS, as the ICCG IMR explains,
"Islington PCT (became) part of the North Central Cluster and then a shadow CCG before becoming a CCG in April 2013".
These organisational changes did not lead to changes in the personnel involved and a good degree of consistency was maintained.

9.8 The influence of social media

9.8.1 When planning this review there were indications that the role of social media might be significant. There had been press interest in the subject, linked in part to the suicide of a young person known to Child O who had visited "self-harm websites". This was the young person about whom Child O's mother contacted Tumblewood on the day before Child O's death.

9.8.2 As the review proceeded little evidence emerged that the use of social media was a particularly significant feature in Child O's life. Simmons House identified no specific concerns relating to the use of social media. The Priory did have concerns, related first to a relationship Child O was believed to have formed with a "Facebook friend", who at one point was believed to have taken an overdose, but the role of social media does not seem particularly significant in this.

9.8.3 Tumblewood cautiously judges that
"it cannot be said with any certainty that… (the internet and social media) did or did not play a significant role".
but their broad conclusion is that they did not play such a role.
They had a protocol for internet use by residents and
"Very early in her placement she was deemed by staff to be a responsible user of computers and the internet and there were never any concerns about internet misuse during her placement".
There was a time when it was discovered that Child O had identified the password needed to access the internet at Tumblewood and had used it, but no evidence that this led to any harmful use of the internet.

9.8.4 Tumblewood note that, coincidentally, a few days after Child O died, the Department of Health issued a report[23] on preventing suicide in which the authors address the
"still emerging issues of the internet and e-safety".
Tumblewood has reviewed and strengthened its training, code of practice and security measures in response to this, and raised the profile of the issue in the young peoples' education programmes.

9.8.5 Overall, while the use of social media was properly identified in the Terms of Reference for this review, it does not appear to have been a significant factor in Child O's life or her death. Nonetheless it has brought to light the fact that neither the Priory nor Simmons House had well-developed guidance on this issue and there is accordingly a recommendation from this report.

9.9 Serious Case Review Process

9.9.1 The review has been complex. It has involved three local authorities in London and one outside London, four LSCB areas, two police forces and thirteen NHS organisations as well as the three independent sector providers that looked after Child O. As often happens, information emerged during the course of the review which led to new enquiries being necessary and new reports sought.

9.9.2 During the review process, the LSCB Manager moved to a post with another Board and there were delays and difficulties in finding a replacement. The term of office of the Chair of the Board, who had also been chairing this

[23] Suicide prevention: second annual report - Publications - GOV.UK

review, came to an end. These changes again delayed the progress of the review. In those circumstances it was clear at an early stage that it would not be possible to meet the government's expectation that SCRs should be completed within six months.

9.9.3 Agencies were required by the Terms of Reference to consider whether there was evidence of having learned lessons from previous SCRs. The only agency to respond to this squarely is CYPS whose IMR notes that *"Regrettably, practice did not appear to have learnt from previous serious case reviews within Haringey, or elsewhere in the sector".*

9.9.4 That judgment needs to be put in context. Practice improvements in response to SCRs will be incremental and will need to be repeatedly reinforced. Staffing changes are frequent and it would be unusual if some deficiencies in practice did not recur. Nonetheless the Board needs to satisfy itself that the processes, findings and outcomes of SCRs are having a positive and enduring impact on practice overall and there is a recommendation to that effect from this report.

10. CONCLUSIONS AND KEY LEARNING POINTS

10.1 The child protection implications of the overall situation were not followed up. There was never a Child Protection Conference and there was no reference to the guidance agencies should use in response to the sexual exploitation of children.

10.2 Police failed to respond adequately to evidence suggestive of sexual exploitation. There were missed opportunities for a focussed investigation. The Sapphire Team became involved without input from the Child Abuse Investigation Team. These officers did not appreciate the child protection concerns arising from the matters reported to them.

10.3 Both Simmons House and the Priory failed fully to meet statutory requirements under the Care Programme Approach. Record keeping was not satisfactory. Simmons House in particular failed to ensure that Child O was purposefully involved in provision at the hospital. She was allowed by both hospitals to spend too much time away from the hospital. She was judged not to meet the threshold for assessment for compulsory detention in hospital, though this was never formally assessed under the Mental Health Act.

10.4 Arrangements for Child O's education foundered especially after she began to be admitted to hospital. National guidance for the education of children in hospital was not followed and this was not challenged by any of the agencies involved.

10.5 Interrupting her placement is the principal example of action taken without sufficient reference to consequent risks. Before moving to Tumblewood there is also little evidence of assessment of the known and perceived risks in Child O's life. Continuing risk assessments should have analysed and addressed the many threats to Child O's well-being – sexual exploitation, her own mental ill health, the extent to which her parents could keep her safe within and outside their home.

10.6 Tumblewood was an appropriate placement but Child O was allowed to spend too much time away from there. This acceded to Child O's unrelenting drive to be "in control". It meant that the benefits of living communally away from her home were not used to best effect. The development of supportive, trusting relationships with staff was inhibited. Throughout the period under review there was a contradiction, which was never addressed, between her needing to be away from home yet continually returning there.

10.7 Being in residential care at Tumblewood offered an opportunity, building on achievements at Crisis Care, to challenge Child O's insistence on wanting her own way, but that opportunity was not grasped. Planning drifted away from a focus on strengthening her mental and emotional health, which should have been the first priority. Instead the emphasis grew more towards practical planning for her education and independence. Child O's avoidance of some of the home's requirements and expectations was not squarely confronted.

10. 8 The arrangements for promoting the health of children in local authority care did not work well, with implications for all the agencies involved. The information gathered was fragmented and there was no clear plan or programme for the oversight of Child O's health. The sharing of information between her GPs in London and the GPs responsible for her in her placement was not adequate. The use of the "Strengths and Difficulties Questionnaire" was formulaic and added nothing to the overall understanding of the situation.

10.9 This review has identified serious failings in the services which should have helped Child O and her family. The greatest cause for concern is the substantial delay in arranging for her to be cared for away from her family home. This was the step which would have given the best opportunities for establishing supportive therapeutic relationships with Child O and her family.

10.10 The need for Child O to be admitted to the public care was demonstrable from early in 2012. That is not to say that such a step would necessarily have resolved her problems, or avoided the tragic events leading to this review. But, even when agencies are genuinely doubtful that admission to care will be a successful step, it remains a step that must sometimes be taken. This was such a situation.

10.11 The review has illustrated how there may be complications in agreeing funding arrangements when a family lives in one local authority area and has a GP in a different local authority. This is a systemic issue, identified in at least one previous Serious Case Review, although it was not the principal cause of delay in Child O's case.

10.12 There is also substantial evidence that the local authority's professional input was of a poor standard. Assessments were slow and did not properly involve the family or other agencies. They were not thorough in establishing facts and analysing them, thus reaching unsubstantiated conclusions. Management and supervision arrangements were weak and ill-directed. By arranging a psychiatric re-assessment without reference to the other parties and in the face of explicit concerns from the clinicians treating Child O, the local authority caused further delay and disharmony.

10.13 Following the Ofsted judgment on Tumblewood the local authority decided, without consultation with Child O, her family, the Independent Reviewing Officer or any other agency, including the ICCG which was jointly funding the placement, that she should not return there. This decision, although taken at a senior level, was hasty and misjudged. It was not necessary and it achieved nothing positive. It further damaged relationships with the family and the other agencies.

10.14 The local authority was in breach of statutory requirements in taking this step without consultation with Child O and her family. The Independent Reviewing Officer objected but could have taken further steps formally to challenge the decision.

10.15 The long dispute about placement and funding responsibility detracted from the management and planning of day to day care. The discussions about admission to local authority care became the focus of agencies' involvement, and there is little evidence of work aimed at engaging Child O and reducing the continuing risks in her life. No agency made appropriate use of formal arrangements for the resolution of such disagreements.

10.16 The issue of safeguarding implications arising from the use of social media was properly identified in the Terms of Reference for this review, but did not emerge as a significant factor during the review. Nonetheless it has brought to light the fact that neither the Priory nor Simmons House had well-developed guidance on this issue.

10.17 The possibility of Child O's suicide was clear and consistent but, in the days and hours before her death, there was no particular indication that Child O might choose that time to end her life. Her actions on that day could not have been anticipated or consequently prevented.

10.18 The most serious gap in the findings of this review reflects the issue that was the most challenging for the agencies. We still have no clearly evidenced understanding of how Child O came to be so troubled and why she so resolutely maintained a position of never fully sharing her worries with any professional.

11. RECOMMENDATIONS TO THE HARINGEY LOCAL SAFEGUARDING BOARD

11.1 Introduction

11.1.1 These recommendations to the Board reflect the key lessons to be learned from this review. They draw on the views of the SCR Panel and the author of this report.

11.1.2 The review does not make a recommendation for every point of learning that has been identified. These recommendations are complemented by more detailed recommendations, specific to each agency, contained in the management reviews conducted by those agencies.

11.2 Recommendations

11.2.1 The Board should require the London Borough of Haringey to demonstrate that, where a child may be at risk of significant harm, investigations and consequent assessments are conducted and completed without delay and meet all procedural and good practice requirements. These will include

- being consistently directed and managed by an appropriate senior officer
- seeing and consulting the child(ren) involved
- consulting with those who have parental responsibility
- making thorough checks with other agencies
- drawing on specialist advice when necessary
- keeping appropriate records

11.2.2 The Board should require the London Borough of Haringey and the relevant NHS organisations to audit and report on their care planning arrangements for young people who are “looked after” by the local authority. This work should include consideration of

- compliance with requirements for documentation and record-keeping, with particular reference to arrangements on admission to and discharge from care
- Independent Reviewing Officer provision, to demonstrate that statutory requirements relating to the independence and authority of this role are met
- the arrangements for promoting the health of young people looked after by the local authority

11.2.3 The Board should arrange for the London Borough of Haringey to provide briefings and guidance to agencies on the role of the Local Authority Designated Officer.

11.2.4 The Board should require the Metropolitan Police Service to demonstrate that the organisational changes they have made will effectively address the concerns that reports of child sexual exploitation were not adequately followed up.

11.2.5 The Board should satisfy itself that, where relevant, the Care Programme Approach is used reliably and effectively for young people from Haringey.

11.2.6 The Board should review and re-issue its Risk Management Strategy to all partner agencies and require the agencies to report back on the dissemination and use of this guidance.

11.2.7 The Board should require the local authority and the relevant NHS agencies to demonstrate that they have made arrangements for taking and implementing decisions about the shared funding of provision for young people in need, and particularly those in the care of the local authority. These arrangements must take account of the issue, arising in this review, of families who have a GP outside the London Borough of Haringey.

11.2.8 The Board should incorporate into its work programme a review of the arrangements made for the education of young people from Haringey who are unable to attend school because of long periods in hospital. That review should include an evaluation of how far those educational services are alert to the safeguarding needs of children and young people in hospital.

11.2.9 The Board should

- require all agencies to remind staff, in the light of the matters arising from this review, of the established arrangements for escalating safeguarding concerns to more senior managers, and, if necessary, to the LSCB Chair.
- develop an audit programme across all agencies to evaluate the use and effectiveness of escalation arrangements

11.2.10 The Board should ensure that guidance is available to all partner agencies dealing with situations where safeguarding concerns arise from the use of social media by young people, and that the use of that guidance is audited.

11.2.11 The Board should ensure that it has continuing arrangements for evaluating the impact of Serious Case Reviews on the quality and effectiveness of safeguarding arrangements in Haringey.

APPENDIX A: THE LEAD REVIEWER

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 50 SCRs in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile SCR reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX B: TERMS OF REFERENCE

The review considered the period from 2010, when Child O was first referred to therapeutic services, until her death in January 2014. The following issues were highlighted.

Were practitioners aware of "what it was like to actually be that child"? Were they sensitive to the needs of the child in their work, and knowledgeable about potential indicators of abuse, specifically physical abuse or neglect, and what to do it they had concerns about a child's welfare?

What did the agency know about the history of each of the parents? Were the parents listened to? Did their professional backgrounds influence how agencies worked with them?

What were the key points for assessment, decision making and effective intervention in this case? What was the quality and timeliness of decision-making? What was the quality of multi-agency risk assessments? Were Child O's mental health needs assessed and treated appropriately?

Was child sexual exploitation/abuse identified and responded to appropriately?

Did professionals consider and show awareness of how social media might affect and influence young people?

Did actions accord with assessments and decisions made? Were appropriate services offered? Were opportunities / requirements for intervention taken (such as Section 47 investigations, multi-agency strategy meetings, Family Group Conferences, Child Protection conferences or Looked After Child reviews)?

Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards? What were the consequences of so many localities and agencies being involved?

How well did education and social care agencies work together? Were the agencies' responses to the child's educational and social needs appropriately balanced? How well did arrangements for finding placements work?

Was there sufficient management accountability for decision-making? What was the quality of supervision? Were senior managers or other organisations and professionals appropriately involved in the case particularly in responding to the impact of parental views?

Were there any issues, in communication, information sharing or service delivery, within, between or across localities and services, including services commissioned jointly by the agencies? This includes those with responsibility

for working “out of hours”. Agencies should make particular reference to the arrangements for escalation of concerns within and between agencies to more senior officers.

Was practice sensitive to issues of racial, cultural, linguistic and religious identity and any issues of disability of the child and family? Were any such issues appropriately explored and recorded?

Evaluate the impact of any organisational change over the period covered by the review.

Did practice reflect/evidence any lessons learned from previous Serious Case Reviews? If not, what were the barriers?

APPENDIX C: REFERENCES

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

- Working Together to Safeguard Children,(HM Government 2015)
- The Victoria Climbie Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- London Safeguarding Children Board – SCR Toolkit (2010)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10th June 2010