Serious Case Review

CHILD KN15

REVIEW REPORT

Lead Reviewer: Dr Cath Connor

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1 Introduction

1.1 This Serious Case Review (SCR) is in respect of KN15, a 13year old girl who died whilst missing from home after a family argument.

1.2 Nottinghamshire Safeguarding Children Board (NSCB) considered the circumstances of KN15's death and agreed that they met the criteria for carrying out a Serious Case Review as defined by 'Working Together to Safeguard Children 2015'.

1.3 NSCB recognised the potential to learn lessons from this review regarding the way that agencies work together in Nottinghamshire and Derbyshire to safeguard children. Working Together 2015 outlines the purpose of reviews is 'to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programs of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'. Good practice and learning identified by this review are outlined within this report.

1.4 This review established that while there were concerns for the emotional well-being of KN15, it could not have been predicted that she would take her own life.

1.5 A summary of the key findings from this review are:

1. Early intervention and support for families will be more effective, cohesive, and focussed, when delivered with a written assessment and plan to clarify the focus of the work and to enable outcomes to be monitored and evidenced.

2. Adults who present with mental health problems can have an impact on the whole family. It is important that the needs of children who live with adults who have reported mental health problems in Nottinghamshire and Derbyshire should be systematically assessed by all partner agencies to ensure that children and families receive the support they require.

3. Assessments, following the identification of emerging needs, should explore the wishes and feelings of the child to further understand the cause of a child's behaviour and possible underlying distress. The intervention should avoid only focusing on the behavioural change of the child.

4 The potential consequences for the child should be considered by those involved before sharing concerns about possible emotional abuse with parents/carers.

5 When a child moves school, professionals should be aware of a child's history and alert to any gaps in that history.

2 Process

2.1 The NSCB agreed that this Serious Case Review (SCR) should be undertaken using the Significant Incident Learning Process (SILP) methodology. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time. This way of

reviewing is encouraged and supported in Working Together to Safeguard Children 2015.

2.2 The SILP model of review adheres to the principles of;

- proportionality
- learning from good practice
- the active involvement of practitioners
- engaging with families, and
- systems methodology

2.3 This review required the completion of Agency Reports followed by a Learning Event[1] which was attended by practitioners, managers and agency safeguarding leads from Nottinghamshire and Derbyshire. A narrative of the circumstances of the case was prepared based on the agency reports and shared in advance of the Learning Event. Participants involved in the initial Learning Event were invited to a Recall Event to study and debate the first draft of the Overview Report. The contribution of all those involved enabled a greater understanding of the context in which practitioners and managers worked which influenced the learning and conclusions of the review and maximized opportunities for organizational learning.

2.4 At the request of Nottinghamshire Police, due to ongoing criminal investigations, the Learning Event with practitioners and first line managers was delayed for 6 months. The Lead Reviewer expressed concerns about the delay to the police and NSCB and suggested a way to progress with the Learning Event which would not impact on parallel investigations.

2.5 Senior managers from the participating organisations in Nottinghamshire and Derbyshire met to consider the findings from the Learning and Recall Events and comment on the draft report.

2.6 It was agreed that the scope of this review would be from 1 January 2014 to 2 June 2015. This period includes the family's move to Nottinghamshire from Derbyshire, a number of missing periods for KN15, and agency involvement due to concerns for the wellbeing of KN15 and Sibling 1. Relevant information prior to these dates was also considered. This included agency involvement with the family whilst living in Derbyshire and the birth of Sibling 2.

2.7 The decision to undertake a Serious Case Review was made by the Independent Chair of Nottinghamshire Safeguarding Children Board (NSCB) in September 2015. Mother and Father of KN15 were informed about the review shortly afterwards and were kept updated on progress by the NSCB. A request to interview family members at the beginning of the review process was strongly advised against by Nottinghamshire Police due to an ongoing investigation. Mother, Father and

[1] The Lead Reviewer and Overview Report Author was Dr Cath Connor, an experienced investigator of complex social care complaints and a SILP associate reviewer. The Learning and Recall events were facilitated by Nicki Pettitt who also acted as an advisor during the course of the review. Nicki Pettitt is an independent child protection social work manager and consultant. She is an experienced chair and author of SCRs, and is a SILP associate reviewer. Both Ms Pettitt and Dr Connor are entirely independent of NSCB and its partner agencies.

Mother's Partner were interviewed by the report author and representatives of NSCB in June 2016 and this report takes account of their comments.

2.8 Much consideration was given to obtaining the wishes and feelings of Sibling 1 in a way that was meaningful, child focused and least likely to cause additional distress. Children's Services remain involved with the family and following significant reflection it was decided not to involve Sibling 1 directly in the review process. On balance it was thought that involvement at the time would be likely to risk further trauma at what is known to be a difficult time. It was considered unlikely that information provided by Sibling 1 would change the learning identified. Further consideration will be given to the most appropriate way of communicating the outcome of this review with Sibling 1 prior to publication.

2.9 The family will be contacted prior to publication to ensure they are aware of the conclusions of the review.

3 Family Structure

3.1 The subject child is to be referred to as KN15. Her siblings are to be referred to as Sibling 1 aged 11 yrs[2] and Sibling 2 aged 11 months. The parents of KN15 are referred to in this report as Mother and Father. Other family members will be referred to by their relationship to KN15 e.g. Paternal Grandmother.

3.2 Mother, Father, KN15 and Sibling 1 lived in Derbyshire until the parents separated in 2011[3] and Father moved away from the area in 2014. Mother's Partner is the father of Sibling 2 and will be referred to as Mother's Partner throughout this report.

3.3 Mother's Partner has children from a previous relationship, one of whom was the subject of family court proceedings regarding contact with Mother's Partner. That child is not considered in this review other than a reference to whether consideration was given to Mother's Partner having contact with other children.

3.4 The children, Mother, Father and Mother's Partner are White British.

4 Introduction to the Case

4.1 The subject of this review is Child KN15, a thirteen-year-old girl who died in 2015. KN15 died of currently unconfirmed causes and was found by the police 2 days after she had been reported as missing from home. The Mother and Father of KN15 separated in 2011 and there was a history of domestic violence between the parents which had been witnessed by the children. When she died KN15 was living with her Mother, her Mother's Partner, and two Siblings.

4.2 The family moved frequently between Derbyshire and Nottinghamshire. KN15 was registered with 5 GP surgeries and had 8 changes of school[4]. Mother and Mother's Partner married in 2013 and the family received support from the Multi Agency

2 Age at the time of KN15's death

3 Father stated that he separated from Mother on Christmas Eve 2011

4 KN15 attended three nursery, three primary and two secondary schools

Team (MAT)[5] in Derbyshire where, in 2014, a CAF[6] was initiated. The family moved to Nottinghamshire before the CAF was completed.

4.3 Alongside this review the Independent Police Complaints Commission (IPCC) has completed an investigation which focussed solely on the final missing from home episode. The report of the IPCC has been made available to the Lead Reviewer, and no practice or systemic concerns were identified.

4.4 A Police investigation into the potential emotional abuse within the household concluded with no further action following consultation with the CPS.

4.5 The cause of KN15's death has yet to be determined by the Coroner and the Inquest has been adjourned pending the outcome of police investigations and this review.

5 The background prior to the scoped period

5.1 Concerns about KN15 were evident in agency records from birth and it was recorded by some professionals[7] that Mother and Father had difficulties in meeting the needs of the children. In interview with the Lead Reviewer Mother reported that she was not aware of any concerns and said that she was experiencing significant domestic violence from Father at the time. Mother informed the Lead Reviewer that she frequently asked for help with the children and received no support. Between 2002 and 2008, 9 domestic incidents between Mother and Father were registered on the Police Incident Computer System and it was noted that both KN15 and Sibling 1 witnessed some incidents of domestic violence.

5.2 Mother had informed the GP about challenging behaviour of KN15 and Sibling 1 and referrals were made to Child and Adolescent Mental Health Services (CAMHS), 'Child Support Services[8]' and the Community Paediatrician. In 2009 Mother cancelled an appointment for Sibling 1 with CAMHS and advised that the service was no longer required, and the file was closed. KN15 was referred to 'Child Support Services' however there is no entry on medical records regarding the outcome of this referral. In 2013 Sibling 1 was not taken to an appointment with the Community Paediatrician.

5.3 At the beginning of 2013 Mother's Partner presented at hospital in Derbyshire and requested help with his mental health. There was no previously known history of mental health concerns. Mother's Partner was assessed at high risk of self harm however he did not attend follow up appointments with the mental health team. Mother reported deterioration in her partner's mental health during an appointment with mental health clinicians in September 2013.

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5 The main role of the MAT is to support children, young people and families who have additional needs, to work with specialist services such as disability teams, and to help children and families become healthier and meet their full potential. The creation of new teams makes it simpler for families to access and use support services. Within Derbyshire, Multi Agency Teams (MATS) are Derbyshire County Council Early Help provision. The teams are made up of Children's Centre staff, Family Support Workers, Youth Workers and Personal Advisors. The MAT work with cases below the Social Care threshold and offer support to individuals and group work.

6 The CAF/Early Help (single assessment) is a standard intervention framework that can be used by all services working with children and young people.

7 GP and Health Visitor

8 The GP records stated Child Support Services, however it is not clear what agency this refers to.

5.4 In October 2013 Mother was pregnant and records of the initial ante-natal booking in Derbyshire noted that Mother was the carer for her Partner who experienced poor mental health at times. It was recorded that Mother's Partner lived with Mother, KN15 and Sibling 1 and that Mother's Partner had access to 2 birth children who lived with their respective Mothers.

5.5 Following enrolment at School 1[9] in September 2013 professionals quickly identified concerns regarding KN15 and met with Mother and Mother's Partner. The focus of discussion was KN15's behaviour in school and support was provided to help KN15 become more cooperative and attend all lessons. This intervention focussed on the need for KN15 to change and improve her behaviour.

5.6 At an appointment with the GP in October 2013, Mother stated that she had brought KN15 to the surgery to reassure Mother's Partner that there were no underlying problems. Mother and KN15 were spoken to separately and together by the GP. Mother highlighted many changes experienced by KN15 during the previous year which included a new house, having to share a bedroom with her sibling, attending a new school, a new step-father, a new baby on the way, and inconsistency of contact with her biological father. KN15 said that she wanted everyone to be happier and thought that she was the cause of Mother's Partners bad moods. The GP liaised with the form teacher for KN15 at School 1 and was informed about KN15's attention seeking behaviour, persistent lateness and other concerns.

5.7 Mother and Mother's Partner went into School 1 in November 2013 as KN15 had been reported missing. KN15 was found in the school building before the police were involved and Mother was advised by School 1 to take KN15 to the GP.[10] Whilst in school Mother informed a senior tutor about historical domestic violence.[11] KN15 was taken to the GP by Mother in December 2013 and records indicate that Mother was keen to receive support from the MAT. During a telephone conversation between the GP and pastoral support staff at School 1 the GP advised that KN15 did not have ADHD and concerns were more likely to be linked to a chaotic home life. The GP made a referral to the MAT.

5.8 Prior to the period being considered in detail by this review, records indicate that the family moved more than four times between Derbyshire and Nottinghamshire. Mother informed the Lead Reviewer that she moved frequently at this time as she wanted to escape domestic abuse by Father.

6 Key Episodes

6.1 Three key episodes were identified as the significant periods which would provide maximum opportunity for agency learning within the timeframe of this review, which is 1st January 2014 until 2nd June 2015. The key episodes are:

- Involvement of services in Derbyshire

9 School 1 and School 2 are Secondary Schools.

10 There were concerns that KN15 may have had an underlying difficulty such as ADHD which was impacting on her behaviour. This was subsequently discounted by the GP who assessed chaotic home life as the possible cause of her behaviour.

11 School had not previously been aware that KN15 and Sibling 1 had experienced domestic violence between their parents.

- Move to Nottinghamshire and information exchange
- Involvement of services in Nottinghamshire

6.2 It is important to note that during a meeting with NSCB representatives Father said that he was very unhappy that he had not been informed about the concerns regarding KN15. Given the history of the relationship between Mother and Father it is understandable that agencies were not proactive in contacting Father about the welfare of KN15. Father did not request information from Mother or take the initiative to seek information about his children from school during the timeline considered for this review.

6.3 **Key Episode 1: Involvement of services in Derbyshire.**

6.3.1 KN15 was reported as missing from home in January 2014[12] by Mother's Partner who stated that KN15 had gone missing previously on about four occasions but had always returned after an hour or two.[13] On return KN15 confirmed to Police the account of Mother and Mother's Partner that she had gone missing after arguments about being made to wash the pots. Children's Services in Derbyshire and the Police Child Abuse Unit were made aware of this incident in accordance with established procedures.

6.3.2 At this time the MAT were processing the referral from the GP in Derbyshire which included information about Mother being pregnant, inconsistent contact with biological father and the mental health of Mother's Partner. The GP noted that there were no safeguarding concerns and conflict in the family was possibly due to the attention seeking behaviour of KN15. Two members of the MAT made a home visit to identify support needs and agree an action plan. KN15 was also seen alone during the visit and a missing person interview was appropriately completed.[14] KN15 agreed to have 1-1 sessions with a youth worker which took place at school.

6.3.3 In February 2014 Mother contacted the police to report that KN15, aged 11 was missing from home. KN15 returned whilst the police were present and said that she had walked out of the house after being punished by having to wash the pots for taking some money. It is not possible to be confident where KN15 had been whilst she was missing from home. The missing from home procedure was followed and the MAT youth worker was informed.

6.3.4 In February 2014 KN15 had an introductory 1-1 session with the MAT youth worker. KN15 said that she had run away because she had been accused of stealing money by Mother and Mother's Partner. In subsequent sessions KN15 said that she was anxious about the pending house move, worried that she couldn't live up to the expectations of others and concerned about relationships within the family.

6.3.5 In February 2014, at the same time the MAT was involved with the family, Mother's Partner presented at hospital following an overdose and received intervention from Adult Mental Health Services. Mother's Partner informed nurses of current

12 KN15 was 11yrs old when reported as missing from home

13 There is no record before January 2014 of KN15 being missing from home

14 When a child has been found an email is automatically generated to inform children's social care in Derbyshire. The Missing Persons Interview is completed by an appropriate agency

social problems which included his daughter[15] (KN15) running away, involvement of the MAT team with the family and other social problems. The MAT team was not made aware of this presentation by the hospital.

6.3.6 An assessment of Mother's Partner by a Clinical Psychologist from Adult Mental Health services was incomplete[16] and based on self report. A clear diagnosis was not made although suggestions about a possible diagnosis and interventions were discussed with Mother's Partner[17]. A letter to summarise the involvement of Adult Mental Health services with Mother's Partner was forwarded to the GP in 2014. The parenting capacity of Mother's Partner and possible impact of his mental health difficulties on the children in his care were not considered within this letter.

6.3.7 Practitioners within Adult Mental Health Services discussed the potential risks to the birth children of Mother's Partner with whom he had limited contact and no safeguarding issues were identified. There was no exploration about the impact of Mother's Partners mental health on the emotional wellbeing of KN15 and Sibling 1.

6.3.8 In March 2014 Mother was 30 weeks pregnant and it was noted that Mother's Partner was expecting to receive a custodial sentence[18] before the birth of the baby. There was clear documentation in the initial booking for antenatal care that Mother was the full time carer for Mother's Partner due to his mental health difficulties. A community midwife forwarded a pre-CAF[19] assessment and referral to Children's Services and the Hospital Foundation Trust. A safeguarding alert was placed in Mother's notes.

6.3.9 The midwife shared information about Mother being a full time carer for Mother's Partner with the MAT team in March 2014 and the MAT Youth worker shared this information with School 1.

6.3.10 In March 2014 KN15 informed the youth worker that Mother and Mother's partner had told her not to talk to others about things that happened in the family. In discussion with the Lead Reviewer Mother and Mother's Partner stated that they had encouraged KN15 and Sibling 1 not to tell anyone about Mother's Partner going to prison as they wanted to protect them from negative comments from peers and others in the local community. KN15 also told the youth worker about punishments at home which included cleaning kitchen cupboards and washing all the pots. Mother and Mother's Partner informed the Lead Reviewer that washing the pots was a strategy suggested by the MAT to use as a consequence for poor behaviour. During the learning event for this review professionals from the MAT disputed that washing the pots had ever been suggested as a strategy to support the behavioural change of KN15. It is noted that KN15 disclosed that she was being punished by having to wash the pots before the MAT were involved with the family (6.3.1).

15 Stepdaughter

16 Mother's Partner attended 6 out of 8 assessment sessions prior to imprisonment

17 Mother's Partner did not receive a diagnosis however both Mother and Mother's Partner reported a specific diagnosis that was recorded in agency records e.g. ante natal notes.

18 Mother's Partner was convicted of financial offences

19 Pre CAF checklist to help determine if a CAF is required

6.3.11 In March 2014 KN15 had her final 1- 1 session with the youth worker and said that the sessions had been really helpful[20]. Mother's Partner thanked the youth worker and stated that both he and Mother had seen a positive improvement in the behaviour of KN15. The youth worker advised KN15, Mother and Mother's Partner that drop-in services at school were available if KN15 required further support.

6.3.12 A few days later KN15 ran away from home (out of school hours) to the school site and tried to contact the youth worker. A teacher took KN15 home after being alerted by the caretaker who had been unable to reach the youth worker. Mother and Mother's Partner had not reported KN15 as missing. The teacher reported being shocked about the lack of emotional warmth towards KN15 when she was taken home and about the refusal of Mother and Mother's Partner to collect KN15 from school. In discussion with the Lead Reviewer Mother and Mother's Partner disputed this account and stated that they had agreed that the teacher would return KN15 home and talk to her about why she had run away. The youth worker saw KN15 shortly after this incident and gained the impression that KN15 was very unhappy and sad about relationships within the family.

6.3.13 Due to increased concerns about the wellbeing of KN15[21] School 1 sought consent from Mother and Mother's Partner to initiate a CAF. School 1 agreed to lead the Team Around the Family (TAF)[22] meetings and begin the CAF process with the support of the MAT youth worker. The family did not identify any unmet needs during a home visit by the youth worker to discuss the CAF. An initial CAF meeting was held in May 2014, however this was brief as Mother was unwell and in the late stages of pregnancy.

6.3.14 KN15 informed School 1 early in June 2014 that she would be leaving as the family were moving away. The behaviour of KN15 deteriorated at this time and staff at School 1 stated during this Review that KN15 did not want to move school. The Deputy Head Teacher from School 1 and the MAT youth worker made a home visit as KN15 had stopped attending school and they informed Mother and Mother's Partner that KN15 would be reported missing to the Police if she did not go to school. KN15 returned to school following this intervention and attended until the family moved to Nottinghamshire.

6.3.15 The MAT manager attended the second TAF meeting in June 2014 to discuss the CAF. This was not attended by the family who later informed professionals that they had moved out of the area.[23]

6.3.16 Sibling 2 was born in May 2014. The family moved to Nottinghamshire from Derbyshire shortly afterwards. A Student Health Visitor undertook the routine transfer in visit to Sibling 2. It was known that a CAF had been started in Derbyshire however the implication of this for Sibling 2 was not considered.

6.3.17 In July 2014 a pre-sentence report prepared by the National Probation Service (NPS) in Derbyshire made reference to the complex mental health difficulties of Mother's Partner, recommended a referral to adult social care post sentence and

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20 The number of sessions were agreed in advance with KN15

21 Following a further instance when Mother and Mother's Partner did not report KN15 missing from home

22 The TAF is a multi agency meeting to offer appropriate support to meet identified needs of the family identified through the CAF/Early Help Assessment.

23 Mother & Mother's Partner told the lead reviewer that they did not know about the TAF meeting in July

noted that Mother's Partner lived with Mother and two children. No safeguarding checks were made with Children's Social Care.

6.3.18 Concerns about the household where KN15 and her siblings lived were raised during a family court case in which Mother's Partner sought to enforce contact with his child from a previous partner. A Family Court Advisor (FCA) from the Children and Family Court Advisory and Support Service (Cafcass) met with the child concerned who told the FCA that his father shouted at him, the house was dirty and he didn't get on with other children in the household. The FCA completed a report in 2014 and the decision of the court was that contact between Mother's Partner and his child was reduced. This information was not shared with those working with KN15. Cafcass were clear at the time and in reports submitted during this review that the issues raised and information received from the GP about the mental health of Mother's Partner did not meet the threshold of concern for investigations to be made about other children. Cafcass did not share information about the wishes and feelings of the child regarding contact with his father and the allegations that he made, with Nottinghamshire Children's Services.

6.4 **Key Episode 2: Move to Nottinghamshire and information exchange**

6.4.1 There was very little information from previous primary schools when KN15 arrived at School 1 and it took time to gather information and identify concerns. When it was known that the family were moving area, School 1 communicated directly with School 2[24] by email in July 2014. The email was detailed and highlighted concerns which included reference to the mental health of Mother's Partner, over-punitive sanctions applied to KN15 and the initiation of a CAF assessment which had not been completed due to the family moving from Derbyshire to Nottinghamshire. The new school were requested to be vigilant regarding the wellbeing of KN15 and Sibling 1. This information was logged on the Safeguarding system of School 2 and shared with the school Inclusion Manager and the head of year 7 and 8.

6.4.2 The GP in Derbyshire responded promptly to requests from HMP 1 and HMP 2 for information about the mental health of Mother's Partner. The letter from the Clinical Psychologist written in July 2014 was scanned into the GP record in January 2015. This information did not trigger a discussion within the safeguarding children meetings at the GP practice in Derbyshire.

6.4.3 Clinician's within the Adult Mental Health Service were made aware by the family that the MAT in Derbyshire were involved with them. The MAT had been informed of concerns regarding Mother's Partners mental health in the referral from the GP and also by the community midwife. There was no communication between the MAT and the Adult Mental Health Service in Derbyshire and information was not shared.

6.4.4 There was good communication between School 1 and School 2, however had the Derbyshire MAT shared information about their involvement and specifically

[24] KN15 started at School two weeks before the 2014 Summer holidays and began to share her worries with staff during September.

their commencement of a CAF with the equivalent early help service in Nottinghamshire, communication would have been enhanced.

6.4.5 An entry on Sibling 2's Electronic Patient Record refers to a phone call from the Health Visiting Services in Derbyshire to the Health Visiting Services in Nottinghamshire advising of a CAF being in place for KN15 & Sibling 1 prior to the move to Nottinghamshire. The school nurse was not in work at this time, an email to inform of the phone call was missed and the CAF was not progressed.

6.4.6 In July 2014 the National Probation Service (NPS) allocated Mother's Partner's case to the Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNRCRC).[25] In November 2014 the case transferred to the Nottinghamshire office of the DNLRCRC as the family moved back to this area. Policy and procedure within the CRC requires completion of safeguarding checks in the area of origin prior to transfer however no checks were made. The case was transferred without safeguarding information from Derbyshire to inform the assessment. Safeguarding checks were made with Nottinghamshire social care where the family was not known.

6.4.7 Letters from Adult Mental Health Services were not easily accessible in the GP records for Mother's Partner and letters from HMP Service were missing[26].

6.4.8 In 2015 KN15 and Sibling 1 were registered at the GP in Nottinghamshire 9 months after moving to the area. Mother, Mother's Partner and Sibling 2 were registered on arrival at the new house. Following registration with the GP the medical notes for KN15 and Sibling 1 were reviewed. Historical domestic abuse was identified and KN15 and Sibling 1 were discussed at a safeguarding children meeting within the GP practice. It was agreed to gather more information and discuss at the next safeguarding meeting, however KN15 died before this meeting was to take place.

6.4.9 The frequent geographical moves of the family, lack of recording in primary schools, the omission to follow policies and procedures and weakness in systems to transfer information had an impact on inter and intra agency communication. Recommendations to improve communication and information sharing are contained in Agency Reports submitted for this review and will be referred to in more detail within the analysis below.

6.5 Key Episode 3 Involvement of services in Nottinghamshire

6.5.1 In the first few weeks of the Autumn Term, staff at School 2 noted concerns regarding the behaviour of KN15 and support was provided to address this behavior. A key worker was allocated in September 2014 as KN15 had been upset at school and told staff that she needed someone to talk to. Mother told the Lead Reviewer that she had been concerned about the amount of time KN15 had in 1-1 with staff as she felt it was more important to support KN15 to develop positive peer relationships. Mother did not share these concerns with school.

25 Following risk assessment, the case was transferred to the CRC

26 Poor communication between HMP Service and the General Practice was identified as a weakness by the agency report for GP Contracted Services in Nottinghamshire and a recommendation to address this was made by the agency author.

KN15 told staff that she had previously run away from home and that she had lots of secrets and one big one that her mum and the family knew but no one else was allowed to know. KN15 also said that she had written to her dad but didn't see him[27].

6.5.2 School 2 contacted the Nottinghamshire Multi-Agency Safeguarding Hub (MASH)[28] in September 2014. The written transcript of the telephone conversation recorded that the school wished to check if any information had been shared between Derbyshire and Nottinghamshire regarding KN15 and if not the school was clear that a referral needed to be made. School 2 shared concerns with the MASH Officer which included information about the secret at home, harsh punishment of KN15 which included washing all the pots, missing from home episodes, step father in custody, KN15 becoming distressed if not allowed access to food, the involvement of Early Help Services in Derbyshire and frequent moves of the family when services became involved. The MASH Officer explained that it would have been unlikely that information from Early Help Services in Derbyshire would have been shared with Early Help Services in Nottinghamshire. The MASH Officer took advice from a Social Worker colleague within the MASH and did not accept the referral as it was decided that the threshold for Children's Social Care involvement had not been met according to the 'Pathway to Provision' thresholds document[29]. School 2 were advised to make a referral to Early Help Services, complete an Early Help Assessment Form (EHAF), monitor and record everything at school and contact the MASH again in a few weeks if the family did not engage with Early Help.[30] School 2 were informed that the call would not be logged at the MASH.

6.5.3 The day after the call to the MASH, School 2 contacted the Early Help Unit (EHU) in Nottinghamshire and were advised that there was insufficient evidence to open a case as the threshold for Early Help Services had not been met. Although there is no transcript of this conversation, School 2 stated at the Learning Event that they repeated the concerns shared with the MASH and stressed that early help services in Derbyshire had been involved prior to the move to Nottinghamshire. The school did not complete an Early Help Assessment Form and a written referral to the Early Help Team was not made. There is no information available from the EHU regarding this contact as it was policy not to record conversations unless a service was provided. School 2 did not inform the MASH about the response from the EHU.

6.5.4 The School Nurse and GP Electronic Patient Records for KN15 noted[31] that School 2 had made a referral to the MASH however there was insufficient information to progress the referral and School were advised to monitor the situation. This information was received via a telephone call from School 2 to school health services.

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27 Mother's Partner was in custody at this time and it was thought this was the big secret referred to. Mother was a single parent with three young children including a new born baby

28 The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all professionals to report safeguarding concerns about children in Nottinghamshire. MASH Officers are trained to receive safeguarding enquiries and have access to qualified Social Workers for advice.

29 The purpose of the 'Pathway to Provision' handbook is to support practitioners to identify an individual child, young person and/or families level of need and to enable the most appropriate referrals to access provision

30 Information obtained from a transcript of the telephone call

31 This record was made by a Community Nurse in 2014

6.5.5 There was frequent communication between School 2, Mother and Mother's Partner to report concerns about the behaviour of KN15. In an effort to focus on positive achievements, weekly phone calls were initiated between School, Mother and Mother's Partner to inform them about the achievements of KN15 within School[32]. In interview with the Lead Reviewer Mother and Mother's Partner spoke very highly about the positive weekly phone calls from School.

6.5.6 A home visit was made by Nottinghamshire Police to Mother's Partner following his release from custody[33]. It was recorded that Mother's Partner was registered as disabled due to his mental health issues. The purpose of the visit was to assess the risk of further offending and police officers were not aware of any concerns for children at the address and had no information about KN15 and Sibling 1. It was reported that Mother and Mother's Partner were willing to engage with the police officer.

6.5.7 In March 2015 KN15 told her form tutor about punishments that she had been given at home which the form tutor considered unreasonable and harsh. KN15 also said that she was made to use a carrier bag instead of her school bag and wear jogging trousers to school as a punishment. KN15's form tutor shared this information with the Head of Year 7/8 by email and stated that she was extremely concerned that KN15 was being 'emotionally abused' by her father (Mother's Partner). The form tutor also said that she thought KN15 had lost weight. When contacted by the school, Mother and Mother's Partner said that this had not been a punishment and provided an alternative explanation which was repeated in discussion with the Lead Reviewer.

6.5.8 In March 2015 School 2 contacted the MASH for a second time to log a concern. Information which was shared verbally included details of the email from the form tutor, concerns about KN15 being emotionally abused by Mother's Partner, frequent moves of the family, the behaviour of KN15 which was described as attention seeking and acknowledgement by Mother and Mother's Partner at a recent parents evening that they were really struggling. There was no reference to the previous telephone contact from School 2 to the MASH in September 2014 and information about the previous involvement of the MAT in Derbyshire was not shared. When the MASH officer enquired about an EHAF School 2 said that an EHAF had not yet been considered. It is important to note that School 2 had been advised to complete an EHAF during the first telephone call with the MASH in September 2014.

6.5.9 The MASH officer advised School 2 that information should be shared in full with Mother before a referral could be accepted and offered reassurance when asked by the caller at School 2 if they were allowed to share all the information.[34] It was also suggested that School 2 continued to monitor KN15 and that Mother and Mother's Partner were referred to the parenting course held at school. It was agreed that School 2 did not need to call the MASH again if satisfied with the response by Mother following sharing of information. Mother was very angry

[32] See good practice section

[33] For tax related offences

[34] School 2 asked if they were allowed to tell Mother all the information – this was in reference to the concern that KN15 was being emotionally abused.

during the telephone discussion with School 2 to inform her about the concerns of the form tutor[35]; this information was not shared with the MASH.

6.5.10 The Agency Report completed by Nottinghamshire Education for this Review noted that school sought the support of other agencies and felt unsupported by the response from the MASH Officer. Transcripts of the telephone calls between School 2 and the MASH (available to this review) both ended with school thanking the MASH officer for the advice provided. During the Learning Event for this review, Staff at School 2 said that they did not feel able to challenge the advice from the MASH and this is considered further within the analysis.

6.5.11 Mother's Partner reported on fourteen occasions to the Probation Service Officer (PSO) in Nottinghamshire and made reference to his mental health on most occasions.[36] The PSO sought advice from a Community Psychiatric Nurse (CPN)[37] and it was thought no further services were required as Mother's Partner reported that he was engaged with treatment. Mental Health Services in Nottinghamshire were not involved with Mother's Partner during this period. It is unclear what treatment, if any, Mother's Partner was receiving and it appears that the self report of Mother's partner was accepted without liaison with adult mental health services. The PSO had no concerns about the presentation of Mother's Partner during this period.

6.5.12 Mother's Partner saw the GP in Nottinghamshire on three occasions between December 2014 and May 2015 and reported that he had been discharged from Mental Health Services in Derbyshire and had seen a Psychiatrist whilst in custody. Mother's Partner requested medication and a referral to Mental Health Services. Mother's Partner did not respond to letters from Mental Health Services inviting him for an assessment and later stated that he had been on holiday. Mother's Partner did not attend an appointment with Adult Mental Health Services in Nottinghamshire during the time frame for this Review

6.5.13 KN15 was reported missing from home in Nottinghamshire following an argument on 30 May 2015. The police provided notification under the local joint protocol[38] and information was forwarded to the Child Missing Officer (CMO). The CMO contacted colleagues in Derbyshire and received information about incidents when KN15 had been reported missing from home in Derbyshire. The missing and found information was shared immediately with relevant agencies.

6.5.14 A social worker was allocated on 2 June and a telephone strategy discussion between the police, health and CSC was held on the same day. Information shared included; instigation of a CAF in Derbyshire, previous incidents when KN15 had been missing from home including times not reported to the police and the probation service shared information about the mental health of Mother's Partner.

6.5.15 The body of KN15 was found on 2 June 2015 at 7.30pm. A multi-agency meeting took place the following day to determine the next steps.

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35 Mother informed school that KN15 had ruined Mother's Day by refusing to do chores and had spoken to someone at school to 'get her own back' at Mother and Mother's Partner

36 Either by referring to his diagnosis, medication or pending appointment with mental health professionals.

37 A CPN visited the Probation Service weekly to advice practitioners about cases

38 Children Who Run Away and Go Missing from Home, Care, or Education protocol http://www.proceduresonline.com/nottinghamshire/miss_home_care_jt_prot.pdf

7 Analysis by theme

7.1 Following examination of what happened during the period of relevance for this review, key themes were identified. Consideration of each theme allows a clearer understanding about why individuals acted in the way that they did and highlights learning opportunities for individuals and agencies.

7.2 The themes identified were;

- Transitions
- The voice of KN15
- Parental Engagement with agencies and professionals
- Parental mental health
- Effectiveness of action planning and support provided
- Communication between agencies

7.3 **Transitions**

7.3.1 Prior to becoming a pupil at School 1 KN15 experienced physical transitions which included attendance at multiple primary schools, changes of address and registration with six different GPs. There were also transitions within the family structure as Father left and Mother's Partner joined the family. KN15's name was changed to that of Mother's Partner when she was 9 years old.[39] At the time of the last house move Sibling 2 had been born and Mother's Partner was in prison.

7.3.2 School files contained limited historic information from previous schools due in part to the frequency with which KN15 moved schools. There was a view shared among professionals at School 1 and School 2 that Mother and Mother's Partner would move if professionals became too close to the family. KN15 told staff at School 1 that she did not want to move school and her behaviour at School 2 was described as problematic at this time which could have been an indicator of her distress. In discussion with the Lead Reviewer Mother and Mother's Partner said that they moved to be closer to extended family and Mother said that during the early years she moved frequently to get away from Father.

7.3.3 Whilst individuals and agencies in Derbyshire and Nottinghamshire held some information about KN15 it was a challenge to piece this together. The frequent transitions made it more difficult for agencies to focus on the voice of KN15 and complete a holistic and systematic assessment to address the needs of all the family. It was also a challenge to understand the emerging discrepancies between the views of professionals, information provided by KN15 and parental explanations.

7.4 **The Voice of KN15**

7.4.1 Direct work to seek and listen to the voice of KN15 was undertaken by the MAT youth worker in Derbyshire and specific staff in School 1 and School 2. However, it was acknowledged in Agency Reports submitted for this review that there was limited information available about the wishes and feelings of KN15 and she was

[39] Mother and Mother's Partner informed the Lead Reviewer that KN15 and Sibling 1 asked to change their name and were excited about doing so.

described as a child who was closed about things that were happening in her home life.

7.4.2 Whilst significant efforts had been made in School 1 and School 2 to obtain KN15's wishes and feelings the focus of work was on the behavioural change of KN15. It is known that KN15 asked for the time limited 1-1 sessions with the MAT youth worker to go on for longer. KN15 ran away from home to speak with the youth worker a few days after the final 1-1 session. KN15 did talk to some adults about her life and examples provided in agency reports submitted for this review are reflected throughout this report.

7.4.3 School 2 stated that it was a significant challenge to evidence the factual accuracy of what KN15 said. This was further complicated as explanations provided by Mother and Mother's Partner often contradicted the account provided by KN15. The incidents when KN15 wore jogging trousers to school and also complained about having to wash the pots provide examples of such contradictions. Whether factually accurate or not, it is a concern that KN15 described these events as a punishment. The discrepancy between the accounts provided by Mother and that of KN15 do not appear to have been explored further. It is evident from health and education records that issues were frequently reported from Mother's perspective which proved difficult for professionals to challenge.

7.4.4 In 2013 a recorded comment by the GP in Derbyshire indicated that KN15 saw herself as being the cause of some of the family difficulties; *'I want people to be happy and I cause my (Mother's Partners) bad moods'*. It is evident that KN15 was beginning to internalise the view that she was the cause of family difficulties and this is likely to have had a significant impact on her emotional wellbeing and self esteem.

7.4.5 The GP repeated Mother's description of KN15's behaviour as attention seeking in the referral to the MAT. There appeared to be a lack of professional curiosity to understand the cause of KN15's behaviour. Use of the term 'attention seeking' has implications of blame and negativity and is likely to have influenced the intervention provided and assessment of level of concern.

7.4.6 The description of her behaviour as attention seeking followed KN15 throughout school. Whilst professionals may have individually questioned the cause of KN15's behaviour this was not explored in a systematic way that addressed all the influences on KN15 including school, peers and family. It is possible that the behaviour of KN15 reflected a resourceful response to an unmet basic need for attention. Use of Attachment Theory to better understand the behaviour of KN15 may have resulted in greater understanding of the function of KN15's behaviour and increased awareness of the lived experience of KN15 (Howe et al. 1999).[40] There was no evidence that the description of KN15 as 'attention seeking' was challenged by any individual or agency.

7.4.7 Management of KN15's behaviour in school was described as problematic. Much effort was made within School 1 and School 2 to avoid exclusions and provide a

[40] Attachment Theory Child Maltreatment and Family Support. Howe D. Brandon M. Hinings D. Schofield G. Palgrave (1999)

caring and supportive environment for KN15. KN15 responded positively and was said to enjoy 1-1 attention from the MAT team and from staff in both schools. Staff at School 2 described the difficulty in obtaining a clear understanding of what life was like for KN15 who could present with very challenging behaviour one day and talk positively about home life and family relationships the next. It is not known what KN15 had made of the historic domestic abuse between Mother and Father or whether this had an influence on her behaviour.

7.4.8 The behaviour of children can be a clear indicator of their emotional state and on occasions KN15 presented as very needy at School 1 and School 2. Professionals did not share a clear understanding of KN15's wishes and feelings, information was not gathered in a systematic way and a CAF was not completed. Without an opportunity to understand the context of the behaviour at the time and external influencing factors it is not possible to state with confidence what KN15 was attempting to communicate by her behaviour. Learning points from previous SCRs have highlighted the importance of recognising behaviour as a means of communication and the implications of doing so for practice. (Ofsted 2011 p 18 [41] Sidebotham P. Brandon M. 2016 p118)[42].

7.4.9 In the absence of a completed CAF it was not possible to plan a consistent and constructive multi-agency response to the voice of KN15. Intervention by the MAT and School 1 and 2 was inevitably limited as this was directed at support and the behavioural change of KN15 and other potential influencing factors including home environment, peers and school were not assessed. A multi agency discussion may have brought together all available information and may have led to an exploration of why KN15 was identified as the child with the problems in this family. The importance of identifying why a child may be treated differently within the family unit has been highlighted within other SCR Reports.[43]

7.4.10 Whilst the voice of KN15 was heard by staff at School 1, School 2 and by the MAT youth worker, the understanding of KN15's lived experience was very limited. This was acknowledged by practitioners at the Learning Event and within agency reports prepared for this Review.

7.5 **Parental engagement**

7.5.1 Mother and Mother's Partner informed the Lead Reviewer that Mother had received no support from agencies although she repeatedly asked for help when KN15 was younger. There is evidence of missed appointments in medical records for the children and Mother advised CAMHS that support was no longer required in 2009 (7.4). Whilst Mother and Mother's Partner had consented to a CAF in Derbyshire they moved authority without informing services which would have enabled continuation of assessment and support. Mother and Mother's Partner also declined to identify support needs when asked by the MAT (6.3.13).

7.5.2 Missed appointments were not pursued by the GP in Nottinghamshire. Had enquiries been made they may have resulted in additional information about the wellbeing of KN15. Nottinghamshire Healthcare Foundation Trust now has a

41 The voice of the child: learning lessons from serious case reviews Ofsted 2011

42 Sidebotham P. Brandon M. et al Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011- 2014 DfE 2016

43 Daniel Pelka serious case review September 2013 http://www.coventrylscb.org.uk/dpelka.html

policy[44] which provides guidance on action to take when patients and families do not attend or cancel booked appointments.

7.5.3 Mother and Mother's Partner told the Lead Reviewer that they would have welcomed help for the whole family. This statement is not supported by the lack of information sharing with the MAT about Mother being the carer for Mother's Partner and involvement of mental health services at the time[45]. The delay of nine months before registering KN15 with a GP in Nottinghamshire (6.4.8) contradicts the assertion of Mother and Mother's Partner that they would have welcomed help.

7.5.4 School 2 communicated regularly with Mother and Mother's Partner and instigated weekly phone calls to report only the positive achievements of KN15. This was an important initiative by school and good practice to highlight positive behaviour and address the frequent negative communication between the school and home.

7.5.5 Mother and Mother's Partner spoke very highly about the key worker who worked with KN15 at School 2. It was evident that staff at School 1 and School 2 worked hard to engage positively with Mother, Mother's Partner and KN15. A culmination of factors which included; missed opportunities to complete the CAF, reluctance to challenge Mother and Mother's Partner due to ongoing efforts to develop a positive relationship with them; and reassurance by the presentation of the family as a cohesive unit on occasion, contributed to the absence of a systematic assessment.

7.5.6 During the time line considered by this Review, Mother and Mother's Partner had contact with various agencies and their level of engagement differed. There was limited information sharing between professionals and inconsistencies in the presentation of Mother and Mother's Partner were not identified. Professionals did not consider whether the actions and views of Mother and her partner were consistent with the best interests of KN15.

7.6 **Parental Mental Health**

7.6.1 Mother's Partner did not have a clear mental health diagnosis although he and Mother informed various professionals that a diagnosis had been given and Mother informed maternity services that she was the full time carer for her partner due to his mental health difficulties. Information about Mother's Partner's mental health was known to a wide range of agencies[46] however the potential impact of his mental health on the family was not assessed.

7.6.2 There was no documented evidence to suggest that KN15's welfare was discussed although mental health practitioners were aware that the MAT were involved, that KN15 was running away from home and that there were relationship

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[44] Do not Attends (DNAs)/ Cancellations and Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way -1.18

[45] In discussion with the MAT Mother and Mother's Partner focussed on the behaviour of KN15

[46] Adult Mental Health Services in Derbyshire, the National Probation Service (Derbyshire), DLNRCRC in Derbyshire and Nottinghamshire, GPs in Derbyshire and Nottinghamshire, the school nursing service in Derbyshire and Nottinghamshire, the MAT Derbyshire, Maternity Services Derbyshire, School 1 and School 2, HMP service and Cafcass.

difficulties and arguments between KN15 and Mother's Partner. It was known that the mental health of Mother's Partner impacted on his behaviour, the extent to which this was normalised within the family home was unknown and remained an unassessed risk.

7.6.3 Inconsistencies in parenting between Mother, Mother's Partner and Paternal Grandmother were identified as a concern by the clinical psychologist in Derbyshire. If this had been shared with practitioners within the MAT who were working with the family at this time it may have informed the support and intervention offered to the family. Practitioners in Adult Mental Health Services were reassured by the involvement of Cafcass, the presentation of Mother's Partner, and information provided by Mother and Paternal Grandmother. There appears to have been an uncritical acceptance of the presentation by adults and misunderstanding of the role and remit of Cafcass.

7.6.4 It has been acknowledged by the Agency Report prepared for this Review that the Adult Mental Health Service were working in isolation with this family and that the threshold for a referral to Derbyshire County Council's Children's Services was met.[47] The Biennial Analysis of Serious Case Reviews 2005-7[48] described this as a form of 'silo' practice. One explanation provided for not making a referral to Children's Services was the normalisation of risk within the caseload of practitioners.

7.6.5 Clinicians within adult mental health stated during the review process that the case of Mother's Partner would have benefited from the allocation of a care coordinator as described in Derbyshire Health Care Foundation Trust policy and procedures[49]. A care coordinator could have provided a better overview of the case and ensured that other agencies were consulted and involved as appropriate. Absence of a care coordinator resulted in poor oversight of the clinical intervention regarding the mental health of Mother's Partner. Organisational constraints, specifically lack of resources, were an explanation provided by practitioners in adult mental health for the omission to appoint a care coordinator. It is unclear what effort was made to address these issues but it is likely that organisational and capacity issues impacted on decision making and contributed to the potential needs of all family members, particularly the children being overlooked.

7.6.6 In the absence of concerns being identified by Adult Mental Health Practitioners the case wasn't raised for discussion in their supervision and was not considered by them to meet the threshold for information sharing.

7.6.7 Actions, decision making, unmet need and minutes of multi disciplinary meetings were not documented in the clinical record for Mother's Partner which is required record keeping procedure. There does not appear to have been a consistent approach to the Electronic Patient Records and limitation of resources was said to have resulted in a breach of the Record Keeping policy. The agency report from

47 Derbyshire Healthcare Foundation Trust, Agency Report submitted for this SCR p4.

48 Understanding Serious Case Reviews and their Impact. A Biennial Analysis of SCRs 2005-7 M. Brandon et al (2009)

49 Core Care Standards and Care Programme Approach Policy and Procedure, DHCFT

Derbyshire Healthcare Foundation Trust contains a recommendation that an audit of record keeping should reflect the learning from this review.

7.6.8 The GP in Derbyshire was aware of Mother's Partner's mental health difficulties and there is no indication that the impact of this on the children was considered. There was no record to indicate that the children were discussed at the practice safeguarding meeting or that a referral to children's services was considered. The Safeguarding Children's Board Threshold Document in Derbyshire[50] notes that adult mental illness may present challenges to a child, represent emerging needs, and should trigger a referral for a multi-agency assessment or early help assessment. Potential challenges to KN15 and other children were not identified due in part to the lack of multi-agency assessment.

7.6.9 There is extensive research evidence that demonstrates the impact of parental mental health problems on children. A Social Care Institute for Excellence guide to parental mental health and child welfare (SCIE 2011)[51] highlights key recommendations for practice which include;

- effective screening tools to identify adults with mental health problems who are parents
- assessment of the whole family
- effective planning to meet the individual needs of each family member.

7.6.10 The omission to identify the impact of adult mental health on the wellbeing of children was also highlighted in the Serious Case Review BDS (Derbyshire 2011, revised 2014). Whilst the circumstances of this review differ, the recommendation from the BDS review regarding information sharing between adult mental health services and relevant children's agencies is of direct relevance.

7.6.11 Mandatory training in Think Family was introduced for all Derbyshire Healthcare Foundation Trust (DHFT) staff in October 2014. Neither mental health practitioner involved in the care of Mother's Partner had completed this training during the time considered within this review as the 'Think Family' training was to be completed over a 3 year period ending in March 2017.

7.6.12 Weaknesses in the practice of the NPS and CRC were identified in the agency report submitted for this review. The NPS Pre-Sentence report concluded that the mental health difficulties of Mother's Partner were linked to his offending behaviour and it is unclear why safeguarding checks were not completed. The recommendation to refer to Adult Social Care post sentence was not followed by probation in Nottinghamshire and safeguarding checks prior to transfer were not made by probation in Derbyshire. In addition it appears that the CPN and PSO in Nottinghamshire accepted the self report of Mother's Partner that he was engaging with mental health services which was not the case. Had practitioners within NPS and CRC taken a more investigative approach this may have resulted in consideration of the potential impact of Mother's Partner's mental health on the children.

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50 www.derbyshire.gov.uk/images/Derby%20City%20and%20Derbyshire%20safeguarding%20thresholds_tcm44-276569.pdf

51 Think child, think parent, think family: a guide to parental mental health and child welfare (SCIE 2011p6)

7.7 **Effectiveness of Intervention and formality of action planning**

7.7.1 The correct procedure was followed by the MAT as a Missing from Home interview was completed during the first home visit. Information provided by the GP in the referral to the MAT contained information about Mother's Partners mental health which was not considered to be an issue at the time. A verbal action plan was agreed between the MAT, Mother, Mother's Partner and KN15 however this was not within the context of a CAF and an opportunity to obtain information about the whole family in a systematic way was lost. As noted previously in this report intervention by the MAT, School 1 and 2 was inevitably limited as this was directed at offering support to and encouraging the behavioural change of KN15 (5.5, 6.5.1). Without a clear plan with agreed objectives it is very difficult to judge what success would look like and it was not possible to assess if the support provided was effective and achieved the required change.

7.7.2 The MAT closed the case following positive feedback from Mother, Mother's Partner, and staff at School 1. As the plan had not been formalised and the purpose of the intervention was not as clear as it could have been, it was difficult for all professionals involved to have a discussion about whether outcomes had been achieved. Senior Managers from the MAT informed this review that it would not have been appropriate to keep the case open given information that was known at the time and positive feedback received from the family, including KN15 herself. It was the view of managers and MAT practitioners consulted during this review that the work of the MAT had been effective.

7.7.3 At the Learning Event staff within School 1 expressed a view that it may have been helpful to continue with the 1-1 between KN15 and the MAT as this would have provided KN15 with someone she trusted to talk to at what was a challenging time. Mother and Mother's Partner told the Lead Reviewer they did not think they had a choice or could ask about continuing the sessions with the MAT youth worker. It is possible that these discussions could have taken place had there been a multi-agency discussion prior to closure of the case. However, it is noted that KN15 was offered a drop-in facility to access on-going support from the MAT Youth Worker at school and she had made use of this previously.

7.7.4 Without a CAF/EHAF KN15 became the focus of intervention and the opportunity to consider additional factors that may have contributed to the presenting difficulties was not taken. Derbyshire has introduced a new integrated structure with a Single Assessment Process for service delivery to children, young people and their families. The case of KN15 was referred to Children's Services prior to these new processes and if referred now Children's Social Care Managers in Derbyshire are confident that a CAF/EHAF would be carried out earlier to identify the needs of all family members and coordinate multi-agency working. School 2 responded proactively to information provided by School 1 and allocated KN15 with a key worker which enabled School 2 to respond quickly to specific incidences usually relating to what was described as challenging or attention seeking behaviour.

7.7.5 Following the initial call to the MASH, School 2 provided a range of support which was described by staff at School 2 as effective. The Agency Report from Nottinghamshire Education provided for this review noted that the difficulties

experienced by School 2 in getting support from other agencies together with an improvement in the behaviour of KN15 and belief that the School support was effective resulted in staff at School 2 continuing to work alone to support KN15. The perception that it had been difficult to obtain support was repeated by teachers from School 2 during the Learning Event. It is noted that advice about how to obtain support had been provided by the MASH however this was not followed by School 2.

7.7.6 The advice given to School 2 when contacting the MASH in Nottinghamshire was appropriate given the information that was shared. It was a significant omission that School 2 did not complete a written referral[52] or provide feedback to the MASH about the lack of progress in obtaining support from early help services (6.5.3) and the angry reaction of Mother (6.5.9) when concerns were shared with her.

7.7.7 The Agency Report for Nottinghamshire Education noted that concerns about KN15 met the threshold for the provision of Early Help support and intervention by other services and from information known by School 2 at the time this would appear to be the case. School 2 communicated concerns verbally during two telephone calls to the MASH in September 2014 and March 2015. Advice given to complete an EHAF, which would have resulted in written communication of the concerns, was not followed by School 2.

7.7.8 School 2 reported they lacked confidence in the effectiveness of the EHAF at the time[53]. They also thought that that the support offered to KN15 by staff was effective and there were reported periods of stability for KN15 within school. This is also likely to have influenced the decision not to complete a written EHAF.

7.7.9 The system of recording safeguarding incidents in School 2 was not consistent with policy. Whilst this did not impact on actions taken there was the potential for significant information to be omitted from the safeguarding log which may have been significant if KN15 had moved schools again or if key staff in the school had changed.

7.7.10 It was an important initiative by School 2 to instigate weekly positive phone calls to Mother and Mother's Partner. These phone calls will have gone some way to break the cycle of negative communication between School 2, Mother and Mother's Partner however the impact of frequent negative communication on the emotional wellbeing of KN15 was not assessed or understood.

7.8 **Communication between agencies**

7.8.1 Communication between agencies was at times very good and child focussed. The transition email from School 1 to School 2 stated that a CAF had been initiated immediately prior to the move and detailed safeguarding concerns, information about Mother's Partner's mental health, and the interventions provided at School 1 by the MAT. This is an example of proactive information sharing by School 1. School 1 had also been proactive in seeking information about KN15 after she arrived in their school. This history was recorded in a

52 To either the MASH or Early Help Services

53 This was reported in the agency report and verbally by school staff at the learning Events.

confidential file and transferred to School 2. The LSCB have since been informed that School 2 had limited appreciation of the information within the confidential file and this was not used to inform interventions and support provided.

7.8.2 It is evident that communication between the MAT and School 1 was good however it would have been strengthened by earlier use of the CAF as noted previously. This may have led to a multi-agency assessment and response which included contact with and the contribution of adult mental health services[54].

7.8.3 The Midwife contacted Children's Social Care in Derbyshire when Mother booked her anti-natal care and prior to discharge to clarify if there were safeguarding concerns. This is an example of good practice however the implications for Sibling 2 of a CAF being initiated for KN15 and Sibling 1 were not considered. Services were provided to Sibling 2 in isolation and there was no assessment of the whole family.

7.8.4 At the routine transfer in visit in July 2014 by Health Visiting Services in Nottinghamshire, following the birth of Sibling 2, it was known that a CAF had been initiated for KN15 and Sibling 1 in Derbyshire. Information was shared via email with the school nurse who worked during term time only. The school nurse changed role before the email was read and this information was not acted upon. Systems have since changed to provide more robust information sharing processes. It would be reasonable to expect that the Student Health Visitor would have been encouraged by her mentor to adopt a Think Family approach and considered the implications for Sibling 2 of a CAF for the older children. It is important that Student Health Visitors receive appropriate oversight and support in their work with families when additional needs have been identified. Nottinghamshire Healthcare Foundation Trust (NHFT) has a Think Family Strategy and a Think Family Safeguarding training course is offered to all NHFT staff.

7.8.5 At the time of the first telephone contact between School 2 and the MASH in Nottinghamshire there were already significant concerns within School 2 about the behaviour of KN15. Whilst KN15 had only just started at School 2 it was evident that staff considered information provided by School 1 together with their own observations to avoid the 'start again' syndrome noted as a cause for concern in previous SCRs[55].

7.8.6 Information about communication between School 2 and the MASH is detailed earlier in this report. The two telephone calls to the MASH were made by different people from School 2[56] and were received by different MASH Officers. Whist all calls to the MASH are routinely audio recorded, the procedure to make a written record of calls not accepted as referrals in the MASH was not in place at the time. This resulted in advice provided during the second call not taking information into account information which had previously been shared by the school. Practice has since changed and an electronic written record is made of all calls whether a

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54 It is now recommended practice within DHCFT that adult services inform child and family services of their involvement with a parent

55 Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009, Brandon et al 2013.

56 Staff were working closely together to support KN15 and person with most detailed view of information made the call each time

referral is taken or not. The purpose and outcome of the call and agreed action are now explicit in records and there is a clear audit trail of all calls being made about a child[57]. However, even if a written record of both calls had been taken it would not have impacted on the decision making in the MASH as the threshold of intervention by children's social care was not met.

7.8.7 Transcripts of the telephone calls between MASH Officers and School 2 indicate that school 2 communicated concerns about KN15 and appeared to be satisfied with the advice provided at the time. Whilst managers at School 2 have stated subsequently that they felt let down and unsupported when seeking support and advice from other agencies, it is noted that these comments have been made with knowledge of what happened to KN15, but communication between School 2 and the MASH may have been influenced by issues relating to power and confidence in the professional ability and knowledge of educational professionals to offer a different view to colleagues perceived as experts in safeguarding.

7.8.8 Advice provided to School 2 by the MASH during the first telephone contact was not followed fully by School 2. They made telephone contact with early help but did not follow this up when they were told that the early help threshold had not been met. There is no record of the contact made within early help services. This raises a question about record keeping processes within Early Help Services at the time, however these have since been reviewed and changed. Processes and procedures within Early Help Services are reportedly now more robust and supported by the increased integration of MASH and Early Help Services.

7.8.9 EHAF is the approved way of identifying the support needs of families and to help signpost them to appropriate services in Nottinghamshire. Whilst the issue in this case seems to be a lack of confidence by School 2 in the EHAF to provide an effective means of accessing early help services it is important to note that there is an escalation process in place to resolve professional disagreement in the handling of specific cases.

7.8.10 Difficulties in escalating concerns has featured in previous SCRs in Nottinghamshire (e.g. IN14) and NSCB has made concerted efforts to raise awareness about good practice with regard to the escalation of concerns.[58] Guidance at the time of the telephone calls between the MASH and School 2 was worded in a way that reflected a hierarchy within organisations through which concerns could be escalated. However this was not helpful for schools as the designated safeguarding lead may be the most senior person in the school.[59] Guidance about escalation of concerns was revised in 2015 and the new procedure provides clarification for colleagues within education about the correct process to follow.

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[57] Having a written record will improve information management within the MASH and ensure that the information supplied is available for future reference. It is the responsibility of the person contacting the MASH to ensure they keep a full record of the advice received and any actions required. Current policy is for the MASH to send a letter to the referrer advising them of the outcome of their referral.

[58] Including; revision of the escalation procedure in 2015 to Resolving Professional Disagreements Procedure; various training events including a presentation to a Schools Designated Persons Event and focus on escalation in news bulletins and NSCB audits.

[59] Agency Report, Nottinghamshire Education p 23

7.8.11 The MASH has a web page which contains information to professionals who wish to report a safeguarding concern. This includes advice about the value of completing an EHAF and a recommendation to follow up referrals in writing within 24 hours. This expectation is also reflected in the NSCB inter agency safeguarding children procedures. There remains a fundamental issue that School 2 lacked confidence in the process as identified during this review. The Board may wish to review whether the EHAF is used effectively by schools within Nottinghamshire and respond to any findings. It is important to note that a survey to review referrer satisfaction to the MASH in Nottingham in 2014 provided positive feedback about the service.

7.8.12 Decision making processes about when to take action without parental consent are complex and there must be justifiable evidence to proceed without informing the parent. There was no evidence to suggest that KN15 would be at immediate risk if the concerns about emotional abuse were shared with Mother. School 2 reported at the Learning Event that Mother was very angry when informed of the disclosure and blamed KN15 for her behaviour and causing upset within the family. Consideration does not appear to have been given to the possibility that KN15 may have been a scapegoat within the family and could have been at risk for speaking out. There was no discussion about the potential impact of this disclosure and the possible consequences for KN15.

7.8.13 It would have been child focussed and appropriate for staff at School 2 to explore the concerns raised by the form tutor with KN15 and Sibling 1 in an attempt to obtain further information to share with the MASH and agree appropriate action. School 2 did not inform the MASH of Mothers angry response and no further communication took place between School 2 and Children's Social Care until KN15 went missing in May 2015.

7.8.14 School 2's safeguarding policy requires the use of standardised forms for recording safeguarding issues. The system used to record concerns about KN15 was electronic and there were gaps in information which included the email from the form tutor in February which contained concerns about KN15 being emotionally abused by Mother's Partner. It is not clear how the significance of this email was considered. In response to findings from previous serious case reviews Nottinghamshire issued guidance to schools on how to audit the effectiveness of record keeping[60]. It was noted in the Agency Report from Nottinghamshire Education that the audit of safeguarding records by the Education Advisory Board at School 2 was judged to have been inadequate as the discrepancy between policy and practice was not identified.

7.8.15 Following a telephone call from School 2 to a school nurse it was recorded on KN15's medical records that the result of the referral by School 2 was that the MASH felt there was insufficient information to take the referral forward and School 2 were to monitor the situation. Whilst this demonstrated information sharing between School 2 and the community nurse the information shared was inaccurate and partial. A referral had not been accepted by the MASH and advice to complete an EHAF was not shared. In addition there was lack of clarity

[60] The audit tool is incorporated as Appendix 12 in the Safeguarding Policy for School 2.

about what monitoring the situation required and how other agencies could support with this.

7.8.16 Communication between Adult Mental Health Services and Children's Social Care was not up to accepted standards, as has been discussed in detail above.

8 Conclusion

8.1 Whilst there were concerns for the emotional well-being of KN15, given the information that was known to professionals at the time it was not possible to predict that she would die in the circumstances which resulted in this Serious Case Review.

8.2 Records indicate that KN15 ran away from home and presented with increasingly challenging and disruptive behaviour at school. Frequent moves of home, school, and GP made it difficult for professionals and agencies to develop a coherent picture of KN15 and the family. It was significant that the family moved at the time KN15 developed a relationship with the youth worker and a CAF had been initiated. Positive communication between agencies in Derbyshire and Nottinghamshire has been highlighted however this could have been more effective had there been a formal process for transfer of Early Help Interventions from one area to another.

8.3 A CAF was initiated in Derbyshire with an initial meeting taking place in May 2014 (6.3.13) although this was not completed due to the family move to Nottinghamshire. However, there were various other occasions within the timeline for this review when a CAF/EHAF could and should have been initiated and these have been highlighted within the analysis. It is important to recognise that the omission to initiate a CAF/EHAF must be viewed as a collective responsibility. Prioritisation of the views of adults within the family and the focus by agencies on changing the behaviour of KN15 may have been identified and challenged if a multi-agency meeting involving all family members had been held.

8.4 Mother and Mother's Partner were viewed as generally positive and cooperative by staff in School 2. KN15 did talk to some professionals at School 1 and School 2 and appeared to have a positive relationship with the youth worker from the MAT. It is not possible however to judge whether KN15 felt heard and understood, as support and intervention was focussed on the changes that she needed to make, without consistently looking at the wider family and exploring what may have been influencing her behaviour.

8.5 Instigation of positive phone calls by School 2 to Mother and Mother's Partner was an attempt to challenge negative perceptions however the behaviour of KN15 remained the focus of change. The view shared by KN15 with the GP that she was causing problems within the family (5.6) appears to have been the dominant narrative throughout this case. The voice of KN15 was limited, and the perception that she was to blame for many of the difficulties within the family was perpetuated, sadly, even by KN15 herself[61].

[61] KN15 told the GP in 2013 that she was to blame for Mother's Partner having bad moods

8.6 Both Derbyshire and Nottinghamshire have robust early help policies and procedures. Whilst the system may be in place this review has highlighted gaps in implementation as in the absence of a CAF/EHAF there was no agreed or coordinated multi agency plan (7.7.1 – 7.7.11).

8.7 Information sharing between Derbyshire and Nottinghamshire was limited with two exceptions of good practice evidenced by the transition email between School 1 and School 2 and the telephone call from a community nurse to alert health services in Nottinghamshire that a CAF had been initiated. Had a CAF/EHAF been started when the MAT in Derbyshire first became aware of emerging needs it is likely that information would have been shared with agencies when the family moved and it would have been more difficult for the family to distance themselves from professionals.

8.8 Communication of concerns about children between professionals in different agencies can be challenging. This case has highlighted the importance of recording and sharing agreed actions following safeguarding discussions to ensure there is clarity and professional accountability. When information is to be shared with parents and carers it is important that the child is at the centre of the decision to do this and possible consequences for the child are considered to ensure that actions taken are in the child's best interests.

8.9 It is acknowledged by the Lead Reviewer that the Agency Reports submitted for this Review contained robust recommendations to improve inter and intra agency working to safeguard children. Findings from this Review whilst particular to the case have striking similarity to findings that have emerged over recent years from other Serious Case Reviews. One senior manager noted during the learning event for this review that professionals within organisations and agencies who had involvement with KN15 and her family are knowledgeable about what makes effective safeguarding practice. Information is available and encompassed in robust policies and procedures for safeguarding children in Derbyshire and Nottinghamshire for which DSCB and NSCB have oversight. Whilst there is learning to be gained from this Review it is important to ensure that this goes beyond recommendations to address recurrent themes, systems and processes which evidence has shown may not achieve any effective learning.[62] Involvement of practitioners in a multi-agency discussion to identify how learning can be implemented in a meaningful way could enhance working practices and relationships and is more likely to achieve sustained change.

9 Good Practice Identified

9.1 There was a lot of good practice highlighted during this Review which is listed within the report and includes:

- Timely and detailed information sharing between School 1 and School 2 to alert School 2 to safeguarding concerns and avoid the 'start again' syndrome.

[62] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014 p232. Sidebotham P. Brandon M et al DfE 2016

- Telephone calls between School 2 and the MASH in Nottinghamshire to share concerns about KN15 and family dynamics.
- Responsive and empathic support offered to KN15 by School 1 and School 2. Mother and Mother's Partner described the relationship between the key tutor in School 2 and KN15 as very positive.
- Home visit by School 1 and the MAT when KN15 did not attend school, this proactive response resulted in KN15 returning to school.
- Provision of 1-1 support for KN15 by the MAT in Derbyshire at School 1.
- Weekly telephone call from School 2 to parents to inform them of positive achievements.
- Review of GP records in Nottinghamshire and early identification for consideration at a safeguarding meeting.
- Efficient and effective communication by the missing from home officer in Nottinghamshire to obtain information from colleagues in Derbyshire about KN15 and the family.

The Lead Reviewer is grateful to practitioners involved in this review who have been open with information and self reflective to ensure maximum learning can result from this analysis of professional involvement prior to the tragic death of KN15.

10 Opportunities to improve practice

10.1 Opportunities to improve practice have been identified by considering the learning from this review and are summarized below. It is anticipated that the recommendations and questions for the Board to consider will strengthen and compliment the current actions plans of NSCB which focus on practice improvement.

10.2 This Review was commissioned by Nottinghamshire Safeguarding Children Board however a number of the recommendations and questions have implications for Derbyshire Safeguarding Children Board, who have been active participants in this process. The findings from this review and subsequent action plans should be considered by both the Nottinghamshire and Derbyshire Safeguarding Children Boards. Single agency recommendations identified in the agency reports will also be monitored by the respective Boards.

Recommendations:

Recommendation 1

NSCB and DSCB to seek assurance that assessments and plans for early help intervention are agreed by families and have clearly identified outcomes.

Recommendation 2

Nottinghamshire and Derbyshire LSCBs to review policy and information sharing processes when a child moves school within and between local authorities to ensure consistent practice that is robust and effective, and which reflects the good practice identified in this review.

Recommendation 3

NSCB to ensure that practice is consistent and child centred when potential safeguarding concerns are to be discussed with parents/carers.

Question to the Board(s) for consideration following this SCR:

Question 1

How can NSCB and DSCB be satisfied that the potential impact of adult mental health difficulties on children is adequately assessed by all partner agencies and any potential impact on children is communicated to relevant agencies?

Question 2

How can NSCB and DSCB seek assurance that policy, procedure and training reflects the importance of identifying the potential root causes of a child's behaviour and the negative impact of labelling children because of their behaviour?

Question 3

How can NSCB seek assurance that all schools comply with policy and procedure when recording and reporting safeguarding concerns?

Question 4

How can NSCB monitor the use of EHAF by schools and the confidence of referrers in the process?

KN15 serious case review Post Inquest addendum - Independent Chair, NSCB

This serious case review was commissioned by the Nottinghamshire Safeguarding Children Board (NSCB) in September 2015. An Independent Chair and an independent Lead Reviewer were appointed. Organisations from Derbyshire and Nottinghamshire contributed to the review; providing information reports and taking part in practitioner workshops. Commissioners of agency reports formed a panel to quality assure the process and consider the findings. The serious case review report was signed off by the NSCB in June 2017. Completion of an action plan, developed in response to the recommendations of the review, was monitored by the Board.

The serious case review report was provided to the HM Coroner in July 2017 and further supporting material was provided by the NSCB and organisations involved when requested.

At the conclusion of the Inquest, in my role of Independent Chair of the NSCB, I have reviewed the findings of HM Assistant Coroner Laurinder Bower to confirm that the learning identified through the serious case review and the action taken as a consequence was supported by the findings at the Inquest. I have also considered whether there were any additional issues that needed to be addressed.

The key findings of the serious case review are summarised as follows:

- The importance of using assessments to support early intervention and the need for a plan to clarify the focus of the work and monitor outcomes
- That the needs of children who live with adults who have reported mental health problems in Nottinghamshire and Derbyshire should be systematically assessed by all partner agencies to ensure that children and families receive the support they require
- Assessments should explore the wishes and feelings of the child to further understand the cause of a child's behaviour and possible underlying distress – the intervention should avoid only focusing on the behavioural change of the child.
- The potential consequences for the child should be considered by those involved before sharing concerns about possible emotional abuse with parents/carers.
- When a child moves school, professionals should be aware of a child's history and alert to any gaps in that history.

The Review of Evidence, Findings and Conclusion issued by HM Assistant Coroner identified these same issues, in particular emphasising opportunities to undertake an Early Help Assessment that were not taken.

During the Inquest further evidence was given and commented on by HM Assistant Coroner which it would be appropriate to address within this addendum:

- Concerns around the quality of the return interview in January 2014 and the failure to undertake a statutory return interview for the missing episodes in February and April 2014 Assurances were provided by Derbyshire County Council to HM Assistant Coroner which detailed the revised protocols and procedures in place to ensure that return interviews are undertaken effectively.
- The quality of supervision within the Derbyshire MAT. Assurances were provided to HM Assistant Coroner by Derbyshire County Council regarding the steps taken to improve supervision and managerial oversight in the MAT.
- That the child going to her school on an evening in April 2014, having been missing for 4 hours in torrential rain, not reported missing and clearly in crisis, should have resulted in a referral to social care for a Section 47 investigation (an investigation under section 47 of the Children Act 1989 where this is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm). The coroner did not explicitly identify any action required consequent to this finding. Information provided by Derbyshire County Council to the serious case review that is relevant to this issue, described the introduction of a new integrated structure for all operational service delivery to children, young people and their families. As part of this development a new single assessment process was introduced, encompassing early help to safeguarding assessments, which is clearly aligned with thresholds documentation.
- Where an Early Help Assessment is required but not completed due to a family moving local authority areas, children's services involved in the case should ensure that information is shared with their counterparts in the new area. Assurances were provided to HM Assistant Coroner by Derbyshire County Council regarding revised arrangements to ensure this takes place.
- During the Inquest HM Assistant Coroner sought clarification regarding the response to an email sent by a Derbyshire Health Visitor to their Nottinghamshire counterpart when the family moved areas. Assurances were provided by Nottinghamshire Healthcare NHS Trust that revised arrangements are in place to ensure that when a worker is away from work incoming emails are monitored and responded to in a timely way and that actions are recorded.
- HM Assistant Coroner also raised concerns in relation to the way that the two contacts with the Nottinghamshire MASH were responded to. This issue was examined in detail during the SCR and as a result the policy for recording enquiries made to the MASH was revised in 2015 so that all contacts are recorded on the system regardless of whether they are accepted as a referral. Further assurances were provided during the inquest regarding the call handling processes in the MASH including the use of prompts for call handlers and the access to social workers for advice.

It is reassuring that HM Assistant Coroner, having heard extensive evidence of the systemic changes made as a result of the serious case review and assurances regarding the concerns identified during the Inquest, recognised "…that extensive work has been undertaken to ensure that safeguarding systems are as robust as they can be." and that issuing a Prevention of Future Deaths Report was not necessary.

During the Inquest evidence was heard about two ligation attempts by the child. These were reported to the Police after the child's death and not previously known to any professional. HM Assistant Coroner's assessment regarding the implication of this information and the opportunity to uncover it are included within her Review of Evidence, Findings and Conclusion as follows 'Whilst I can see the force in the submission that the child would have been more likely to have divulged information about her previous ligation attempts had the appropriate support have been in place, and that appropriate support would have been expected to have reduced her risk of dying in such circumstances, I am unable to conclude that the child *probably* would not have died if any of the opportunities had been taken to assess her and put interventions in place. However, I do consider that it is a real *possibility* that the child might not have responded the way she did on 30 May 2015 had work have been undertaken with her and her family as it should have been. The CAF and EHAF tools, when used properly, provide a platform for assessing thoughts, wishes and feelings including ideas of self-harm and suicide'. I fully concur with this finding which is supported by the learning identified by the serious case review.

Chris Few
Independent Chair
Nottinghamshire Safeguarding Children Board
11th March 2019