Newham Safeguarding Children Board
Serious Case Review Report

Re: Child KA

Date: 2 May 2017

Review Process

This serious case review was commissioned by the Independent Chair of Newham Safeguarding Children Board (NSCB) on 12th July 2016, in agreement with the recommendation of the NSCB Serious Case Review Sub Group that the circumstances surrounding the death of a child met the criteria for a serious case review.

Subject of the review: Child KA: Died aged 17 years.

The Mother of KA has provided valuable information to this serious case review. Her contributions are included where relevant within the report.

KA was described by Mother as "a wonderful, caring and special child".

The true initials of the subject child are not KA to protect the identity of the child and family. KA's Mother was consulted on her preference for what her child should be called in this serious case review report. The initials KA were the choice of the family and will be used throughout the report.

Circumstances and history resulting in the review

KA had lived locally in a close family. KA's birth mother (to be referred to as Mother throughout the report) was the primary carer. KA had older adult siblings, a stepfather and a birth father, all of whom shared good relationships with KA.

The timeframe for the review will be explained later in methodology. At the start of the period under review KA attended a secondary school which was not the local school to KA's home. In early 2011 KA reported to the school being attacked by an unknown perpetrator whilst on the way to school. The allegation was a robbery with sexual overtones and the Police were informed. As a result a referral was made by the Police to Children's Social Care. An investigation was completed but a suspect was not identified. Around the same time of the robbery incident KA had reported a separate physical assault by some similar aged children. This was also investigated but no suspects traced.

KA moved to a different local school nearer to the family home in the spring term of 2012 and remained as a student there until leaving for college in 2015. KA attended college only briefly before taking up employment.

In late 2012 when aged 13 years KA attended a local youth club. It is alleged that KA was a victim of a serious sexual assault after the youth club. The alleged perpetrator was a similar aged child to KA and

could be identified by KA and Mother. The day after the sexual abuse Mother reported KA missing to the Police as KA failed to return home during that day after being out with a friend. The sexual abuse was mentioned by Mother to the Police in the initial missing report. After being missing for only a short period KA returned and was taken to the Police station for an officer to complete a safe and well check, which is a routine occurrence when a missing episode has occurred. During the safe and well check the sexual abuse is not recorded as being discussed, and no action was taken to commence an investigation at that time. The full circumstances surrounding this incident, including Mother's recollection of what happened, will be explored later.

Two days after the alleged sexual abuse Mother and KA attended the GP and the sexual abuse incident from the youth club was disclosed. It was suggested that the abuse was gang related, that KA was fearful of repercussions and did not want to involve the Police or make a formal complaint.

Within 24 hours the GP referred the information to Children's Social Care, including the fears which KA and Mother had shared and that the perpetrator was known. Subsequent action, which will be scrutinised later, included a strategy meeting/discussion between the Police and Children's Social Care two weeks after the referral, followed by a number of contacts between the Police and Children's Social Care to progress the actions agreed. A single agency visit by Children's Social Care did take place to see KA and Mother. Records for the visit indicate that KA was clear about not wishing to make a formal complaint to the Police, but that some details were shared about the alleged perpetrator with the visiting Social Worker, which could enable further checks regarding the perpetrator's identity.

After the social work home visit, liaison took place between the Social Worker and a Police Officer on an unrelated matter involving a different child. The Police Officer worked on the Sapphire unit which is a specialist sexual offences investigative team. As a result of the contact the Social Worker mentioned the allegation made by KA, and the Police Officer subsequently recorded the information on a crime report.

The Children's Social Care involvement regarding the sexual abuse incident of KA was closed early in 2013 with no ongoing safeguarding concerns highlighted. There was no Police investigation regarding the alleged perpetrator and no action was taken by Children's Social Care regarding the perpetrator also being a child.

The School Pastoral Centre provided ongoing support to KA during KA's time at the school. The School Pastoral Centre at the time provided support for students with emotional or behavioural difficulties. Support was required for KA for a number of issues including low self esteem, peer relationships, bullying and anxiety. In early 2014 as a result of a theft allegation, KA spent a brief time detained in police custody. Whilst there KA suffered a panic attack which is noted on Police records.

In early 2015 after a gang related incident when KA was spat at, KA spoke of taking seven pain killers in an attempt to self harm. This was disclosed to the School Pastoral Centre.

The School Pastoral Centre had already referred KA for one to one mentoring sessions with Gangsline which is a non-profit organisation providing help and support to young men and women involved in gang culture. The Gangsline involvement for KA was to continue periodically throughout the next two years and KA made frequent reference to the alleged sexual abuse incident in 2012, during the sessions.

In Spring 2015 KA reported concerns to the school of alleged inappropriate behaviour by a school staff member towards a friend of KA. Allegations against Professionals procedures were properly instigated and Children's Social Care and the Police interviewed KA as a possible witness. At the time school had some concerns for KA of risk of possible sexual exploitation. A referral was made to Children's Social Care but Mother declined any further support for KA. After an assessment the referral was closed.

In late 2015, after leaving school in the summer, KA attended hospital with a superficial cut to the arm disclosing feeling "low about life". Reference was made by KA to the sexual abuse incident when aged 13

and feeling suicidal as a result. A false name was provided by KA and unfortunately KA absconded before treatment could be completed. The hospital referred the incident to Children's Social Care and the Police were informed.

When the correct details were traced the Police attended KA's home to conduct a follow up as part of a missing person safe and well check. KA again made reference to the sexual abuse incident and the Police flagged this information on their records from the visit. Children's Social Care received the Police safe and well check information. Due to Mother being supportive of KA, a decision was made that there were no safeguarding concerns and, after signposting to the GP and the Child and Family Consultation Service, no further action was taken. The Child and Family Consultation Service is the name for the local Child and Adolescent Mental Health Service (CAMHS) which is part of East London Foundation Trust.

The day after the hospital attendance Mother and KA attended the GP to discuss KA's low mood, the self harm episode and the sexual abuse. The GP agreed for a referral to the Child and Family Consultation Service for KA's mental health to be assessed. Unfortunately, due to an error which will be explored later, the referral was closed and there was no assessment or intervention regarding KA's mental health.

There was no further service involvement with KA and family until six months later when sadly KA was found dead at home. Subsequently an inquest has recorded a verdict of suicide.

Legal Context:

A serious case review was commissioned by Newham Safeguarding Children Board, following agreement at Newham Serious Case Review Sub Group in accordance with *Working Together to Safeguard Children (Department for Education 2015).*

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1)(e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter- agency working, the LSCB must commission an SCR.

The methodology used was based on the Child Practice Review process (*Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).*

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice.

However, because a review has been held, it does not necessarily mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

The opportunity to conduct serious case reviews in this, and other ways, is as a result of the change in statutory guidance following *The Munro Review of Child Protection: Final Report: A Child Centred System, May 2011.* Munro suggests that Local Safeguarding Children Boards should use any learning model which is consistent with the principles in the *Working Together to Safeguard Children Guidance: Learning and Improving, HM Government 2015.*

Methodology:

Following notification of the circumstances of the death of Child KA in this case, and agreement by the chair of the Newham Safeguarding Children Board to undertake a serious case review, a Review Panel (known as the Panel) was established in accordance with guidance. This was chaired by Susannah Beasley-Murray, Head of Child Protection, Newham. The Panel included representation from relevant organisations within Health, Children's Social Care, Education, the Police, the Youth Offending Service and the voluntary sector. Amanda Clarke, an independent reviewer (the Reviewer) from Derbyshire was commissioned to work with the Panel and to undertake the review.

The Panel identified the review timeframe as commencing from March 2011 which is when the first allegation occurred, and ending June 2016 when the death was reported. Full terms of reference for the review are attached as Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and analysis of their involvement. These were considered by the Panel and provided opportunity for Panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The Reviewer met with Mother of KA to gain an understanding of the family's experiences of the services offered to them, and services provided to KA during the review timeframe. A further contact was made with Mother to clarify certain points raised at the practitioner learning event. Mother's thoughts are summarised at relevant points throughout the report.

This valuable insight into KA' and the family's experiences was shared with practitioners at the learning event, and with the Panel at draft report stage. Account was taken of the views when writing the final report and formulating recommendations and the Reviewer is grateful for Mother's contribution.

The learning event was held in December 2016 and was attended by 15 professionals who had had direct involvement with child KA and the family, or who were representing agencies with involvement. The Reviewer facilitated the session assisted by the Partnerships and Workforce Development Manager, Newham and officers from Newham Safeguarding Children Board. The learning event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and notes were recorded. With the support of Panel members and the Newham Safeguarding Children Board team, further enquiries were made with professionals who were unable to attend the learning event, and this information is included in the report.

Following the learning event, the Reviewer collated and analysed the learning to date for discussion with the Panel. Practice issues originally identified by the Panel were re-examined in the light of the findings of the review. A draft report was provided to the Panel in advance of the Panel meeting in January 2017. In reviewing the findings, the Panel gave consideration to what could be done differently to further improve future practice.

The Reviewer will offer to meet again with the Mother of KA to provide an opportunity to see a copy of the report when agreed by the Newham Safeguarding Children Board. Learning from the full report will be made publically available after consideration by the Newham Safeguarding Children Board of any issues affecting publication.

A Health Overview Report was completed as a result of KA's death. This is a task undertaken within Health when a serious incident occurs. The purpose of the Overview Report is to evaluate how (i) health organisations are working together to deliver services and (ii) meeting their statutory duties to safeguard children. The Reviewer has considered the findings of the Health Overview Report and has referenced these where necessary throughout the serious case review report.

NHS agencies are required by statute to participate and contribute to a serious case review when requested by a Local Safeguarding Children Board. Clinical Commissioning Groups are required to provide a panel member who will maintain oversight of the health involvement. In addition the Clinical Commissioning Groups Panel representative for the KA serious case review has shared information from the Health Overview Report to ensure robust analysis of the known circumstances. Learning from both reviews will be disseminated across the NHS locally. The Newham Safeguarding Children Board will require assurance that actions identified in the Health Overview Report have been completed.

ANALYSIS: Practice & Organisational Themes Identified

Child KA had received services from a number of agencies during the period of the review. Scrutiny of the timeline, information shared and reflections at the Panel meetings and the learning event have highlighted areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together. The following is an analysis of the themes identified:

1. Responses to child sexual abuse

During the agreed timeframe of the review the child, KA, made allegations of crimes which were reported to the Police. The separate circumstances involved a physical abuse incident by peers, a robbery with a possible sexual motive, and a third incident which involved serious sexual abuse. The third crime reported is referenced by KA through much of the review timeframe and has been the main focus of the Panel's scrutiny.

The physical assault was alleged to have taken place the day before the robbery incident in early 2011. This circumstances involved peers and KA was not injured. A full investigation took place which included liaison with KA's school and home, but suspects were not identified. Details of this incident were shared by the Police with Children's Social Care.

The robbery allegation was reported by KA to the Police via the (first) school. The crime was fully investigated but no perpetrator was traced. The robbery and the assault the day before were unconnected. Children's Social Care were informed about the robbery, and provided information as appropriate to the investigation, but this was minimal due to limited service involvement previously. The contact was recorded by Children's Social Care but no further action was taken, which was expected practice due to the details of the crime. Mother told the Reviewer she recalled the Police taking the

robbery allegation seriously. GP records show that KA and Mother shared details of the robbery incident during a GP appointment around ten weeks after the crime occurred, and that the Police had facilitated victim support involvement. This was positive practice by the Officers involved who had noted that KA reported being unhappy around that time.

The serious sexual abuse was brought to the attention of services in late 2012. The incident occurred when KA was aged 13 and the alleged perpetrator was known, including by name and address and said to be a similar age to KA.

At the time the crime was not reported directly by KA to the Police but Mother states she did speak about the allegation to an Officer at a Police station within 24 hours. This was at the same time when Mother was reporting KA missing, the day after the abuse had taken place. Mother and KA returned to the Police station later the same day and a different Police Officer conducted a safe and well check in response to KA's return from being missing. Mother's recollection, and opinion, is that the second officer spoke firmly to KA. The Police record regarding the safe and well check indicates there was no specific follow up with KA regarding the sexual abuse despite Mother disclosing this earlier the same day when reporting KA missing, and a note having been made on the missing report by the first Officer seen.

The responses to the sexual abuse allegation are explored below:

I(i) Joint working

An appropriate referral was made to Children's Social Care by the GP after the incident in late 2012 was reported by KA and Mother in a GP consultation. Information was shared between Children's Social Care and the Police Child Abuse Investigation Team (CAIT) via the standard 87a form two weeks after the referral had been received by Children's Social Care. The reason for the delay is not known and due to time elapsed cannot be explained. However, the delay in sharing the allegation with the Police is unacceptable. Significant harm to a child (KA) was suspected and an immediate strategy meeting or discussion should have taken place.

The 87a form, which was eventually used by Children's Social Care to share the allegation is a method used by Children's Social Care to refer cases into the Police. In 2012 the Child Abuse Investigation Team (CAIT) was, and still is, the single point of contact for referrals. This was, and is, the position even when referrals do not meet the CAIT's own criteria of familial abuse. CAIT is then required to direct referrals to the relevant Police team. In late 2012, the referral for KA should have been transferred to the Police Sapphire team, the specialist team for serious, non familial sexual offences.

It is unclear from records available why there was no attempt by officers in CAIT to involve the Sapphire team at this initial stage, despite the type of allegation being referred meeting the Sapphire team's criteria for investigation. In records from the Havens sexual assault referral centre, which have been scrutinised for the review, Sapphire reported no record of the incident on their system after a contact from a Havens centre over a month after the offence took place.

The arrangements that CAIT are responsible for initial Police management of referrals remain the same now, with cases being transferred from CAIT to other Police teams as necessary. At the learning event and at Panel meetings an issue was raised of the apparent disconnect which is still seen to exist, in the view of some professionals, within the Police service between CAIT and Sapphire. This may help to explain the lack of coordination between the teams in 2012 which appears to have resulted in a lack of ownership of KA's case. It was explained that the Metropolitan Police Service is in a process of change, which will help address this issue, with the introduction of pilot Police Safeguarding Hubs which will better direct referrals to the appropriate team (see below).

What is known is that records for late 2012 show a strategy discussion took place regarding the incident

as soon as the Police CAIT received the 87a referral from Children's Social Care. This was actually two weeks after the initial referral by the GP. This was followed by a number of contacts between Police and Children's Social Care to track progress. *Working Together to Safeguard Children, HM Government, March 2010* was the guidance in place at the time and was consistent with the current *Working Together to Safeguard Children guidance, 2015* which states *"Whenever there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm there should be a strategy discussion".*

Two agencies were involved in the strategy discussion; Children's Social Care and the Police Child Abuse Investigation Team (CAIT). A decision is recorded that a single agency visit should be undertaken by a Social Worker to obtain more information including details of the alleged perpetrator. The record shows that a strategy meeting would be reconvened once the home visit had taken place. This second strategy meeting, when the latest position regarding the allegation and the perpetrator would have been discussed, did not take place but a record indicates that the Police (CAIT) signposted the Social Worker to the Sapphire Team who should have continued the investigation. An email contact did take place between the Social Worker and a named Sapphire officer soon after the Social Worker's visit to KA and a conversation subsequently took place between the two professionals.

Newham now has a local protocol known as the *Newham Safeguarding Children Board Child Protection Strategy Meeting Protocol, 15.01.15.* This reflects the requirements from *Working Together to Safeguard Children, HM Government 2015.* The protocol states *when identified risks include "sexual abuse/exploitation, and gangs/serious youth violence, strategy meetings must be held".*

In KA's case, which did involve sexual abuse and possibly gangs, records indicate an initial strategy discussion did occur. However other requirements of *Working Together to Safeguard Children 2010* were not met. The guidance states *s*trategy discussions should, as a minimum, involve a local authority Social Worker and their manager, Health professionals and a Police representative. Other relevant professionals will depend on the nature of the individual case. In KA's circumstances in late 2012, this should have included school involvement, but did not.

The Police have advised that there are clear procedures in place for strategy discussions between the Police Child Abuse Investigation Team (CAIT) and Children's Social Care. However there are no formal arrangements between the Police Sapphire Teams and Children's Social Care. A new system will be piloted in 2017, which will involve the restructuring of police arrangements for protecting vulnerable people. This will ensure all referrals go the new Police Safeguarding Hub to manage a merge of MASH (Multi Agency Safeguarding Hub) and CAIT referrals. Strategy meetings should then take place regarding all vulnerable persons and dependant on the outcome cases will then be referred, as appropriate to the relevant investigation team.

Timescales are not specifically outlined as to when a strategy meeting or discussion should take place but two weeks after the initial referral, as in KA's case is not an acceptable delay. The reason for the delay in Children's Social Care sharing the referral with Police is unclear, but this explains why the strategy meeting was overdue. It is recorded that the initial meeting took place within hours of the Police receiving the 87a form for KA. The current *Working Together guidance, March 2015,* and all earlier versions, suggests timely action in all responses to safeguarding, but particularly when significant harm is known or suspected.

Regarding KA's case the record and outcome of the Social Worker's visit indicates that KA provided a detailed account of the incident including the location of the offence, 'street name' of the perpetrator and suggestion that the same perpetrator may have sexually assaulted another similar aged child to KA, with some details provided to the Social Worker. Despite the information shared by KA and Mother it is clearly recorded that their wishes at the time were for no Police action. A formal strategy meeting was not reconvened by Children's Social Care to discuss the position and to share the further information which had been obtained. Other safeguarding agencies were not provided with the opportunity to become

involved in the case, to offer support to KA, and to explore reasons for not wanting to pursue a complaint to the Police. This is examined further below, as is the position regarding the alleged child perpetrator.

The schools which KA and the perpetrator attended were not included in any information sharing or discussion about the incident, which meant safety planning for KA, and wider safeguarding considerations for other children did not take place.

In Newham now, since mid 2015, all referrals to Children's Social Care come through Newham's Triage which includes the Multi Agency Safeguarding Hub (MASH). The current arrangement is that the referrals are processed by duty managers and decisions are made on whether to allocate for assessments, step across to early help services or subject the referral to MASH checks. A decision may also be made to undertake a screening visit if the information on a referral is unclear or warrants a quick but more in depth check. There are several partner agencies involved with the MASH team and the core roles include; Social Care, Police, Health, Education and Housing. There are other agencies that provide their services and support to MASH from their satellite locations. These extended partners include; CGL (drugs and alcohol support work), Probation, ANCHAL (independent domestic violence support), Shelter, Early Help, Youth Offending Service and Families First. These extended agencies sit within MASH every Tuesday for relevant meetings and input.

Under the Triage arrangements described above referrals requiring assessment, either under Section 17 (child in need) or Section 47 (child protection investigations), are immediately progressed through to the assessment teams based within local areas and allocated promptly. Cases that require further multi agency checks are identified and are subject to multi agency discussions within Triage which assists in decision making regarding thresholds of need.

The Reviewer was told by the Triage manager that strategy meetings are currently undertaken by the Social Worker who has been allocated in the relevant area's assessment team, and their manager. In some local safeguarding children board areas arrangements are in place to enable strategy meetings to take place within the 'front door setting' (Triage/ MASH) to utilise the partners who are available on site due to their co-location.

Due to different 'front door' processes being in place in 2012 when KA's referral was received and being managed the new opportunities for multi agency working at the front door to services were not available. Despite positive changes, particularly regarding joint working and co-location within the Newham Triage Service, there may still be a lack of true multi agency involvement in strategy discussions and possible delay, due to the arrangements in place to hold strategy meetings in assessment teams out in areas. The pilot Police Safeguarding Hubs which are being introduced, see above, should help to improve strategy meeting arrangements.

The Newham Safeguarding Children Board should conduct an immediate audit of strategy meetings convened in the last three months to include scrutiny of agencies involved, timeliness of meetings and decisions and actions recorded.

Newham Safeguarding Children Board should conduct an audit to examine referrals received specifically relating to sexual abuse of children age 12 and above, to explore that strategy meetings are being held for these cases and that the statutory and local requirements for strategy meetings are being met. The audit sample should include some cases where the sexual abuse is allegedly gang related and peer on peer abuse.

1(ii) Police enquiries

As stated above, KA did not want to make a formal complaint to the Police regarding the sexual abuse. This is consistently recorded by both the GP who made the initial referral to Children's Social Care, and

by the Social Worker who visited KA over two weeks after the incident took place. Reasons recorded for the lack of a formal complaint were fear of reprisals by the alleged perpetrator and associates, as there was an indication that the offence on KA was gang-related.

There is an indication that there was confusion regarding ownership and allocation of the enquiry and which Police team had overall responsibility. The case should have been investigated by the Police Sapphire team but was not formally transferred to them. Whichever Police team was to continue the investigation, a crime report should have been submitted about the known circumstances at the earliest opportunity. This is explored below, but as soon as an allegation of crime is received by the Police, it should be recorded. This did not happen until six weeks after the date when the incident was first reported. This is a practice issue for the Police as protocol and guidance regarding timescales and expectations for crime recording is already in place.

There was no Police visit to KA at all regarding the allegation, despite this being a serious crime against a 13 year old child with an identified suspect. Whilst it is accepted that KA had a voice and a right to make decisions there is no evidence that a multi agency strategy discussion explored this aspect of the case; what action was required or that the rationale for no action being taken was recorded. Strategy meetings are discussed above.

There is no record of any efforts being made to trace other possible witnesses but this was unlikely to occur without ownership of the investigation. The incident was only shared with Sapphire when the Social Worker who visited KA and a Police Officer happened to be speaking about another unrelated incident a short time after the home visit took place. This was not a planned formal discussion about KA specifically but did result in an email being sent by the Social Worker to the Officer to confirm details. The Police Officer was a specialist in sexual offences attached to the Police Sapphire Unit and as a result of the contacts, after establishing whether the crime was already being investigated and completing other intelligence checks and preliminary enquiries, recorded KA's allegation as a crime, with a note that the child (KA) did not want to make a complaint themselves. A link was also made to KA's missing report of the same time period. The enquiries to track the investigation and high case load of the Sapphire Officer meant there was a delay of a further two weeks from the Children's Social Care/ Sapphire contacts taking place to the crime report actually being submitted. Records indicate that this was the first point that Sapphire had any involvement with the case. After being recorded as a crime over a month after the date of the incident, no further investigation or action to supplement the initial enquiries by the Sapphire Officer took place.

It is apparent throughout the review timeframe that KA was able to share some details about the allegation with different professionals. Therefore if options had been explored and support offered, KA's view regarding a formal complaint may have been different.

Unfortunately it seems KA and family were not provided with advice, options or support regarding the situation. The decision to "not complain" was taken at face value and the case from a Police perspective was not progressed. There was no evidence of consideration of forensic opportunities, regarding the victim or the crime scene, details of which had been provided by KA. However, opportunities to obtain meaningful forensic evidence, commonly referred to as the 'forensic window' would have closed, due to the length of time elapsed.

The Crown Prosecution Service (CPS) has issued *Guidelines on Prosecuting Cases of Child Sexual Abuse, CPS, 2013,* which includes information on additional support available to children via special measures and other guidance relating to specific models of child sexual abuse including gangs and peer on peer abuse. The allegation by KA related to both such models.

Special measures are a range of measures that can be used to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses, Youth Justice and Criminal Evidence Act 1999.

The CPS guidance was not in place at the time of the allegation in late 2012 but special measures for vulnerable and intimidated witnesses had been available for the Police to consider using for many years prior to that date. Furthermore, supporting victims and witnesses of serious crimes, who are presenting as frightened and unwilling to make formal complaints, and finding solutions for such scenarios, is a task which Police Officers, particularly child abuse investigators, are routinely required to face.

There is no record of consideration of the involvement of an Independent Sexual Violence Adviser (ISVA) if such a resource was available in the area at the time. An ISVA could have been a valuable source of support for KA and family.

An Independent Sexual Violence Adviser supports victims of sexual violence, including child sexual abuse. They are independent from the Police and are victim focused advocates.

The Metropolitan Police were inspected by Her Majesty's Inspectorate of Constabulary (HMIC) during 2016 and findings, published in *Metropolitan Police Service – National child protection inspection, HMIC, 25 November 2016,* indicate that there were concerns about the quality of some aspects of some child protection investigations. The case of KA in late 2012 was not a case example examined for the HMIC inspection but the findings of this serious case review indicate that there are concerns regarding the Police response to KA's allegation of child sexual abuse. A number of recommendations have been made by the HMIC to the Metropolitan Police Service as a whole, and it is positive that the Newham Safeguarding Children Board has already considered the local Borough policing response to the inspection findings. Furthermore, as mentioned earlier, the local Police' commitment to the new Triage Service arrangements in Newham, with co-location of operational specialist officers to enable immediate collaborative working is to be commended.

The Metropolitan Police response to the HMIC inspection includes the formation of a Gold Group at Deputy Assistant Commissioner level, with representation from Children's Social Care. This Group, and other new leadership and governance arrangements (internal and independent) aims to scrutinise the inspection recommendations and action plan, and to ensure learning is shared as appropriate.

Newham Safeguarding Children Board through the Local Improvement Board should request a further opportunity to scrutinise the local Police position in Newham as a result of the findings of this serious case review, and in conjunction with the findings of the HMIC inspection to ensure the identified local Police response and improvement plan is accurate and actions are robust.

The Chair of the Newham Safeguarding Children Board should request assurance from the Metropolitan Police after the Police Safeguarding Hub pilots are implemented that the interface and working arrangements between Child Abuse Investigation Teams and Sapphire Teams in Newham and elsewhere, regarding management of referrals and subsequent investigations of child sexual abuse is effective.

1(iii) Sexual health and support after an allegation is made

In the London area the Havens are a network of specialist sexual assault referral centres jointly funded by NHS England and the Metropolitan Police Service. Self referrals are accepted by Havens but the majority of referrals are made by professionals. The GP advised Mother to make contact with a Havens site and Mother did attend with KA three weeks after the sexual abuse had taken place. A similar account of the circumstances was provided by Mother as had been shared previously to the GP. At the time in 2012 not every Havens site had resources for managing cases involving children, and records indicate that the site Mother and KA contacted did not then have capacity to see children. Alternative provision and support was arranged within a sexual health unit which KA and Mother were signposted to.

Records indicate an attempt was made initially by the Havens to clarify the Police involvement in the case

as Havens routinely work closely with the Police on sexual abuse investigations. However, as stated earlier, the Police Sapphire team at that time had no recorded knowledge of the incident or of KA.

It is positive that the GP provided information to Mother and KA regarding the Havens service and that Mother acted on this advice. Not all parents or carers would have acted as proactively as Mother did in taking responsibility to self refer KA to the Havens service and in those circumstances children alleging sexual abuse may possibly not have received the care and support needed.

There was an assumption by the GP that Police involvement in the investigation would occur triggered by the referral to Children's Social Care. As discussed earlier, this did not happen until almost two weeks after the initial referral, but the GP was right to assume that the Police would have been informed. A further expectation from the GP's perspective was that the Police would also liaise with Havens regarding KA and any forensic evidence opportunities. This is one of the key functions of the Havens, but due to the delay in Police involvement and the subsequent confusion over Police ownership of the case this liaison did not happen.

Within the Health Overview report completed as a result of KA's death, as explained earlier, a need was identified for awareness-raising for GPs of sexual assault referral centre pathways to ensure children and families receive accurate information and effective support.

The Newham Safeguarding Children Board should obtain assurance and evidence from Health partners that all recommendations made as a result of the Health Overview Report regarding sexual assault referral centres have been completed.

1(iv) Safeguarding enquiries regarding child perpetrators

The alleged perpetrator was identified by name and address, and the age of this child was said to be near to the age of KA, who was 13 at the time. Furthermore there was a suggestion that the same perpetrator was already known to Children's Social Care and may have been involved in a similar gang related, but unconnected incident against another child. Research by *Berelowitz et al, 2012* found "the majority of sexual exploitation within gangs was committed by teenage boys and men in their twenties". In Newham there is now a Police Gangs Unit which works closely with other agencies to respond to child sexual exploitation.

Nationally current figures demonstrate an increase in recorded cases of children committing sexual offences against other children, with a rise by 78 per cent in England and Wales between 2013 and 2016. "The number of alleged offences reported to Police forces in England and Wales rose from 5,215 in 2013 to 9,290 in 2016", *Barnardo's press statement, 3 February 2017.*

In late 2012 and early 2013 when KA's referral had been received none of the information regarding KA's perpetrator was the focus of any other safeguarding referral or enquiry by Children's Social Care or the Police. As a consequence no assessment of risk or needs of the alleged child perpetrator or consideration of any wider safeguarding issues took place.

Children who are suspected of committing sexual offences are as much in need of a service from all safeguarding agencies as those who have offences committed against them, and a statutory child protection referral should have been made regarding KA's identified perpetrator, leading to a multi agency strategy discussion highlighting the sensitive nature of the specific circumstances, including the wishes of KA. As stated earlier the local protocol in place now regarding strategy meetings identifies sexual abuse and gangs/ serious youth violence as risks for when strategy meetings must be held.

No professionals involved at the time recognised that the alleged child perpetrator had safeguarding needs themselves, and the reason for this is unclear. This is a practice issue to be highlighted for all partners as distinct safeguarding procedures were in place, prominently available, and should have been

used, regarding statutory requirements for action when abuse is known or suspected. Other guidance regarding children who display sexually harmful behaviour was also available.

Raising awareness and providing information to all children and young people, and the professionals working with them, regarding healthy relationships, consent and other related issues is explored later.

2. Information sharing with/ between/and internally in schools

KA moved schools during the timeframe of the review and spent a brief period out of school whilst Mother considered education options. The school which KA attended when the first allegation was made had only limited information to contribute to the serious case review due to the short time KA was a student there and the time elapsed since KA left. Representatives from the main school where KA was a student, which included the period when the 2012 allegation occurred up until KA left school at age 16, attended the learning event and have provided additional information to the Reviewer.

It is a concern that there is no information of the first allegation in KA's school records which were the responsibility of the school attended at the time. The second (main) school had no knowledge of that incident and therefore any support provided to KA was not informed by the previous allegation, other than information shared by KA them self.

Keeping Children Safe in Education, Department for Education, Part 2: September 2016 (first published March 2015) states "as part of meeting a child's needs, it is important for governing bodies and proprietors to recognise the importance of information sharing between professionals and local agencies". This guidance was not implemented at the time of KA's allegations but *Section 175 of the Education Act 2002* was, and still is, relevant. This places "a duty on local authorities (in relation to their education functions and governing bodies of maintained schools) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school".

By not sharing the specific safeguarding issues which had related to KA whilst at the first school, there was a missed opportunity to allow the second (main) school to make proper arrangements to support KA.

Of more concern is that the second allegation which occurred when KA was attending the second (main) school, but out of school hours, was not shared formally with the school by the safeguarding agencies initially involved. It is apparent that KA mentioned to school staff that "something had happened at the weekend" but the detail and seriousness of the allegation was not known by the school, despite a referral having been made to Children's Social Care by the GP within days of the incident occurring.

As a result in the early period that the incident had taken place the school were unable to properly plan for the safety of KA and any possible repercussions relating to the allegation.

Newham Safeguarding Children Board should work with Education partners to ensure there is sufficient awareness in every education setting, and specifically the two schools involved in this review, of information sharing protocols, including timescales for the effective sharing of school records when children move schools.

Children's Social Care did eventually make contact with KA's school in early 2013, over two months after the actual incident, to complete agency checks for the core assessment to be completed as a result of the allegation and referral. It transpired that the alleged perpetrator, whilst not a pupil at the same school, was known locally around the school and therefore may have been a risk to other students. Soon after the agency check with school the Children's Social Care case regarding KA was closed, with the assessment highlighting that Mother was supportive and able to protect KA.

As described earlier the Newham Triage, which currently receives and manages all referrals to Children's Social Care, includes representatives from Education. Therefore information sharing to and from schools

and between other agencies, should be more robust, and relevant education information should be available immediately to inform decisions and assessments. The situation where a particular school is not aware of a serious safeguarding concern about a student at the school should not occur.

KA at this point and during 2013 had accessed support from the School Pastoral Centre, within the main school. As stated earlier the School Pastoral Centre operated similarly to a pupil referral unit, but internally, by providing educational and behaviour support to those students with emotional or behavioural difficulties, sometimes through complete withdrawal from the mainstream setting or partial support whilst still in the mainstream.

KA had reported incidents of bullying and issues related to gangs, and eventually in Spring 2013 a referral from the School Pastoral Centre to Gangsline resulted in one to one sessions for KA with a Gangsline mentor.

Gangsline is a non-profit organisation providing help and support to young men and women involved in gang culture.

Throughout 2013 and 2014 KA received regular support via a Gangsline mentor, a relationship which Mother described very positively to the Reviewer. Mother said KA "spoke highly" of the Gangsline mentor. The mentor attended the learning event and recalled KA, early on in the mentoring sessions, reflecting on the alleged sexual abuse from 2012, and the impact this had had on KA. Other issues discussed included bullying, and later as the mentoring relationship developed, low self-esteem and self- harm. The mentor described how any pertinent safeguarding information from the one to one sessions was shared with the School Pastoral Centre but it was unclear where and how much information was shared on from that point, or what formal recording systems were in place. The school population were organised into school year teams with every student allocated a school year team. At the time the relevant school year team to which KA was attached, would have been aware that KA was receiving support but not the reason why or other details.

There was a change in leadership at the school in September 2014. The Deputy Head explained the current position regarding safeguarding in the school and that a dedicated child protection team had been developed since the end of 2014/ early 2015. The team meets weekly and the Head of the School Pastoral Centre attends to share information and discuss any concerns. Specific staff in each school year team, who manage lower level safeguarding issues and early help intervention, are linked into communication as relevant. Panel meetings with each school year team take place once every half term (bi-termly). Vulnerable students are identified through a number of indicators, and interventions for these students and the impact of these interventions are reviewed. The new arrangements offer improved information sharing opportunities across all sections and levels of safeguarding within the whole school setting.

Regarding School Health involvement in the new arrangements within school, it was explained that currently School Nurse time allocated to the school is extremely limited due to staffing shortages. Time allocated is currently around half a day a week and this is affected if there are pressures elsewhere. The limited capacity means that it is almost impossible to ensure that there is the opportunity for proactive planning of interventions for students and planned attendance at meetings. Efforts are made to liaise effectively via messages in a log book, emails and the open invitation for School Nurses to visit the child protection team office whenever a School Nurse is onsite.

It was highlighted at the learning event that the Newham Triage system is not benefiting from a consistent presence by the School Nursing Service and vice versa. However Health and Education information is normally accessible via the agency professionals located in the Triage service. School Nurses are said to receive 'Merlin' information, see below, on children, which will provide details of incidents where vulnerabilities have been identified and, as described later, School Nurses do receive notifications of children attending the accident and emergency department with a follow up protocol in place.

The Help and Protection for Children, Young People and Families Practice Guide: A guide to services in Newham explains Police 'Merlin' forms as being created when a child comes to the notice of the Police, including when reported missing, and there are concerns about the child's vulnerability. There are currently over 4,000 Merlin forms created in Newham a year.

However, if School Nursing presence within schools is minimal due to resource issues there is limited opportunity for relevant safeguarding information which School Nurses do receive, such as Merlin forms as above, to be shared with schools.

In the Health Overview Report conducted after the death of KA it is concluded that the school health record for KA was "uneventful". This indicates a different awareness of the issues KA faced possibly explained through lack of availability of School Nursing professionals to work regularly with the school and access the full information available. If the School Nurse had been aware of the involvement which the School Pastoral Centre and Gangsline had with KA, an "uneventful" school health record would not have been an accurate reflection of the circumstances. Unfortunately due to the lack of a presence of the School Health services in the support package planned and being provided to KA throughout the time at the main school the involvement of, and any subsequent benefit from the School Nurse for KA was minimal.

From detail now known from the timeframe of the review it is positive that KA felt supported enough to share sensitive personal information with some professionals, in particular the Gangsline mentor whose relationship with KA has been commended by Mother.

However schools who commission external services, such as Gangsline, must be assured that clear protocols are in place for safeguarding information to be properly recorded and shared particularly when relating to children in receipt of additional support arranged by a school. This will ensure appropriate, timely action is taken if and when required and records can inform assessments as necessary. Furthermore all professionals involved in supporting children who may disclose issues relating to safeguarding, must be aware of, and follow when required, the child protection procedures of the relevant Local Safeguarding Children Board. This is mandatory with clear procedures already in place, and therefore a practice issue for all safeguarding agencies and professionals.

It is encouraging that the main school involved with KA, and its School Pastoral Centre have developed more robust child protection processes including for recording, which are hopefully now fully embedded. Designated staff can now focus solely on managing child protection within the school setting.

The Chair of the Newham Safeguarding Children Board should request a report on the current position of School Nursing provision within secondary school settings in order that an adequate and consistent service in terms of resource and frequency is available.

3. Consideration of Early Help Support

The Help and Protection for Children, Young People and Families Practice Guide, 2014 sets out Newham's approach to supporting families across all levels of need. The key elements of Newham's offer of support are universal services, early help and statutory intervention. Child KA mainly accessed universal services such as education and routine healthcare. However, the allegation of sexual abuse in late 2012 resulted in a statutory intervention, which was eventually closed.

Professionals supporting KA particularly after the 2012 incident did not formally identify KA as requiring early help support. This is despite concerns of low self esteem, self harm, bullying, gang related pressures, possible mental health issues all of which were examples of *Indicators of Need levels 1(b) and 2(a)* in the Help and Protection Practice Guide, levels which meet the criteria for early help support.

Working Together, HM Government 2015, 1.1, emphasises that early help means providing support as soon as a problem emerges, at any point in a child's life which can also prevent further problems arising. However for early help to be effective local agencies need to work together to identify children and families who would benefit from early help and to undertake an assessment of the need for that support. Earlier versions of Working Together, which were in place throughout the review timeframe, gave similar consistent messages regarding the timing and processes for early help.

Whilst it is acknowledged that some support was being provided to KA through the School Pastoral Centre and Gangsline, the coordinated approach which a formal early help process should bring was not initiated. In Newham there is now an Early Help Partnership team made up of coordinators and practitioners who advise and guide professionals in their responsibility of providing safeguarding and early help support. For the period within the timeframe when the Early Help Partnership support was available there is no evidence that professionals involved with KA requested assistance from the service, to help implement formal early help support for KA. It should be highlighted that when the Early Help Partnership service was introduced initially there was just one officer providing support.

In early 2015 KA disclosed to school of being spat at in a gang related incident which resulted in an attempt to self harm by taking seven pain killers. Two other episodes of anxiety and dizziness had also been reported by KA to separate professionals around the same time. Despite such incidents clearly being examples of concern at early help level on the *Help and Protection Practice Guide Indicators of Need* there is no recorded consideration of instigating early help processes. Response to the self harm incident will be explored in more detail later.

At the learning event early help support did not appear to be a consideration for the professionals who had been involved with KA.

In Spring 2015 KA reported a concern for a friend regarding alleged inappropriate behaviour by a member of school staff on the friend. This was investigated but unsubstantiated. As a result of KA being interviewed as a possible witness, and due to concerns from the school, at this time KA themselves was referred by a senior member of school staff to the Children's Triage Service, the 'front door' for all requests for support or protection of Newham children, as described earlier.

As there were concerns regarding possible child sexual exploitation of KA at the time that the concerns for the friend were raised the level of need for KA was identified as level 2(b) on the *Help and Protection Practice Guide Indicators of Need*. This level, as before, was categorised as eligible for consideration for early help support.

As a result of the school's referral to Triage, an invitation was made to meet with Mother to discuss concerns for KA. Children's Social Care was undertaking an assessment on KA due to the current concerns and the previous sexual abuse allegation. Mother refused to engage with the Social Worker as, in her view, KA was worried for a friend and there were no issues or concerns for KA. Mother felt she was a supporting factor in KA's life and also said that KA was accessing support in school. It is not clear whether formal early help processes were considered as an option for the family at this point, but family engagement and consent is a requirement for early help support to be of benefit, as services and families work together collaboratively to find solutions for the concerns identified.

The Children's Social Care assessment was completed and closed; school support was highlighted as being in place and no other concerns were identified through agency checks. However records indicate that the school shared details about the overdose and the continuing disclosure by KA of the 2012 sexual abuse when providing information for the assessment. The 2(b) level *Indicator of Need* had been identified but formal early help support was not considered, possibly due to the support in place for KA through the school. Advice was not requested from any specialist services by Children's Social Care, school or Gangsline, regarding the self harm or other concerns, and this will be explored below.

Despite the emphasis in statutory guidance, as in *Working Together 2015,* of the importance of early help, and the best efforts of many Local Safeguarding Children Boards to ensure the early help offer is properly embedded, early help processes again appear not to have been considered by professionals as an option. The lack of coordinated early help support offered to KA and family, or a team around the child approach, is another example of a missed opportunity for such support to be provided to an individual in circumstances which meet the criteria of identified levels of need for early help.

The Newham Safeguarding Children Board may want to consider whether further promotion and raising awareness for professionals is necessary to ensure the Early Help strategy and what support is available locally is widely known across the partnership and in all agencies.

4. Thresholds regarding self harm

During the timeframe of the review there is evidence that KA suffered with low self esteem. This was discussed with the Gangsline mentor and her professional opinion, as early as autumn 2013, was that KA appeared "low, lost and unsure of them self". Around this time, which was one year after the 2012 sexual abuse allegation, the school had asked for support for KA from Gangsline regarding possible gang related child sexual exploitation.

In early 2014 as a result of a theft allegation, KA spent a brief time detained in police custody. Whilst there KA suffered a panic attack which is noted on Police records but no further action was taken regarding an assessment of KA's presentation and needs. No referral was made to Children's Social Care. *Thurrock Safeguarding Children Board* published a serious case review in December 2016 regarding *'James',* which included a recommendation for the Metropolitan Police Service to "remind custody officers to ensure any vulnerabilities disclosed to a Forensic Medical Examiner (FME) by a child in custody must be risk assessed. Furthermore if the assessment highlights concerns these must be referred to appropriate agency partners". In KA's case a FME was not involved but more robust action should have been taken to share information to ensure other professionals had opportunities to offer support. Newham Safeguarding Children Board should consider requesting an update from the Metropolitan Police Service of progress against the recommendation in the *Serious Case Review "James", December 2016.*

In the Spring of 2014 dizziness, exam stress and a fainting episode was reported resulting in an attendance at hospital from school, but medical tests were noted as unremarkable. It was explained at the review's learning event that the School Nursing service safeguarding team do receive notifications of accident and emergency hospital attendances but follow up for a teenager fainting was unlikely. Three attendances of a child at an accident and emergency department within six months would trigger an automatic follow up by the School Nursing service.

In late 2014 there is a record that KA discussed the 2012 sexual abuse allegation with a member of the School Pastoral Centre. Into early 2015 dizziness was reported to the GP, and KA suffered a panic attack in school after a problem with a staff member. Soon after, KA disclosed to school of "taking seven pain killers at the weekend" in an attempt to self harm. As described earlier this was as a result of an alleged gang related incident. The disclosure was recorded by school staff and a re-referral made for further support for KA with Gangsline. The incident of self harm was not referred to the Child and Family Consultation Service (CFCS), but at the learning event representatives from CFCS said that such an incident of self harm would have been expected to be referred to the Service for an assessment.

Newham CFCS is a multi-agency specialist mental health service for children and young people with complex, severe or persistent emotional, behavioural or developmental problems. Referrals are accepted from birth to 18th birthday.

School did not pass on KA' disclosure of self harm or seek advice from other specialists in mental health services, or the Early Help Partnership Officer. However, as well as the referral for further Gangsline support a request for support was also made to the school counselling service. Records show that this

request for school counselling was agreed by KA. It is positive that the same Gangsline mentor was able to quickly re-commence one to one sessions with KA, and once again low self esteem was noted. There was again no consideration of referring KA for a specialist mental health assessment, or as discussed early, for coordinated early help support.

It was explained at the learning event by those who had been involved that as KA was being supported by both a Gangsline mentor and school counsellor, and due to KA's reluctance to trust other professionals, this arrangement was considered to be appropriate in terms of supporting the child at the time.

Despite the ongoing support via the school, and the good intentions of professionals already involved, it is important to understand that self harm is a complex issue particularly in children and at a minimum a consultation with a Child and Family Service professional should have taken place after the overdose self harm disclosure. In *Truth Hurts: Report of the National Inquiry into Self Harm among Young People, Mental Health Foundation 2006* it is suggested that "at least one in fifteen children are self harming and some evidence suggests that rates of self harm in the UK are higher than anywhere else in Europe". Obtaining accurate figures on children who self harm is difficult as most children do not tell anyone about what is going on. However, in 2014 figures were published by the *National Institute for Health and Care Excellence (NICE)* suggesting a seventy (70) per cent increase in ten to fourteen year olds attending accident and emergency departments for self harm related reasons over the preceding two years, *The facts: self harm statistics*, www.selfharm.co.uk.

The school where KA was a student, and other schools, now work closely with a CFCS clinical nurse who completes consultations with pastoral staff when concerns are raised regarding mental health. A self harm disclosure such as the one made by KA would now be followed up through the consultation process. Early feedback from the school regarding the new consultation arrangements is very good.

The decision by Children's Social Care not to consult with or seek any specialist support regarding the overdose disclosure, when this was eventually shared by the school in late Spring 2015 is a concern. The information came to the attention of Children's Social Care during the assessment agency check requested by Triage when KA was referred to them (after raising the concern for a friend regarding the staff member). This was over three months after the actual self harm overdose incident.

In *Fundamental Facts About Mental Health 2015 Executive Summary, The Mental Health Foundation,* it is noted that "ten per cent of children and young people (aged 5-16 years) have a clinically diagnosable mental problem, *Mental Health of Children and Young People in Great Britain: 2004. Office for National Statistics,* "yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age", *The Good Childhood Inquiry: Health Research Evidence, London, The Children's Society (2008).*

Due to the school and associated support network deciding to manage internally KA's developing mental health issues there was no opportunity for a clinical assessment of KA's needs. This was at a time when KA's exams and leaving school were imminent, and the trusted and supportive relationships built at school would no longer be available.

After leaving school in Summer 2015 then starting a college course for a brief time, it is now known that in late 2015 KA attended hospital accompanied by a friend. KA had superficial injuries which had been self inflicted and during the consultation disclosed a previous incident of self harm (an overdose). It is unclear if this was the same incident as disclosed to school in early 2015. KA also told the hospital of "feeling low about life" and records state "sometimes suicidal after being sexually abused when aged 13".

Unfortunately a false name was provided to the hospital, and KA and friend left before being seen by the Child and Family Consultation Service. This should have been the next stage in treatment having received an initial mental health assessment, as specified in the *East London NHS Foundation Trust*

Pathway for under 18s with self-harm or other psychiatric emergencies- out of hours- age 16 to 18 birthday, pre January 2016 version.

In the Health Overview Report an issue was identified that KA "was an unaccompanied vulnerable minor left without supervision in a health setting" for a period of seventy-five minutes prior to the absence being noticed. This linked to concerns noted in the Health Overview Report about older children (age 16 and 17) being cared for within an adult setting (the adult accident and emergency department) without paediatric input into their care.

The Newham Safeguarding Children Board should obtain assurance and evidence from Health partners that all recommendations made as a result of the Health Overview Report regarding the attendance of KA at hospital have been completed.

On realising the patient (KA), had absconded, an appropriate report was made by hospital staff to hospital security, and a referral made to the Police and to Children's Social Care. Through intelligence checks the Police managed to trace KA to the correct name and home address on the same evening. During the missing person safe and well check KA again referenced the sexual abuse allegation, which was noted as a concern by the officer on the Merlin report. The Merlin report completed after the visit requested follow up for KA by 'the Social Worker'. Unfortunately there was no allocated Social Worker at the time as the case was not open.

The Merlin form regarding the self harm and subsequent missing incident was considered in Triage within required timescales. The Police record clearly referenced that "all problems (KA) was having were as a direct result of 'that incident' (the sexual abuse)". The Triage outcome was for no further action with "no safeguarding concerns" and "Mother's continuing support" being noted. A standard letter with signposting information on local support services was sent to the family and the case was closed.

This point in the chronology of the case could be identified as a missed opportunity by Children's Social Care to offer more proactive support to KA if the full history of the circumstances and information on record had been properly considered and assessed. This included in the same year of the self harm and missing episode, a previous self harm incident which became known via a referral for Triage for possible child sexual exploitation and gang related issues. In addition, on record were the two non-recent sexual abuse allegations, significantly one of which was still being referred to by the child as a reason for the self harm. It is acknowledged that Mother had informed the Police of her intention to seek medical help for KA but the specialist support did not materialise, for reasons explored below. Therefore KA did not receive any further specialist or other support, apart from that provided by Mother. Sadly KA was found dead at home six months later.

The Newham Safeguarding Children Board drawing on the expertise of partners, should explore ways of raising the awareness of all children's practitioners of the complexities of self-harm for children and young people and the requirement to take self-harm episodes seriously and to clarify pathways for professionals to consult specialist mental health services for advice and support.

5. Referral processes to CAMHS

The review timeline shows that Mother and KA did attend a GP appointment one day after the late 2015 self harm and missing episode, as described above. The GP notes indicate that sexual abuse was referenced at the appointment and that KA had "felt low in mood over several years". An appropriate examination of the minor self harm injury took place and the GP made a referral to the Child and Family Consultation Service (CFCS). Mother and KA were aware that a referral had been made, and in her

meeting with the Reviewer, Mother recalls assuming they would be on a waiting list but that KA would have eventually been sent an appointment.

Unfortunately only minimal demographic information was recorded on the referral form with no additional information attached, so the explicit reason for the referral was not included. Therefore the actual details of KA' full circumstances at the time of the referral were not included by the GP, although the referral was marked as 'urgent'. The Health Overview Report highlighted that clinical information is usually attached to the referral form but it is unclear why that did not occur on this occasion.

It is known that the referral was received in the Child and Family Consultation Service and was sent to the administrator of the Front Door (Referrals) Team. It was discussed in the Front Door Referrals meeting and as the referral contained no clinical information an action was made for this to be obtained. The action was emailed for allocation but no clinician was identified specifically to follow up. Consequently the case was closed at the Front Door Team but no further action was being taken by any clinician which resulted in no further communication with the GP. The outcome was KA never being contacted or seen by a professional from the CFCS.

Mother explained to the Reviewer that, at the time during early 2016 and prior to KA's death, she just presumed that the lack of contact from any mental health services was due to high demand and long waiting lists. Only after the death did she realise the referral had been closed soon after it was made.

It is encouraging since July 2016 that a revised *Operational Policy for Front Door/Duty* has been in place for the Child and Family Consultation Service. A detailed process is included from a referral being received to the point of allocation, and a system for liaison when there is insufficient referral information. As part of the new operational policy a duty system is in place which aims to ensure prompt response to queries from potential referrers and to advise on alternative services for referrals not meeting the threshold for CFCS.

The Newham Safeguarding Children Board should seek assurance and evidence from East London Foundation Trust that the Child and Family Consultation Service Operational Policy for Front Door/Duty is fully embedded in the Service, is providing an appropriate initial response to all referrals and that the updated Policy has been circulated widely across all potential referrers. In addition, NSCB should seek evidence that an audit has been conducted, as highlighted in the Health Overview Report, regarding quality and content of referrals made to the Child and Family Consultation Service since July 2016, and that any further action/improvement identified as a result of the audit has been taken.

6. Contact with children who return after being reported missing

KA was reported missing twice during the review time frame. The first missing episode was reported on the day after the sexual abuse incident had taken place, in late 2012. KA was missing for a brief time before coming home. Mother recalls attending a Police station with KA soon after KA returned and that this was when KA was spoken to about being missing. Mother's opinion is that she (Mother) assumed this conversation related to both the sexual abuse and missing incidents but there is no record of any specific discussion or questioning about the alleged sexual abuse in the Police safe and well check which took place with KA from the 2012 missing episode. The note regarding KA's lack of any further sexual abuse allegation was made after the Officer had completed the safe and well check and had chance to see the earlier recording about Mother reporting the sexual abuse.

The position at the time was that information gathered from a Police safe and well check, after a missing child had returned, would inform the Children's Social Care response but the safe and well check for KA included no actual reference to the sexual abuse, albeit the missing report, completed afterwards, did.

The Police explained that during a safe and well check, basic questions would be asked including; "Where have you been?" "Why have you been missing?" "Did anything happen to you whilst missing?" This

would have given KA opportunity to tell the Police about anything that may have happened, but KA chose not to. There was a reference to the sexual abuse on the missing documentation completed earlier after Mother's initial report to the Police, but this was not mentioned in conversations during the safe and well check with KA carried out by a different Officer. It is noted within the safe and well report that KA "did not make any allegations in relation to the sexual abuse". The Officer recalls not asking KA directly about a specific allegation as the Officer did not notice that an incident of sexual abuse had been mentioned by Mother on the initial missing report. On completing the documentation to share on to Children's Social Care, the second Officer saw reference to the sexual abuse on the missing report and therefore added that KA had not disclosed any abuse in the safe and well check, although KA had not been questioned in more detail other than the standard safe and well questions as above.

Had the information on the report been read thoroughly prior to the safe and well check, more questioning of KA could have taken place to explore what Mother had already reported. Consequently the information shared by Police with Children's Social Care regarding the sexual abuse, but as part of the missing report, was minimal. Children's Social Care did not act on the brief information about the sexual abuse in the missing report. The sexual abuse of KA was referred in full after the report from the GP two days later. No follow up, immediate or otherwise, took place by Children's Social Care regarding the late 2012 missing incident, and as stated earlier, no visit took place with KA regarding the sexual abuse until more than two weeks after the GP's referral.

The second missing episode was in late 2015 when KA absconded from the hospital after reporting self harm. The Police visited KA at home for a missing person safe and well check, and KA referenced the sexual abuse in 2012. The officer added the information to the Merlin report for the missing episode and this was shared, as was protocol, with Children's Social Care. In 2015 the process for Children's Social Care follow up after a missing/return incident was as in 2012. If the Police debrief identified safeguarding concerns then Children's Social Care follow up would be considered. However as explored earlier, despite the officer highlighting clearly the reference to the 2012 sexual abuse as a result of what KA had said, the decision by Children's Social Care was not to initiate follow up, other than in writing signposting to support for self harm.

At the time in 2015 there was no formal process in Newham for children returned after being missing, and who were not already involved with Children's Social Care, like KA was not, to be seen and supported by a professional other than a Police Officer conducting a safe and well check. This was a gap in service provision for children who were not classed as open cases, when a follow up contact would be required to take place by the allocated Social Worker.

In 2015, a risk indicator of possible child sexual exploitation had already been identified nationally as children being missing from home, care or education, *Signs, Symptoms and Effects of Child Sexual Exploitation, NSPCC,* and in the individual case of KA sexual exploitation had already been reported.

Since September 2016 Families First have been commissioned in Newham to undertake return interviews with children who have been missing and who are not open cases to Children's Social Care. At time of writing this report a supporting policy and procedure is awaiting publication. The new arrangement is positive and should enable vulnerabilities, risks and additional support needs to be identified, across all groups of children who have been reported missing.

The lead for Child Sexual Exploitation (CSE) and Missing in Newham explained the number of return home interviews has significantly increased over the last six months with no notable increase in children going missing. Return interviews are being completed in a timely way and children are being offered the choice of who should conduct the interview. A positive outcome from the new arrangements is that themes and triggers are now being identified for missing episodes which will be shared with frontline professionals to inform practice.

The Newham Safeguarding Children Board through the CSE and Missing sub group should audit the new

arrangements for return visits by Families First after nine months of the service being introduced. The audit should include focus on interface between Families First and the Police regarding information shared from Police safe and well checks, and that appropriate referrals are being made as necessary by Families First or the Police when safeguarding concerns are identified.

7. Child Sexual Exploitation involving Gangs and Groups

There is a link to gangs which is evident throughout this serious case review timeline. The allegation of sexual abuse in late 2012 was said to involve a gang member as the perpetrator. The main reason for KA not wanting to pursue a formal Police complaint was due to fear of gang related intimidation and reprisals. Other issues throughout the timeline relating to gangs include concerns of verbal and physical abuse, bullying, and peer/friendship problems.

The school were aware of some of the gang culture which was impacting on KA. It is positive that KA felt secure enough to confide in some school staff, and the School Pastoral Centre identified the need for a referral to Gangsline, which was a resource available to the school at the time. As mentioned previously the Gangsline mentor is praised by Mother for the relationship which developed with, and the support provided to, KA.

Extensive research has been conducted regarding exploitation and gangs, including *"I thought I was the only one in the world" (interim report) November 2012* and *"If only someone had listened" (final report) November 2013, The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Sue Berelowitz et al.* What is now known about the experiences of KA, which coincidentally were happening at the exact time the research above was underway, highlights two areas for development in particular from recommendations within the *Final Report (November 2013)* of specific relevance to services in Newham.

Problem-profiling involves information and data being collated and assessed to inform strategic decision making and local practice development. By including all aspects as recommended in the research above and as relevant to the experience of KA will ensure a more rounded and effective response due to the fuller profile of exploitation in the area being obtained and scrutinised. Therefore the local problem profile should include detailed information and data about victims, perpetrators, gangs, gang-associated girls, and neighbourhoods.

A CSE audit was undertaken in Newham in 2016 which highlighted the overlap with CSE and gangs as an emerging theme within Newham. This will inform the local problem profile. The audit recommended that the Youth Offending Service produce an action plan detailing how the gangs overlap will be addressed locally and how the findings will supplement the CSE problem profile. Reporting areas include ensuring that those victims associated with gangs through social networks are identified and adequately safeguarded; data on cross border activity specific to CSE is provided regularly; the overlap between harmful sexual behaviour and CSE offending is monitored. These recommendations were approved by the Newham Safeguarding Children Board and progress will be overseen by the CSE and Missing sub-group. This continued local scrutiny of the links between CSE and gangs is reassuring.

The theme of gangs and sexual exploitation within the timeframe of this review starts with the significant incident of sexual abuse in 2012, which was alleged to be gang related. In particular the School Pastoral Centre and Gangsline worked hard to provide help and guidance to KA in response to this and a number of other issues. Sadly KA was not the only student requiring support and there was, and still will be, others affected by similar life experiences and concerns in the same and neighbouring school(s), and in the local area.

The changes in approach to child protection in KA's last school have been outlined earlier and responses now should be more robust. However such a framework for responding to actual safeguarding and child protection concerns needs to be underpinned by an holistic/whole school approach to managing and

raising awareness on a wide range of issues linked to exploitation and gangs, including safe/healthy relationships, all forms of bullying and harassment, the getting and giving of consent, and online safety. In an environment where messages of respect, confidence and safety are consistently promoted, and where responses to concerns are appropriate and strong, children and young people will be more equipped to at least identify concerns and seek support as necessary.

The school reported that these issues are taught to students through the Personal, Social and Health Education (PSHE) curriculum and the Information Technology (IT) curriculum. Current research by Barnardo's shows that recorded cases of children committing sexual offences against other children rose sharply by 78 per cent in England and Wales between 2013 and 2016. Furthermore Barnardo's research suggests that age-appropriate compulsory sex and relationship education (SRE) would better protect children and help them understand consent, respect and what a healthy relationship should look like, *Barnardo's, 3 February 2017.* The school where KA attended explained that the suggested areas are covered comprehensively within that school but there is inconsistency around what other settings are including for PSHE and SRE.

In the *Tackling Child Sexual Exploitation: A Progress Report, HM Government February 2017* the Government has shown a commitment to provide further funding for the *Disrespect NoBody* campaign which educates young people in respectful and safe behaviour and how to access support.

The Newham Safeguarding Children Board should consider ways to improve the awareness of children and young people, and the professionals working with them, about issues linked to sexual exploitation and gangs particularly safe/healthy relationships, consent and bullying. Provision should be consistent across all educational settings, including secondary and post sixteen sites, for those not in full-time education, and in other hard to reach categories.

8. Suicide prevention planning

An inquest into the death of KA has recorded a verdict of suicide. Statistics regarding numbers of children and young people known to have taken their own lives are very difficult to collate. However what is known is that each day in England around 13 people take their own lives, *Suicides in the UK in 2014. London: Office for National Statistics, 2016* with each death being a tragedy.

Despite the conclusion of this serious case review being that KA's death could not have been predicted there is a need to develop local suicide prevention strategies and action plans that engage a wide network of stakeholders in reducing suicide. A local suicide prevention plan will combine actions by local authorities, mental health and health care services, primary care, community and voluntary agencies, police, employers, schools and colleges, prisons and others.
Public Health England has issued *Local suicide prevention planning*: *A practice resource, October 2016* which is a useful resource for development of local suicide prevention strategies.

The Newham Safeguarding Children Board should collaborate with Public Health and other local strategic bodies to ensure a proactive and effective approach to suicide prevention within Newham is underway.

Practice issues

Practice issues were highlighted for individual organisations as a result of the review. These issues are not subject to separate recommendations as policies, procedures and training are already in place, but the individual governance arrangements of organisations will need to monitor that issues have been, and continue to be resolved:

- The Metropolitan Police Service must ensure the protocol of recording crimes at the earliest opportunity is followed by all Police officers and relevant staff;

- All professionals involved in supporting children who may disclose issues relating to safeguarding, must be aware of, and follow as required, the child protection procedures of the relevant Local Safeguarding Children Board. In addition, of particular relevance to this case are existing procedures and guidance relating to strategy meetings and managing referrals where the alleged perpetrator is also a child.

Good Practice Identified

Good practice is highlighted when it is judged that more than 'expected practice' has taken place; it is acknowledged that many professionals worked hard to support KA but practice is highlighted where professional commitment, persistence and/or professional curiosity resulted in an enhanced service.

Mother identified the support provided by the Gangsline mentor to KA throughout the timeframe as good practice. Mother said KA had valued the time spent with the mentor and that this often made a positive difference to KA.

Conclusion

The findings of this serious case review do not indicate that the outcome of the case could have been predicted by any individual or organisation involved at the time. However, there were missed opportunities to fully investigate the sexual abuse and to coordinate the wider support being provided to KA. Information about the health and wellbeing of the child was not properly shared and specialist advice was not requested to enable a clinical assessment of specific mental health needs.

Scrutiny of practice always provides an opportunity to reflect on ways in which services can be further enhanced. As a result of the significant incident(s) involving KA there is an opportunity to ensure that services and practice continue to be developed and assurance will be obtained that change and improvement, if required, has occurred.

Recommendations, as below, have been made based on the learning from the case:

Recommendations

In order to promote the learning from this case the review identified the following actions for Newham Safeguarding Children Board (NSCB) and its member agencies:

1. The Newham Safeguarding Children Board should conduct an immediate audit of strategy meetings convened in the last three months to include scrutiny of agencies involved, timeliness of meetings and decisions and actions recorded

Intended outcome: Evidence is obtained of the current position regarding procedural compliance relating to strategy meetings, enabling direct action, and development of staff where required to ensure effective initial responses to all referrals where significant harm is known or suspected;

2. Newham Safeguarding Children Board should conduct an audit to examine referrals received specifically relating to sexual abuse of children age 12 and above, to explore that strategy meetings are being held for these cases and that the statutory and local requirements for strategy meetings are being met. The audit sample should include some cases where the sexual abuse is allegedly gang

related, and peer on peer abuse

Intended outcome: Allegations of sexual abuse by older children are taken seriously, including in referrals involving gangs and peer on peer abuse, with robust multi agency responses enabling the needs of all children to be appropriately assessed and support provided;

3. Newham Safeguarding Children Board through the Local Improvement Board should request a further opportunity to scrutinise the local Police position in Newham as a result of the findings of this serious case review, and in conjunction with the findings of the HMIC inspection to ensure the identified local Police response and improvement plan is accurate and actions are robust

Intended outcome: Additional scrutiny and challenge of the current local Police position regarding responses to actions form the KA Serious Case Review and the HMIC inspection of the Metropolitan Police Service will allow for, and lead to, a more effective service in child protection investigations in the future;

4. The Chair of the Newham Safeguarding Children Board should request assurance from the Metropolitan Police after the Police Safeguarding Hub pilots are implemented that the interface and working arrangements between Child Abuse Investigation Teams and Sapphire Teams in Newham and elsewhere, regarding management of referrals and subsequent investigations of child sexual abuse is effective

Intended outcome: The Safeguarding Hub structures enable improved joint working arrangements within the Police Service internally which in turn enhances partnership working externally regarding management of referrals, improving outcomes for children and families involved;

5. The Newham Safeguarding Children Board should obtain assurance and evidence from Health partners that all recommendations made as a result of the Health Overview Report regarding sexual assault referral centres have been completed

Intended outcome: GPs are better informed of sexual assault referral pathways to ensure appropriate information is provided to children and families to facilitate attendance at centres, meaning support can be provided in a sensitive and timely way to those affected by sexual abuse;

6. Newham Safeguarding Children Board should work with Education partners to ensure there is sufficient awareness in every education setting, and specifically the two schools involved in this review, of information sharing protocols, including timescales for the effective sharing of school records when children move schools

Intended outcome: Information held by education settings, including safeguarding records, is transferred securely and quickly when children leave one setting, enabling the receiving setting to be fully aware of all circumstances relating to a child's journey. This allows for a more holistic assessment of the child's needs and for any future interventions to be informed by what has happened in the past;

7. The Chair of the Newham Safeguarding Children Board should request a report on the current position of School Nursing provision within secondary school settings in order that an adequate and consistent service in terms of resource and frequency is available

Intended outcome: A review of the School Nursing offer within secondary school settings is completed with actions identified as necessary to enable an effective, resourced service across the area;

8. The Newham Safeguarding Children Board should obtain assurance and evidence from Health partners that all recommendations made as a result of the Health Overview Report regarding the

attendance of KA at hospital have been completed

Intended outcome: Older children aged 16 and over, attending hospital unaccompanied by an adult and waiting to be seen by Mental Health Services, are reviewed at regular intervals to ensure they are being appropriately supported whilst waiting, and reassured that further mental health assessment will take place as soon as possible;

9. The Newham Safeguarding Children Board drawing on the expertise of partners, should explore ways of raising the awareness of all children's practitioners of the complexities of self-harm for children and young people and the requirement to take self-harm episodes seriously and to clarify pathways for professionals to consult specialist mental health services for advice and support

Intended outcome: All professionals working with children have sufficient awareness of self harm thresholds and pathways for referrals, and are confident to access specialist support. This will ensure those children and young people identified as possibly in need of mental health support are managed appropriately and receive a specialist response where necessary;

10. The Newham Safeguarding Children Board should seek assurance and evidence from East London Foundation Trust that the Child and Family Consultation Service Operational Policy for Front Door/Duty is fully embedded in the Service, is providing an appropriate initial response to all referrals and that the updated Policy has been circulated widely across all potential referrers. In addition, NSCB should seek evidence that an audit has been conducted, as highlighted in the Health Overview Report, regarding quality and content of referrals made to the Child and Family Consultation Service since July 2016, and that any further action/improvement identified as a result of the audit has been taken

Intended outcome: All requests for services for children and young people referred to the Child and Family Consultation Service are made, received and allocated in accordance with the Front Door/Duty Operational Policy ensuring an improved service for children and families by requests for service being responded to in a timely manner and all referrals receiving a documented response;

11. The Newham Safeguarding Children Board through the CSE and Missing sub group should audit the new arrangements for return visits by Families First after nine months of the service being introduced. The audit should include focus on interface between Families First and the Police regarding information shared from Police safe and well checks, and that appropriate referrals are being made as necessary by Families First or the Police when safeguarding concerns are identified

Intended outcome: Children and young people who are not open cases to Children's Social Care are given safe opportunities to talk about their experience of being missing, which will provide time and space for safeguarding concerns to be identified. An audit of the arrangements will ensure that when safeguarding issues have been raised appropriate action has been taken by professionals;

12. The Newham Safeguarding Children Board should consider ways to improve the awareness of children and young people, and the professionals working with them, about issues linked to sexual exploitation and gangs particularly safe/healthy relationships, consent and bullying. Provision should be consistent across all educational settings, including secondary and post sixteen sites, for those not in full-time education, and in other hard to reach categories

Intended outcome: All children and young people are provided with consistent messages for safe and healthy relationships, in a coordinated way, which improves individual awareness and ultimately affects and improves how children and young people view and treat themselves, and others;

13. The Newham Safeguarding Children Board should collaborate with Public Health and other local strategic bodies to ensure a proactive and effective approach to suicide prevention within Newham is

underway

Intended outcome: Issues relating to suicide and suicide prevention are considered in a local multi agency forum enabling national and local data and themes to be explored with the aim of helping to reduce levels of suicide and to learn from, and better support, families affected.

References

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- Working Together to Safeguard Children, HM Government, March 2010
- Newham Safeguarding Children Board Child Protection Strategy Meeting Protocol, 15.01.15
- Guidelines on Prosecuting Cases of Child Sexual Abuse, Crown Prosecution Service, 2013
- Special measures: Youth Justice and Criminal Evidence Act 1999
- Metropolitan Police Service – National child protection inspection, HMIC, 25 November 2016
- "I thought I was the only one in the world" (interim report), Sue Berelowitz et al, November 2012
- Barnardo's press statement : reported offences, 3 February 2017
- Keeping Children Safe in Education, Department for Education, Part 2: September 2016 (first published March 2015)
- Section 175 of the Education Act 2002
- The Help and Protection for Children, Young People and Families Practice Guide 2014: A guide to services in Newham
- Thurrock Safeguarding Children Board Serious Case Review 'James' , December 2016
- Truth Hurts: Report of the National Inquiry into Self Harm among Young People, Mental Health Foundation 2006
- The Facts: self harm statistics, www.selfharm.co.uk 2014
- Fundamental Facts About Mental Health Executive Summary, The Mental Health Foundation, 2015
- Mental Health of Children and Young People in Great Britain: Office for National Statistics 2004
- The Good Childhood Inquiry: Health Research Evidence, London, The Children's Society 2008
- East London NHS Foundation Trust Pathway for under 18s with self-harm or other psychiatric emergencies- out of hours- age 16 to 18 birthday, pre January 2016 version
- Child and Family Consultation Service Operational Policy for Front Door/Duty, July 2016
- Signs, Symptons and Effects of Child Sexual Exploitation, NSPCC, 2015
- "If only someone had listened" (final report), The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Sue Berelowitz et al, November 2013
- Tackling Child Sexual Exploitation: A Progress Report, HM Government February 2017
- Suicides in the UK in 2014. London: Office for National Statistics, 2016
- Local suicide prevention planning: A practice resource, Public health England, October 2016

Statement by Reviewer

REVIEWER
Amanda Clarke (Independent)

Statement of independence from the case *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.
Reviewer (Signature) *A.Clarke* **Name** Amanda Clarke **Date** 2 May 2017
Chair of Review Panel (Signature) **Name** **Date**

ANNEX 1

KA Serious Case Review

Terms of Reference

Reason for undertaking the SCR

KA, a 17 year old, was found dead at home in June 2016. KA was known to a number of services and had been the victim of assaults and had been referred to the CAMHS service. There is also a reported history of bullying during KA's school years.

SCR criteria and decision for commissioning the review

Working Together 2015 sets out the SCR criteria where:

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

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

In this instance the young person had died and the members of the SCR panel considered that the previous abuse, and the effect that is had on KA, may have contributed to the circumstances which appear to have led to KA taking their own life.

The panel recommended that an SCR was commissioned and the Independent Chair confirmed this decision on 28th July.

Communication

Ofsted, the DfE and the National Panel of Experts have been informed and an overview writer, Amanda Clarke, has been confirmed. A panel of multi-agency partners will work with Amanda to see this review through to its conclusion. The expectation is that the review will be complete within six months and that, once it has been signed off, it will be published on the LSCB website.

There has been contact with the Coroner's office and an inquest is scheduled for November (date tbc). It is possible that there will be media interest at this point.

KA's mother has been informed about the review and was visited on 9th September. She has confirmed that she would like to be involved in the review.

Communication about the SCR, including any media enquiries, should be through the LSCB office who will liaise with the council's media and communications team.

Review terms of reference

1. To understand the factors that led to KA's death and the extent to which any vulnerability was recognised and understood by those close to KA.

2. To consider what opportunities there were during the period leading up to KA's death for KA to seek and receive help and the outcomes of this.

3. To analyse what impact the reported historic sexual abuse and bullying of KA (and any other risk factors that come to light during this review) had on KA's ability to function and enjoy life.

4. To review the protective and preventive actions taken by all relevant agencies in response to the reported incidents of victimisation and the effectiveness of these.

5. To review how well agencies worked singly or together to meet KS's needs and support the family in keeping KA safe and well; and the views of KA's family about the effectiveness of agency involvement.

6. To explore whether there are any other reviews, including the recent review undertaken by Sunderland LSCB, whose learning may have a bearing on KA's case.

Scope of the Review

To start from the date of the first reported sexual assault in 2011 to the present .

Involvement and support of KA's close family / friends

KA's mother has said that she would like to be part of the review. It is possible that wider family members and some of KA's friends would also wish to be involved. This is to be confirmed.

Involvement and support of staff

All agencies that had contact with KA in the period the review is considering:

- Bart's Hospital
- Children's Social Care
- Education settings
- ELFT Community Child Health
- ELFT Child and Adolescent Mental Health Services
- Gangs Line
- GP
- Police

Information and evidence to be gathered

To be confirmed at first panel meeting

Are there any learning points and/or recommendations that have already been enacted?

If so, are these being achieved and sustained?

Dissemination of learning

The LSCB will ensure that the learning and any recommendations from this review are disseminated within the partnership through the LSCB training programme, specific briefing events and information on the LSCB website.