LONDON BOROUGH OF BARKING & DAGENHAM

LOCAL SAFEGUARDING CHILDREN BOARD

EXECUTIVE SUMMARY

SERIOUS CASE REVIEW 'CHILD A'

Date of death 14.08.07

24.01.08

1 INTRODUCTION

1.1 CHILD'S DEATH & MOST RECENT AGENCY INVOLVEMENT

1.1.1 Child A was a female child of African origin and French nationality who lived with her mother in Barking & Dagenham, and was two years and seven months old when she died.

1.1.2 On 14.08.07, Police were called to the family home and upon entering the flat found that child A and her mother (referred to in this report as Ms A) had suffered a number of stab wounds. Ms A and her child were transferred to hospital where child A was formally pronounced dead and her mother treated for what were concluded to be self-inflicted injuries.

1.1.3 A post mortem completed next day provided a provisional cause of death as 'shock and haemorrhage and a stab wound to the chest'.

1.1.4 Ms A was subsequently detained for assessment under the Mental Health Act 1983 and placed in secure accommodation pending completion of a criminal investigation. On 05.12.07 Ms A was charged with the murder of her daughter and at the time of writing [14.01.08] awaits trial.

1.1.5 The following agencies were or had recently been involved with Ms A:

- British Transport Police – issuing a fixed penalty notice for Ms A's conduct at a railway station
- Metropolitan Police Service - responding to calls from members of the public
- Barking and Dagenham's Council's Emergency Duty Service – responding to a Police request for a mental health assessment for Ms A whilst in custody
- Mental Health Services – providing a Home Treatment Team, 'approved social workers' and 'approved doctors' to respond to Ms A's apparent mental health needs whilst in custody
- Barking and Dagenham's Safeguarding & Rights – a division of Children's Services – which received from the Police two 'information only' notifications, under different names

2 REVIEW PROCESS

2.1 INITIATION & CONDUCT

2.1.1 Following child A's death, a professionals' meeting was convened and concluded that the circumstances of this child's death met the criteria for convening a serious case review contained in chapter 8 of the government's statutory guidance *Working Together to Safeguard Children* 2006.

2.1.2 A recommendation was made by the above forum and within a further two days, Barking & Dagenham's Safeguarding Children Board made a formal decision to initiate a serious case review. The Office for Standards in Education (OFSTED) was formally notified and detailed terms of reference were subsequently agreed.

2.1.3 Local managers who had had no direct responsibility for child A or her mother were identified and completed 'individual management reviews' of the involvement of their respective agencies.

2.1.4 Agency representatives also provided advice and support to the independent authors selected to collate all individual management reviews, develop an integrated chronology of all contacts with Ms A and her child and to draft the overview report and its anonymised executive summary.

2.1.5 A clear timetable was agreed for submission of individual management reviews, and for consideration of drafts of the required overview report.

2.1.6 An invitation to contribute was issued to family members though no response was received.

2.1.7 Following completion of some additional interviews with key professionals, a final version of the overview report was agreed by the serious case review sub-group and formally signed off by the Safeguarding Children Board on 24.01.08.

2.2 REPORT CONSTRUCTION

2.2.1 The remainder of this executive summary contains:

- An overview of agencies' involvement with child A and her mother
- Findings arising from the serious case review
- Practical recommendations for action by Barking & Dagenham's Safeguarding Children Board and member agencies

3 OVERVIEW OF AGENCY INVOLVEMENT

3.1 BACKGROUND

3.1.1 It is understood that Ms A and daughter child A had lived in France prior to arrival in the UK some eighteen months earlier, and that other family members, including child A's father, may live in Paris.

3.1.2 Safeguarding & Rights attempted to research Ms A's background for the purposes of this review by contacting International Social Services, the Foreign & Commonwealth Office and the French Consulate, but was unable to obtain any information.

3.1.3 Police have learned that child A's maternal grandmother and eleven year old uncle visited the UK on the afternoon prior to child A's death, so as to see her and her mother. The visit was said to have been prompted by the grandmother's concern about her daughter's well-being.

3.1.4 Child A's estranged father has described a context in that country, of relationship difficulties and some apparently odd conduct by Ms A (though this is unconfirmed and was anyway unknown to any UK agencies).

3.2 MOVE TO THE UK: 2006

3.2.1 By January 2006 Ms A and her daughter had moved to the UK and presented at the Community of Congolese refugees in Plaistow, where a community advisor (also a Minister in the 'Gilbert Deya Ministries') assisted her to complete a housing application and birth certificate translation.

3.2.2 By March 2006, the family were living in Walthamstow and had registered with a GP. Child A's immunisation history showed she had received relevant inoculations and there were *no* concerns during this period either from health services or from those who provided child care for child 'A' (described by nursery staff as developing normally and being a happy, bubbly and outgoing child).

3.3 JANUARY – JULY 2007

3.3.1 During this period Ms. A and child A lived in Barking & Dagenham and had routine or unremarkable contact with their GP, Housing and Metropolitan Traffic Police (the latter as a result of a road traffic accident).

3.3.2 Ms A's contact with British Transport Police in May 2007 provided the first concerning report of her behaviour, when as a result of her use of obscene language and acting threateningly at a station ticket desk, she was issued a Fixed Penalty Notice. Though Ms A's daughter was present at the time, notification of the incident was not passed to Barking & Dagenham's Safeguarding & Rights Service.

3.4 FIRST WEEK IN AUGUST 2007

3.4.1 During the first week in August the Metropolitan Police were informed of Ms A's disturbed behaviour in relation to her repeated harassment of a local shopkeeper, alleging that he was the father of her child. However, Police only became aware of Ms A's name on 07.08.07.

3.4.2 Police records described Ms A, in consequence of her repeated harassment of the shopkeeper, as suffering from 'mental health issues' though other than this, her behaviour was considered normal and she was observed to be 'loving' towards her daughter.

3.4.3 During the same week, Police also assisted a woman who presented a different name (but is now known to be Ms A) who had called to report that her toddler has accidentally locked her out of their home.

3.5 8TH & 9TH AUGUST 2007

3.5.1 On Wednesday 08.08.07 following further harassment of the shopkeeper, Ms A was issued a 'final warning' by 'Safer Neighbourhood Team' officers. Whilst speaking to the officers Ms A alleged that *they* were the fathers of child A.

3.5.2 She immediately returned to the shop and was arrested and taken (with her daughter) to Barking Police Station. Whilst she was there, Ms A shouted, screamed and displayed erratic behaviour, going from extreme mania to complete calm within moments.

3.5.3 Initially Ms A provided details of a nominated person to collect child A and care for her whilst she was questioned. An hour later (as the first nominee had failed to arrive) she nominated the Congolese community advisor / Minister. He subsequently attended and agreed to look after child A.

3.5.4 A 'Forensic Medical Examiner' attended the police station at 21.18 hrs and advised that Ms A would need a Mental Health Act assessment. An initial attempt was made to deploy the 'Home Treatment Team' (its aim is to provide a safe and effective home based assessment / treatment service as an alternative to in-patient care).

3.5.5 The above team attended but the language barrier and general communication difficulties made assessment difficult and they suggested an assessment (under s.12 of the Mental Health Act 1983) should take place. The Mental Health Act assessment commenced but was subsequently postponed until the next morning because Ms A appeared to be distressed and having difficulty communicating in English.

3.5.6 Next morning, concerned at behaviours that might have indicated self-harm, the custody officer arranged for Ms A to be visited at fifteen minute intervals until the Mental Health Act assessment (this time supported by an interpreter) could be completed.

3.5.7 The two doctors who undertook the second assessment were of the opinion that Ms A was not mentally ill; therefore no grounds existed for detention under the Mental Health Act. Ms A said she had fallen in love with the shopkeeper, who did not reciprocate her feelings and acknowledged that she would have to accept this. She was able to focus, answer questions appropriately, conveyed a level of insight and appeared to have a network of support in place.

3.5.8 Following several unsuccessful attempts to interview her and because she had by then been detained for approaching twenty four hours, Police decided to bail Ms A to return to the police station on 13.08.07, and to seek the advice of the Crown Prosecution Service with respect to the justification for any further action.

3.6 10TH – 13TH AUGUST 2007

3.6.1 On the afternoon of Friday 10.08.07, Safeguarding & Rights received a standard notification form from the Police including some of the above details. The matter was not considered by Police or Safeguarding & Rights to be urgent.

3.6.2 Between these dates, on Saturday 11.08.07, Police received a further report about Ms A. On this occasion Ms A had entered a barber's shop and approached the owner stating *he* was her daughter's father.

3.6.3 Police were aware of the previous incidents and the Mental Health Act assessment conclusion that Ms A was *not* suffering from a mental illness. Consequently officers focused on the child's welfare, observing she looked healthy and happy.

3.6.4 They escorted mother and daughter home to ascertain the environment in which they were living. The flat was noted to be immaculate and Ms A reported that her mother was coming over from France and might take child A back with her for a holiday. Child A was described as 'very healthy, well and full of life, constantly smiling and playing with the officers'.

3.6.5 The report of this contact was faxed on Sunday 12.08.07 to Safeguarding & Rights' Assessment Team by the Police 'Child Abuse Investigation Team' and seen by Safeguarding & Rights' staff on Monday 13.08.07.

3.6.6 The details on this second notification form referred to a different name, date of birth and address to the form sent after the incident on 08.08.07. It was therefore opened as a different file and no links were made with the previous incident. The form recorded the child protection risk assessment as 'low', with no traces of previous reports in the 'Index Results' (indicating if the family is known to other agencies) and was marked 'for information only'.

3.6.7 Safeguarding & Rights' Assessment Team followed up this notification on Monday 13.08.07 by contacting the Community Mental Health team to share the information on the Police notification and check if the family was known. The fact of the Home Treatment team's involvement on 08.08.07 was established, but the Community Mental Health Team's records did not provide information on subsequent events.

3.6.8 There was a difference of understanding about the conclusion of the telephone discussion, with the Safeguarding & Rights' Assessment Team expecting the Community Mental Health Team to organise a visit to assess Ms A whilst mental health staff planned in the first instance to establish the outcome of the Mental Health Act assessment at the police station on 09.08.07. This difference of understanding had no impact upon the tragic events that followed later that night.

3.7 14TH AUGUST 2007

3.7.1 When Police responded to the emergency call initiated by a neighbour soon after midnight on 13.08.07, the maternal grandmother and her eleven year old son were found at the scene. The grandmother stated she had been concerned about her daughter's well being and decided to visit her. They had arrived from France earlier, and because Ms A had failed to meet them, made their own way to the flat.

3.7.2 Child A's grandmother reported that at some point in the evening, she had decided, due to Ms A's unreasonable behaviour and verbal abuse, to leave the flat. Ms A tried to stop her, and then walked into the bedroom. The grandmother has said she followed her and saw Ms A in the dark room with something in her hand (later concluded to be a knife), which her daughter then dropped. Her son managed at this point to open the front door and they got out of the flat and asked the neighbour to call the Police.

4 FINDINGS & LESSONS TO BE LEARNED

4.1 SUMMARY OF LESSONS EMERGING

4.1.1 The potential opportunity for local agency intervention was limited to:

- Eleven days following the first complaint about the (then unidentified) mother's behaviour and
- Only six days between a positive identification of mother and child and the latter's subsequent death

4.1.2 Prior to child A's death:

- No local agency possessed any information that Ms A had ever threatened or been physically aggressive to anyone
- Agencies had (respectively) little or no knowledge of any concerns about Ms A's care of her daughter and consequently no explicit referral for an assessment was made to Safeguarding & Rights
- Though Ms A was assessed under the Mental Health Act 1983, no evidence of mental illness was detected and it was concluded that she was not detainable

4.1.3 Thus, on the basis of what was known to local agencies, *no* grounds existed that would have justified or provided evidence for initiating any protective legal steps.

4.1.4 Police enquiries following child A's death have revealed that there were incidents in which various members of the public had witnessed odd behaviour by Ms A. Had any or all of these been reported and collated, an earlier opportunity would have been offered for intervention.

4.1.5 Individual professionals provided a sensitive and conscientious response based on the information available to them.

4.1.6 A rigorous examination of the actions of all relevant local agencies suggests a need to:

- Consider how to encourage and enable the public to report concerns to the relevant statutory agencies
- Review the purpose, design and effectiveness of the system of police notifications and accompanying risk assessments
- Reinforce amongst professionals the critical importance of accuracy in completing basic biographical details on forms and in electronic information systems
- Alert the Department for Children, Schools and Families (DCSF) to the inadequacy of the arrangements cited in government's statutory guidance *Working Together to Safeguard Children* 2006 with respect to international liaison about families who have been living abroad

- Take the opportunity presented by this tragedy to raise professional awareness in identifying and recognising the potential child protection implications of parental delusional behaviour involving a child/ren
- Enhance systems so that those undertaking Mental Health Act assessments have access to as much information as is practicable about an individual's history and circumstances
- Introduce a number of other improvements detailed in this report in communication methods used within and between Local Safeguarding Children Board agencies

4.1.7 The serious case review revealed scope for a number of agency-specific service improvements and these are reflected in the recommendations in section 5 of this executive summary.

4.2 REVIEW PROCESS

4.2.1 Despite concerns about parental mental health, it was not possible for the authors of the Primary Care Trust individual management review to access the mother's GP records for the purposes of this serious case review; consequently any information on mother's health record and consideration of professional practice have depended upon the current GP's verbal account.

4.2.2 Given Ms A's very limited contact with her GP, there is no reason to suppose that those records contained any undisclosed information of relevance to *this* serious case review. As a matter of principle though, GP records should be made available to those conducting serious case reviews.

4.2.3 The value of supplementary interviews and direct correspondence in clarifying apparent differences was highlighted by the authors' contacts with Safeguarding & Rights, Community Mental Health Trust staff and police officers.

4.2.4 Multi agency discussions following child A's death highlighted the unsuitability of 'child protection strategy meeting forms' [as supplied in the DCSF formats] in these circumstances and that a specific template will need to be developed in relation to recording such incidents.

5 RECOMMENDATIONS

5.1 INTRODUCTION

5.1.1 The following recommendations are divided into those of relevance to the Safeguarding Children Board, those applicable to the agency/ies specified and some that are (potentially) of national significance and which will require progression via OFSTED.

5.2 BARKING & DAGENHAM SAFEGUARDING CHILDREN BOARD

5.2.1 Barking & Dagenham's Local Safeguarding Children Board (LSCB) should review what information is already available and accessible to the local population and produce or commission material that could inform, encourage and enable reporting to relevant statutory agencies of anxieties about risks to local children.

5.2.2 The LSCB should write to British Transport Police to seek confirmation that all its staff have been reminded of the requirement in 'Standard Operating Procedures' to use form CYP 1 in relevant circumstances.

5.2.3 The LSCB and its member agencies should:

- Consider how 'ContactPoint' [a national database being developed by government to enable professionals to know which other agencies are providing services to a child with additional needs] might assist in minimising inaccurate recording of names, dates of births and addresses and its potential for monitoring the whereabouts of vulnerable families (reporting to relevant national bodies, any emerging issues that require wider consideration)
- Ensure that relevant staff from all the agencies involved in this serious case review attend the training and development sessions linked to it
- Use the briefings and training linked to this case review to remind staff of the critical importance of accurate recording of key data such as names, dates of birth etc and take responsibility for this learning to be implemented in the workplace as part of an overall performance management framework
- Take the opportunity to confirm that all front line staff across member agencies have access to mental health training to enhance their ability to identify possible 'delusions involving children' and the consequent need to ensure that these are communicated to staff undertaking mental health assessments and to Safeguarding & Rights [see 5.29.3 in current London Child Protection Procedures]

5.2.4 The LSCB and its member agencies should (reflecting the needs of a diverse and mobile community), develop local intelligence-led systems by:

- Reviewing the extent to which current databases are fit for purpose including facilities to search widely for variations in spelling
- Confirming that staff are being fully trained to use facilities offered by the IT systems and routinely searching for different spellings, potential reversal of fore and surname, use of truncated versions and nicknames
- Identifying opportunities for more analytic / enquiring approaches to incoming information
- Developing quality assurance systems that evaluate accuracy, completeness and transmission of information and
- Reporting to relevant national bodies, any emerging issues that require country-wide consideration

5.2.5 The LSCB should seek to ensure that the Metropolitan Police Service, in consultation with agencies to which reports generated by 'MERLIN' [a Metropolitan Police database] are sent, should review purpose, arrangements and effectiveness of the current system, to include:

- Ensuring consistent completion of MERLINs (and consequent Police notification to Safeguarding & Rights) whenever a child has come to the notice of Police, regardless of the designation of the officer involved
- Efficacy and common understanding of the use of the risk assessment
- Common understanding of the categories of 'referral' and 'information only' (on the risk assessment)
- Importance of reference to all previous incidents, even if not previously subject to a MERLIN
- Consideration of the possibility that notifications of incidents involving children whose identity and/or address is not known should be communicated to other agencies, especially when the child's identity is subsequently established
- Ensuring accuracy in basic information and links made with alternative names etc

5.2.6 The LSCB should take steps to maximise agencies' understanding and implementation of the guidance in Chapter 7 of Working Together, particularly in addressing the Rapid Response Team's requirements and the need to have protocols for convening multi agency professionals meetings following unexpected deaths of children.

5.2.7 The LSCB should suggest that:

- Newham's Safeguarding Children Board support and enable the Community of Congolese Refugees in Great Britain to develop and operate robust safeguarding children policies
- Lewisham's Safeguarding Children Board make contact with a representative from Gilbert Deya Ministries to support development of appropriate safeguarding policies and procedures

5.2.8 The LSCB should take steps to support the development of a protocol between the North East London Mental Health Trust, Metropolitan Police Service, Primary Care Trust and Safeguarding & Rights that addresses the need for seeking and providing full background information (medical, mental health, criminal and welfare concerns) to relevant agencies if a parent is being assessed under the Mental Health Act.

5.3 SPECIFIED AGENCIES

FAITH

5.3.1 The Faith and Community sector leaders should assist Barking and Dagenham Faith Forum to:

- Identify the Faith based organisations that do not currently have robust twenty four hour child safeguarding procedures (including use by external organisations of faith premises and any work commissioned by the faith organisations)
- (Where relevant) support the development and implementation of such procedures
- Develop safeguarding training programmes suitable for application across the faith communities

LONDON BOROUGH OF BARKING & DAGENHAM ADULT SERVICES AND NORTH EAST LONDON MENTAL HEALTH TRUST

5.3.2 The London Borough of Barking & Dagenham's Adult Services and North East London Mental Health Trust should complete their proposed work on developing a single, twenty four hour access point for mental health services, staffed by dedicated experienced staff thus eliminating breakdowns in communication, delayed service response and lack of clarity around team protocols.

5.3.3 Barking and Dagenham Adult Services and the Mental Health Trust should make arrangements to ensure that:

- Access to SWIFT [Safeguarding & Rights' client database] is restored for all 'approved social workers'
- When appropriate, relevant staff in Adult and Children's Services have access to RiO [Mental Health Trust's client database]

BARKING & DAGENHAM HOUSING

5.3.4 The Council's Corporate Director of Customer Services should complete a review of the assessment of waiting list application process so as to ensure adequate verification of information supplied

5.3.5 The Council's Corporate Director of Customer Services should develop a training plan for officers required to carry out assessment visits to improve understanding of their purpose and their potential affect on application

BARKING & DAGENHAM SAFEGUARDING & RIGHTS & NORTH EAST LONDON MENTAL HEALTH TRUST

5.3.6 Safeguarding & Rights and the Mental Health Trust should review and brief relevant staff on the use of an explicit protocol to clarify and distinguish the circumstances for transmission of information and referrals one agency to the other.

NORTH EAST LONDON MENTAL HEALTH TRUST

5.3.7 The Mental Health Trust should by annual audit cycle ensure that staff who have not been updated on the use of the Risk Module of RiO receive this training.

5.3.8 The Mental Health Trust should ensure that current RiO software problems are addressed including the provision of relevant staff access twenty four hours a day.

METROPOLITAN POLICE SERVICE

5.3.9 Barking & Dagenham Borough Operational Command Unit should instruct all relevant officers that any suspicions of self harm by a person in custody must itself be fully recorded and:

- Communicated accurately to relevant others in the Police Service and other professional agencies
- Be recorded so that it is clear to whom, when and how such information was given

5.3.10 Barking & Dagenham Borough Operational Command Unit should issue instructions to all staff for the need to complete a risk assessment and carry out all necessary checks as to the suitability of any person collecting a child from the police station [it is understood that this recommendation has already been implemented in Barking & Dagenham and reflects standard Metropolitan Police Service practice].

PRIMARY CARE TRUST

5.3.11 Barking & Dagenham Primary Care Trust should review its system for informing health visitors of new patients, under the age of five years, who register with GPs in Barking.

5.3.12 In consultation with the LSCB, the Primary Care Trust should establish a clear expectation and process for ensuring that any future serious case reviews have the benefit of access to relevant GP records.

5.4 NATIONAL ISSUES

5.4.1 The DCSF should be notified by the LSCB Chair of the experience of seeking advice and assistance about families who have lived abroad from sources provided in *Working Together to Safeguard Children* 2006

5.4.2 The Department of Health (DH) should be notified by the LSCB Chair of the findings emerging from this review of the need for:

- The safety and welfare of children to be made a requirement of the work of s.12 doctors and highlighted in relevant training
- s.12 assessors to ensure that the relevant department within children's services are made aware of the outcome of the process and assessment of a parent, even if the person assessed is not detainable under the Mental Health Act or not assessed as suffering from a mental illness
- s.12 doctors to make contact with GP's both to obtain relevant information prior to a mental health assessment and subsequently to inform the GP of the outcome
- Risk to be comprehensively assessed within Mental Health Act assessments, using approved tools and documentation, and for potential risks to children to be identified as part of the risk assessment process and appropriate action to be taken

24.01.08