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Limited

NJ

SERIOUS CASE REVIEW: EXECUTIVE SUMMARY

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On behalf of the Havering (Interim) Local Safeguarding Board
Completed 12th November 2005

1. Introduction

1.1 NJ died at the age of 12years 9 months on April 7th 2005. He was found hanging from a door in the family home. On November 11th 2005, a Coroner's Inquest returned a verdict that he had died through misadventure.

1.2 Some years previously NJ and his family had been in contact briefly with statutory agencies. There had more recently been reports that he had been bullied at school.

1.3 In the circumstances it was decided that a Serious Case Review should be carried out, in line with government guidance contained within Chapter 8, Working Together to Safeguard Children (1999). This is the Executive Summary of the report of that Review.

2. Serious Case Review Process

2.1 On 1st July 2005 Marilyn Richards, Executive Director of Social Services and Chair of the Havering Area Child Protection Committee (and its successor body, the Havering (Interim) Local Safeguarding Board), wrote to partner agencies to advise of her decision that a Serious Case Review should be carried out. There had previously been a number of multi-agency meetings to discuss this.

2.2 The agencies asked to contribute to the Serious Case Review were

- Havering Social Services Department
- Havering Education Department
- Barking & Dagenham Social Services Department
- Metropolitan Police
- Havering Primary Care Trust
- Barking, Havering & Redbridge Hospitals Trust
- North East London Mental Health Trust

2.3 NJ's family were offered the opportunity to contribute to this Serious Case Review but did not respond.

2.4 A specialist independent agency, Kevin Harrington Associates Ltd, was commissioned on lead the Review and draw up its report. A draft of that report was discussed at the Havering (Interim) Local Safeguarding Board on 7th November 2005. It was agreed that the report be updated following the Coroner's Inquest and re-presented to a further meeting of the Board for confirmation.

2.5 The formal recommendations of the report are attached at Appendix A

3. Summary of Events Detailed in the Overview Report

3.1 NJ lived with his mother, step-father and sisters in Romford. His mother and father had separated some 5 years ago. Around that time it was reported that NJ was displaying aggressive and self – harming behaviour, at home and at school. Some therapeutic assistance was made available to the family, but contact was not sustained.

3.2 In December 2002 NJ's mother approached Havering Social Services for advice after she learned that NJ was involved in a situation which was being investigated by Barking and Dagenham Social Services Department. NJ's mother and step-father were visited by a Havering social worker and a police officer on one occasion. There was no further involvement with child protection or child welfare agencies.

3.3 NJ started attending King's Wood School in September 2003. He appears to have settled down well, receiving a number of commendations for excellent attendance and fund-raising for good causes. At no time was he identified as in need of support, in relation to his behaviour, welfare or academic progress. There was no evidence of the self-harming behaviour which had been of concern previously, or any other disturbance.

3.4 In the two months before his death, NJ was subject to bullying at school. This was described by the school as "low level" and was dealt with by NJ's Head of Year. Procedures for dealing with this were in place, but written records were not kept, and the Head Teacher was not aware of the situation.

3.5 On April 7th 2005 NJ attended school as usual and there is no evidence that anything eventful happened that day. When he came home he was involved in a minor argument with his sister, not an unusual occurrence. As a consequence his mother would not allow him out. She herself went out briefly with her daughters. On returning they found Nathan hanging by a tie wrapped around the hook on the bathroom door. He had left a note.

3.6 Emergency services were called and NJ was taken to Oldchurch Hospital, where he was pronounced dead. A post mortem, conducted on April 11th 2005, confirmed that death was a result of suspension, and there was no evidence that anyone else was involved.

3.7 The Coroner's Inquest held on November 10th 2005 returned a verdict of misadventure. The Coroner was not fully satisfied that NJ had intended to end his life or fully understood the consequences of his actions. She felt that NJ, as with other children aged between 10 and 14, did "not have sufficient reasoning power to appreciate the consequences of (his) actions".

4. Key Themes and Lessons Learned

4.1 The Serious Case Review confirmed that statutory agencies had played only a small part in the life of the family. That is reflected in the brevity of the Overview Report and this summary. The recommendations in full are attached at Appendix A.

4.2 There was no evidence of underlying disturbance or distress in NJ's behaviour or presentation at school.

4.3 King's Wood School should have kept written records of bullying and what action was taken to deal with this. The Head Teacher should have been aware of the situation. The Education Department's Management Review should have provided more information and analysis of this.

4.4 Information was not fully shared across agencies when police and Social Services were involved with the family in 2002. This was caused, in part, by their assessment of the situation, which failed to take account of all the circumstances.

4.5 Serious Case Reviews, even when they are relatively straightforward, are demanding exercises. Agencies must ensure that they organise themselves adequately and commit sufficient resources, so that they can be completed in line with government timescales and quality standards.

APPENDIX A

RECOMMENDATIONS

Introduction

The recommendations detailed below have significance for all agencies, even where they are addressed to specific services.

This Review, in line with guidance contained in *Working Together to Safeguard Children 1999* seeks to ensure that

- the number of recommendations for each agency is minimised
- recommendations are directly relevant to the content of the Review
- recommendations are specific and capable of being implemented

Recommendations to all agencies

1) All agencies must ensure that they allocate adequate resources to ensure that the requirements of Serious Case Reviews are met in a thorough and timely way

2) All agencies should be aware of the difficulties that commonly arise when child protection enquiries involve more than one local authority, and must ensure that the requirements of the London Child Protection Procedures are met.

Recommendations to Havering (Interim) Local Safeguarding Board

1) The Local Safeguarding Board should remind all partner agencies of the guidance relating to Serious Case Reviews and the requirement to comply with that guidance

2) The Local Safeguarding Board should draw up a specification for the content of individual agency Management Reviews, setting out more precisely what is expected of agencies.

3) The Local Safeguarding Board should raise the issues relating to procedural guidance, which are highlighted in this Review, with the London Child Protection Committee

Recommendation to Havering Children's Services Department

1) The Social Services Department should consider the findings of this Serious Case Review in respect of its approach to the assessment of children and their families.