LONDON BOROUGH OF ISLINGTON
SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD E

May 2016
1 INTRODUCTION

1.1 BACKGROUND & EVENT TRIGGERING A SERIOUS CASE REVIEW

1.1.1 In late June 2013, child E (a Black British female of Somali origin aged 7 years and 4 months) fell to her death from the 11th storey of a block of flats where she lived with a twin sister and a younger brother, all cared for by a single parent mother. For some years, child E had presented challenging behaviours and was diagnosed during 2009, as being on the autistic spectrum.

1.1.2 Child E had also been accepted by Islington’s Children’s Social Care in accordance with s.17 Children Act 1989 as being a ‘child in need’ and was a pupil at a special needs school. Child E’s family had moved into the accommodation at which child E died in late 2009. From mid-2010 Islington’s Housing Department had been directly involved in considering mother’s request for re-housing.

1.2 SUMMARY OF OVERALL CONCLUSIONS

1.2.1 The extent to which the risk of child E’s death might have been reduced is concluded in the following report, to be a function of:

- An unmet parental need for assistance in navigating the housing allocation system
- Insufficient inclusion of housing professionals in multi-agency planning
- A lack of direct involvement of housing or other professionals e.g. occupational therapists, social worker or advocate to accompany mother to viewings or explore the potential for adaptations in alternative properties
- A focus across local agencies on advocating for more suitable accommodation rather than appreciating a growing and more urgent need to initiate protective responses whilst such accommodation was being sought
- A collective presumption amongst involved professionals that child E’s mother would be able to think and act rationally in spite of the high levels of stress experienced in consequence of her parenting responsibilities, which could potentially have impacted upon her ability to make informed decisions
- An absence of any shared understanding between the involved professionals and mother, of what would constitute suitable alternative accommodation that might satisfy the many and complex needs of a very special child E

1 A child is ‘in need’ if s/he is unlikely to achieve or maintain, or have the opportunity to do so, a reasonable standard of health or development without the provision of services by a local authority, or if her/his health or development is likely to be significantly impaired or further impaired without such services or s/he is disabled
RAPID RESPONSE & CONSIDERATION OF A SERIOUS CASE REVIEW

1.2.2 In accordance with the Local Safeguarding Children Board Regulations 2006 and local procedures, child E’s death was reviewed at ‘rapid response meetings’ on 28.06.13 and 23.07.13. Those in attendance concluded the primary criterion for initiating a ‘serious case review’ (SCR) (reproduced in paragraph 1.3.1) was not satisfied i.e. abuse or neglect was not suspected. A ‘multi-agency management review’ was completed to establish whether any organisational changes were required. Its report is dated 22.02.14.

1.2.3 A Coroner’s Inquest was also completed in February 2014 and concluded that ‘the fall was foreseen by various organisations working with the family who had been communicating concerns to the Council since May 2010’. The formal verdict was one of ‘accidental death’. Following that verdict, Islington’s ‘child death overview panel’ (CDOP) considered the case. It did not refer the case back to the Local Safeguarding Children Board (LSCB) chairperson for consideration of whether a serious case review was required, because neglect or abuse was not suspected to have been a factor in child E’s death.

LEGAL CHALLENGE & RE-CONSIDERATION OF RELEVANCE OF A SERIOUS CASE REVIEW

1.2.4 In response to the Inquest verdict, child E’s mother asked again if a serious case review would be commissioned. She was informed that for the reasons outlined above, CDOP had not recommended one. An application for permission to apply for a Judicial Review of the failure to commission a SCR was considered by the High Court on the papers on 26.06.14. One of the arguments for seeking to justify an SCR was that the term ‘neglect’ in the criteria for completing such an exercise, should be interpreted to include alleged shortcomings by Islington’s system for allocating social housing. The Court initially rejected that argument and refused permission to apply for a Judicial Review.

1.2.5 Meanwhile the independent chairperson of Islington’s LSCB (Alan Caton) had sought the advice of the ‘National Panel of Independent Experts (NPIE)’. Mother’s renewed application for permission to apply for a Judicial Review was postponed whilst NPIE’s response was awaited. On 18.08.14 the NPIE confirmed that it had convened and given careful consideration to the case. Its letter concluded that it was:

- Strongly of the view there is clear evidence of Islington’s failure to protect the safety and well-being of child E
- Clear that the Department for Education (DfE) needed to issue a policy directive, or a Court determine, the narrow issue of the scope of the term ‘neglect’ referred to in regulation5(2)(a) of the LSCB Regulations 2006

2 The NPIE was established by the government in 2013 to advise LSCBs on the initiation and publication of serious case reviews
1.2.6 This advice was provided to mother’s legal representative on 26.08.14 and followed up next day by letter. That letter indicated that following a meeting of Islington’s Safeguarding Children Board which had considered the NPIE response, it had been concluded that it would be helpful, and the chairperson had made a formal decision that he would exercise his discretion and commission a serious case review.

1.2.7 The serious case review was conducted between April 2015 and April 2016 (initiation and conduct were reported to have been delayed in consequence of parallel High Court proceedings). Informed by the above legal proceedings and by direct contact with child E’s mother, terms of reference were extended beyond those of the earlier multi-agency management review to include the allocation of the property at which child E died and sought also to entertain the possibility of ‘institutional neglect’ [a concern of those representing the family]. An attempt at the outset to also involve child E’s father was unsuccessful, though the results of the review were shared with him.

1.3 PURPOSE & CONDUCT OF THE SERIOUS CASE REVIEW

1.3.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of ‘serious cases’ in accordance with ‘Working Together to Safeguard Children’ HM Government 2013 [revised in 2015]. A ‘serious case’ is one in which abuse or neglect is known or suspected and either the child has died, as in this case, or alternatively has been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child. Its purpose is to identify required improvements in service design, policy or practice amongst local or if relevant, services elsewhere i.e. to learn lessons.

1.3.2 A serious case review (SCR) is not concerned with the attribution of culpability (a matter for a criminal court when relevant) or cause of death (the role of the Coroner). A copy of this report is being sent to the government-appointed national panel of independent experts and to the Department for Education.

1.3.3 The review group consisted of the lead reviewer who received support and challenge from the:

- Designated Doctor for Child Protection Islington Clinical Commissioning Group
- Designated Nurse Child Protection Islington Clinical Commissioning Group
- Service Director Housing Need & Strategy
- Head of Safeguarding Whittington Health
- Senior Education Welfare Service Team Manager
- Director Targeted & Specialist Children & Families Service+
- Safeguarding Board Business Manager and Co-ordinator

1.3.4 The review group was also provided with independent legal advice.
1.3.5 Following a renewed application by child E’s mother for permission to apply for a Judicial Review, the Judgement of the High Court on 27.11.14 was placed in the public domain. It included identifying detail relating to the accident and to the family. In consequence, and with the agreement of mother and father, this report has not sought to remove relevant detail about what is already publicly known about the tragedy.

1.3.6 An independent report was commissioned from [www.ca.eu.uk.org](http://www.ca.eu.uk.org) (a consultancy with experience of approximately 70 serious case reviews). It was agreed that upon receipt of relevant material, lead reviewer Fergus Smith would:

- Collate and evaluate it
- Conduct any required supplementary enquiries
- Develop for consideration by the review group a narrative of agencies’ involvement, an evaluation of its quality and conclusions and recommendations for action by Islington’s Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

1.3.7 The review group concluded that a proportionate approach would be to acknowledge the value of the information generated by the earlier multi-agency management review and to build upon and if necessary, challenge its outputs.

1.3.8 The scope of the current exercise was widened to include further consideration of the educational services provided to child E and deepened in terms of obtaining greater understanding of the system for offers and allocation of social housing. The time period to be covered was extended to cover the period when a search for an alternative to the family’s then 1 bedroom flat had begun through to the completion of the ‘child death overview process’ i.e. from 01.01.09 to 31.08.13.
TIMETABLE FOR COMPLETION OF SERIOUS CASE REVIEW

<table>
<thead>
<tr>
<th>Event</th>
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<tbody>
<tr>
<td>Decision to initiate serious case review</td>
<td>27.08.14</td>
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<tr>
<td>Commissioning of lead reviewer</td>
<td>02.10.14</td>
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<td>Initiation of SCR upon receipt of High Court Judgment</td>
<td>28.11.14</td>
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<td>Consultations with mother</td>
<td>16.02.15, 30.06.15</td>
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<td>Panel meeting 1</td>
<td>29.04.15</td>
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<td>Panel meeting 2</td>
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<td>Panel meeting 3</td>
<td>10.07.15</td>
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<td>Completion and return of:</td>
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<td>(Updated) integrated chronology</td>
<td>21.05.15</td>
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<td>(Updated) individual management reviews</td>
<td>20.05.15</td>
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<td>18.06.15</td>
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<td>Submission of preliminary draft overview</td>
<td>23.06.15</td>
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<td>Submission of draft 1</td>
<td>14.09.15</td>
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<td>Feedback meetings with parents</td>
<td>27.10.15 (father);</td>
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<td>30.10.15 (mother)</td>
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<td>Presentation of proposed final report to Islington Safeguarding</td>
<td>17.11.15</td>
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<td>Children Board</td>
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<td>Panel meeting 4 to address remaining issues</td>
<td>18.01.16</td>
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<td>Submission of proposed final report</td>
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<td>Meeting to address legal advice</td>
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<td>Submission of revised report</td>
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<td>Sharing of report with family and legal representative</td>
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<td>15.03.16, 12.04.16</td>
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<td>group’s final agreement on wording on issues raised by mother’s</td>
<td>03.05.16</td>
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<td>legal representative)</td>
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<tr>
<td>Sharing of final report with mother and father</td>
<td>May 2016</td>
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<tr>
<td>Submission of report to national panel of independent experts</td>
<td>May 2016</td>
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<td>(NPIE), Department for Education (DfE) and Ofsted</td>
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<td>Formal acceptance of report by Islington LSCB</td>
<td>17.05.16 - publication to follow</td>
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2 BACKGROUND

2.1 FAMILY IN 1 BEDROOM FLAT & TRANSFER TO 11TH STOREY FLAT

2.1.1 Both parents and all three children had, until late September 2009 been living in a 1 bedroom flat provided by Islington council. The health visiting team had been in regular contact and supported charity applications for furniture and reviewed child E’s severe and chronic eczema. In recognition of child E’s additional needs, the health visiting service was at an enhanced ‘universal +’ status. A range of specialist services e.g. speech and language and occupational therapy, clinical psychology and dietetic and nursing services were also provided.

DEVELOPMENTAL ASSESSMENT OF CHILD E BY ISLINGTON ADDITIONAL NEEDS & DISABILITY SERVICE (IANDS)

2.1.2 Islington’s Additional Needs and Disability Service (IANDS) had become aware of child E when it received a referral in May 2009 from the Health Centre speech & language therapist. She sought an assessment to determine whether child E was autistic. The assessment began on 29.06.09, completed in September 2009 and a diagnosis of autistic spectrum disorder (ASD) shared with mother in mid-October. In the completed assessment, child E (then aged 3) was described as being ‘sensory seeking’ and very active.

2.1.3 Child E had been due to start at school 1 nursery but, in the light of her diagnosis, severe eczema and consequent complications, this was put ‘on hold’. Islington’s ‘Under Fives Advisory Group’ (a panel that determines the need for allocation of placements at Children’s Centre for those with significant additional needs) awarded her a place at Children’s Centre 1. Child E began attending in January 2010, later moving on to school 2.

PRESENTATION AT A&E

2.1.4 On 28.09.09 child E was brought to University College London Hospital and a fractured right elbow, reported by mother to be the result of jumping off a settee whilst playing with her sister was diagnosed. Given child E’s age (3.5) and a delay of over a day between the time the injury was said to have occurred and her presentation, the hospital had appropriately informed Islington Children’s Social Care. Islington’s ‘Referral & Advice Team’ liaised with medical staff at the hospital and were reassured that there was no suggestion of non-accidental injury or neglect.

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3 An ‘enhanced’ health visiting service should mean (according to NHS England) at least monthly recorded communication with a GP, gathering information from other professionals / agencies involved or who may hold information, and ensuring continuous reviewing / updating / inputting to any Common Assessment Framework (CAF) at least quarterly; confirming key information provided by a parent; clear action plan / outcomes recorded so progress can be monitored and plans for future visits agreed with client.
2.2 EVENTS FOLLOWING TRANSFER

2.2.1 The day after child E’s A&E presentation, the family moved into the 3 bedroom 11th storey flat. Transfer was based only upon overcrowding (though health records do refer to damp at address 1 aggravating the child’s medical condition). At the time the transfer application had been completed, there was no reference, other than chronic eczema, to child E’s health-related needs.

Comment: thus the diagnosis of child E having an autistic spectrum disorder did not inform the offer nor acceptance by the family of the 11th storey flat. Naturally, as she grew, child E was becoming increasingly mobile and knowledgeable and in need of even higher levels of supervision.

2.2.2 When collecting some decorating vouchers about a week before the family moved into its new accommodation mother had made a passing and unelaborated reference to the ‘Customer Services Team’ about her daughter’s ‘mental health’ difficulty and in a written exchange with Housing agreeing the start date for her tenancy, she referred to child E developmental delay and autistic spectrum diagnosis. She did not suggest that the accommodation was or would become unsuitable.

INITIAL INVOLVEMENT OF DISABLED CHILDREN’S TEAM (DCT)

First expression of concern by a local professional

2.2.3 On 30.10.09 the Disabled Children’s Team (DCT) in Children’s Social Care received a referral from the speech and language therapist in the Child Development Team (CDT). She requested an assessment of the need for direct payments and ‘Family Outreach’. The referrer had ticked a box to indicate that there was a ‘risk of significant harm’ but when asked to clarify, she stated she had done so, not out of concern for mother’s parenting, but to illustrate her concern about child E’s lack of sense of danger and a consequent need for constant supervision.

2.2.4 DCT’s assessment was completed on 10.11.09 and noted the family’s move to the 11th storey. It referred also to child E’s severely autistic behaviours and eczema. Initially a number of hours of respite care were provided. These were later increased in number to match child E’s growing level of need as she grew older.

2.2.5 In the course of the assessment, mother was quoted as saying that she needed to remain vigilant because ‘the balcony door had to remain locked’. She was, nearly 5 years in advance of her daughter’s death, concerned about what would happen if she ever forgot to lock the door or if child E learned to unlock it. Though no evidence to support the possibility has been located, it does not appear as though there had been at this time or later, consideration of the possibility that mother’s ability to make fully informed decisions might have been compromised by the stress she was experiencing.
2.2.6 On 19.11.09 DCT made a referral for an early years placement for child E’s brother based upon the disproportionate amount of time mother had to commit to child E. In the event, once child E was settled at nursery, mother chose not to take up the place. The first of several ‘Scrutiny Panels’ (a standing group of senior managers who employ a ‘supported assessment questionnaire’ to ensure an equitable and needs-led allocation of resources) was held later that month and additional information about need was sought. Later panels also responded to reported needs and authorised funding for extended school provision and, at mother’s request, ‘direct payments’ so that she could engage a carer.

ONGOING FAMILY SUPPORT

Second expression of concern by a local professional

2.2.7 Further to the contact by the DCT worker in November, a request for a ‘housing assessment’ was initiated. An occupational therapist OT1 from the Whittington Health Islington Additional Needs and Disability Service (IANDS) completed what has been described as an ‘in-depth assessment’ on 17.12.09. She requested ‘internal locks’ and in an email of 05.01.10 recommended urgent re-housing because of a fear child E would climb over the balcony. In the meantime, it was agreed that mother would need to keep the balcony door closed, windows shut and hold child E’s hand coming in and out of the flat.

2.2.8 On 13.03.10 a call was made by ‘tenancy management officer’ (TMO1) to the Housing Services Tenancy Team seeking permission for ‘extra locks to be fitted to windows due to child having severe autism’. Locks were reported to have been fitted within a week to bedroom windows and balcony door. The TMO request is said by mother, to have been initiated by her, after a conversation with a neighbour and not as a result of OT1’s report.

2.2.9 Mother’s recollection is also that these events did not occur until 2013. In response to that contention, further exhaustive searches of records were completed by OT, Housing and Tenancy Management Services. Changes of personnel and some loss in consequence of a flood have reduced the certainty that all TMO record have been traced. This further search suggests that an original appointment to fit locks on 27.01.10 was not kept by the technician, and that on 19.03.10, locks were fitted to the balcony but not the front door because it was metal. Instead, on 19.04.10, a chain was fitted.

2.2.10 Other measures e.g. netting were not considered, though advice from a consultant paediatrician suggests that netting would not necessarily reduce and could (if supervision slipped momentarily) add to risk. A phone interview with OT1 was undertaken in November 2015. Her memory was that at her last contact with the family in May 2010, locks for internal doors (her recommendation in 2009) had not been fitted.

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4 Responsibility for minor repairs and alterations in child E’s estate rested with Brunswick TMO as part of the management agreement with the Council.
2.2.11 Differences between memories and formal records have been difficult to reconcile, but the lead reviewer’s judgment is that the original concerns of OT1 with respect to ‘high level internal door locks’ was not acted upon until 2013, whilst installation of ‘window locks’ and a ‘front door chain’ was prompted by mother and completed in early 2010.

Assessment of special educational needs

2.2.12 The assessment of child E’s special educational needs began whilst she attended school 1. On 27.04.10 the involved educational psychologist noted that ‘the children live in a flat with their mother, but there are concerns about child E’s safety as she has a poor awareness of danger and some aspects of the flat are not suitable for her needs’. Child E’s special educational needs were summarised as… ‘a diagnosis of autistic spectrum disorder and experiences difficulties with social interaction and social communication and presents with restricted and repetitive patterns of behaviour’. Notification of the assessment was sent to Children’s Social Care which responded by confirming its involvement with the family.

PARENTAL APPLICATION FOR RE-HOUSING

2.2.13 The family initiated a re-housing application on 18.05.10. A supportive ‘medical assessment form’ (MAF) was submitted by consultant community paediatrician 1 who referred to mother’s ‘constant fear that if anybody forgets to lock the door leading to the balcony, child E may get out and fall over the bannister which could be fatal’. An email was sent by speech and language therapist SALT 1 to the DCT stating that mother was not managing on her package of care previously approved at the November 2009 Scrutiny Panel (the level and nature of support provided by the DCT was then and continued to be determined and monitored by the agency’s Scrutiny Panel).

2.2.14 In response to advice from Health sources, the family was in June awarded 50 ‘medical points’ (the maximum then being 100). ‘Medical’ and ‘welfare’ points was later increased as described below. ‘Health advice’ interprets medical information provided by the applicant, clinicians, care providers and advocates to provide an assessment of housing need. The advice in this instance awarded points and described the type of property needed. Assessments are generally informed by scrutiny of records, discussion with housing staff and consideration of any recent professional reports (in this case from the independent Centre 404 and paediatric OT report). The adviser recommended:

- ‘Wheelchair access not required, lifetime home not required, mobility not required, level access shower not required, extra bedroom not required’
- ‘Ground floor essential, child with autism living on the 11th floor poses risk associated with climbing’

2.2.15 From September 2010 (after she challenged proposals for 3 hours per week respite), mother was provided with direct payments. Subsequent panels agreed increases in line with child E’s growing level of need.
STATEMENT OF SPECIAL EDUCATIONAL NEEDS

2.2.16 A formal statement of special educational needs was completed on 06.07.10. Child E was awarded a place at school 3 with effect from the Autumn term. The statement also identified a need for non-educational provision e.g. advice from speech and language and occupational therapists as well as monitoring by Health professionals and transport to school.

2.2.17 On 14.07.10 a housing officer HO1 from ‘Homes for Islington’ confirmed that the family had been awarded 50 ‘medical points’ in June. According to the Housing report of May 2015, an additional 50 ‘welfare points’ were also added on an unspecified date that Summer.

ROAD TRAFFIC ACCIDENT

2.2.18 On 16.07.10 child E reportedly slipped out of her mother’s hand and was hit by a car. By chance, she escaped injury. Mother referred to this accident when she informed the Scrutiny Panel of 16.09.10 of her preference for direct payments. The speech and language therapist (SALT) responded to the accident by complaining of insufficient support from the DCT. In response, the allocated social worker was asked to convene a ‘team around the child’ meeting. Child E began school 3 in September and was said to be happy and doing well.

TEAM AROUND THE CHILD (TAC) PLANNING

TAC meeting 1

2.2.19 On 27.09.10, four days after the Scrutiny Panel that had agreed direct payments, the first of four ‘team around the child’ (TAC) meetings was convened. Notes of this, though not all TAC meetings have been located on the Children’s Social Care database. Participants agreed that a ‘behaviour management plan’ be drawn up for child E and mother be reminded about schemes at school 3. The intention was that the DCT would close the case leaving the occupational therapist as the ‘lead professional’. In fact, as described below, the case was not closed until a later date. Following the team around the child (TAC) meeting of September, the IANDS report refers to SW1 agreeing to follow up the need for re-housing and to a number of emails sent ‘reminding’ the DCT to do so.

Comment: on the basis of the known circumstances the outputs of the meeting were not unreasonable.

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5 School 3 is a community special school; pupils who attend are described as having autism and/or severe learning difficulties or profound and multiple learning difficulties. The school’s specialist area of work is addressing communication and interaction difficulties. The school and its pastoral support systems operate in a very different manner to an ordinary primary school; its team around each child (and family) are extensive, well resourced, complex and mostly school-based. All members of the team have specific roles and functions and broaden the support for each child and family by means of referrals to specialists or work with external agencies.
2.2.20 The understanding within the DCT differs from that of IANDS and is that SW1 emailed Housing on 09.12.10 (approximately 10 weeks later) in response to an email from SALT 1 on the same day (not because an agreement had been reached at the October meeting). This was followed up by a comparable request from Health summarising the then situation. SW1’s email indicated that... ‘parent will do her utmost to ensure the safety of the children at home. However, child requires constant supervision, the safety measures that parent is using is not going to be sustainable longer-term as child gets bigger and smarter’.

Comment: the lead reviewer’s view is that SW1 probably had received reminders in the period between September and December.

2.2.21 OT1 was also stressing to HO1 concerns about the 11th floor being ‘a real safety risk’ (this had been debated by those present at the TAC meeting). OT1 told the DCT she had been informed by housing officer HO1 that mother had now acquired the minimum total of 150 points meaning that she could bid for properties herself. HO1 wrote to mother on 20.01.11 to remind her of the bidding process which included a choice of bidding via the local housing team, by phone or on-line. The letter confirmed mother’s then total of 200 points though indicated that ‘you have been assessed as needing accommodation on either the ground floor’… [the sentence ends there].

Comment: the letter was generally clear though mother has no recall of this particular correspondence; she reports that she did understand the search at this time to include the possibility of some internal steps in a ground floor property (in fact, as explained below, between June 2010 and January 2012 child E’s mother was excluded from offers of properties with any internal stairs as she had a ‘ground floor only’ recommendation.

**Third expression of concern by a local professional**

2.2.22 The planned case closure by the DCT (leaving the occupational therapist as the lead professional) had been postponed when on 15.11.10 an email was received from the health visitor HV1. She described mother’s difficulty in getting child E to eat and also raised her concern about the risks to child E in consequence of her accommodation. Mother was referred to a dietician at school 3.

Comment: this was the third record of a professional’s concern about the safety of child E, though the first to make explicit the need for re-housing. The decision to postpone case closure showed an appropriate sensitivity to the family’s difficulties.

2.2.23 OT2 and SALT 1 completed a joint visit on 02.12.10 to complete a feeding assessment. Mother showed them the risks associated with windows and balcony. OT2’s record indicates that ‘people have been to the home to fit security locks to windows, but it is not possible to do so’ (however, the supplementary records submitted for the purpose of the serious case review in 2015, refer to an inability to fit locks to ‘metal doors’ as opposed to the windows which already had standard locks). SW1 was updated via an email on 09.12.10.
2.2.24 Subsequent correspondence between SW1 and HV1 (15.12.10) suggests that the former was actively involved with Housing with respect to two issues - firstly rendering the home more secure and secondly supporting an urgent transfer to a ground floor home.

**POTENTIAL TRANSFER 1**

2.2.25 In January 2011 a 3 bedroom Housing Association ‘new-build’ with ground floor level access and no garden was advertised. The ‘number 1 bidder’ declined to take up the home which meant that mother (short-listed as number 2) could potentially have accepted it. Mother’s reasons for not pursuing this option were not captured (an individual professional failing as well as a weakness in the system). Mother recalls viewing the accommodation and described it as a basement flat with several steps which she believed would cause child E to panic. She concluded that the accommodation was unsuitable (a later record referred to in para. 2.2.37 suggests other reasons for its perceived unsuitability).

**TAC meeting 2**

2.2.26 A further team around the child meeting was convened on 20.01.11. Notes from it refer to additional hours of respite and a delay in setting up a ‘Saturday club’. On 20.01.11 following receipt of information from Children’s Social Care (reportedly SW1’s email of 16.10.10) the family was awarded a further 50 ‘welfare points’ making a total of 220.

Comment: the points total (according to Housing) was by then 200 not 220.

2.2.27 At a Scrutiny Panel on 05.05.11 SALT1 and OT2 submitted what was described as an in-depth analysis of all the risks in the current home including that of child E climbing out of the balcony. The issue of safety in the home was addressed. The number of agencies involved in advocating for the family was noted and it appears that the involved social worker had advised mother to write to her MP about the delay in obtaining suitable accommodation. Panel members (managers) reportedly shared the concerns felt by all involved professionals.

Comment: the reported concern did not though prompt any action by these managers over and above what involved practitioners were already doing.

**ADVOCACY BY LEGAL CENTRE**

2.2.28 According to her first annual special educational needs review in May 2011 child E was progressing well and enjoying school. At the end of the month the DCT received a faxed letter from the involved Legal Centre. It referred to child E ‘hunting for a way out’ and being able to open the window child locks. The letter reported that mother had by then been awarded 200 points + 50 welfare points (it was actually 200 in total) and urged DCT to request what would be the maximum of 100 welfare points. That request was subsequently made 2 days later and was supported by a report from the occupational therapist which confirmed her view that the current accommodation was unsuitable.
2.2.29 Confusingly a fax from the same source and [probably] on the same
date to the ‘Homes for Islington Transfer Team’ assumed a current
total of 200 points and asserted that even if mother were to be
allocated another 50 ‘welfare points’, the total (supplemented by
‘waiting time points’) rendered it ‘unlikely that she is going to be able to
bid successfully for a ground floor 3 bedroom property (ideally with a
garden) for some considerable time’. The above fax urged a referral to
an ‘Exceptions Panel’ so that additional priority might be attributed.

Comment: Islington at that time operated a system which allowed the
respective directors of Housing and Children’s Services to agree a response
to identified ‘exceptional cases’; this system was intended to meet
exceptional need not covered by the housing allocation scheme. In this case,
the bidding process appeared to have been progressing and such a
response might not anyway have made a material difference.

2.2.30 The OT at this stage was recommending a ground floor property
ideally with no stairs. If there were stairs, railings should be installed.
Just over a fortnight later on 16.06.11 the Housing transfer manager
confirmed that welfare points had been upgraded to 100 making a
total of 250.

2.2.31 Presumably before mother was notified of the award of 250 points
(later marginally supplemented to reflect waiting time) she had on
16.06.11, sought further advice from Centre 404. Mother reiterated
what SALT 1 said about it being ‘a case of when not if child E will fall
out of the window’.

2.2.32 SALT 1 noted child E suffered from severe eczema and was a patient
at Great Ormond Street Hospital where relevant medication had been
prescribed. SALT 1 understood that child E was unlikely to be able to
continue taking it for much longer because it would impact adversely
upon her liver and that without it, she would be in constant pain.

Comment: aside from the ever-present danger the windows and balcony represented
to her active and impulsive child, mother was having to manage her significant
medical needs as well as the more typical demands of two other children.

2.2.33 A response to the Legal Centre’s representations of late May was
(belatedly, after a fax follow-up was sent on 17.06.11) sent on
05.07.11 (and re-sent on 14.07.11 when a change of address for the
Centre became known). The response confirmed a total of 257 points
and that the average total for a successful bid for a three bedroom
property was (at 234 points) lower than mother had by then accrued.

2.2.34 The possibility of some short-breaks for child E were explored by
Centre 404 and mother for the Summer. On the 20.07.11 the
chronology supplied refers to the result of an email from a local
councillor whom Centre 404 had consulted as being ‘clarity about
ground floor accommodation’.

2.2.35 A copy of the response to the elected Member’s enquiry was sought
and supplied to the review group. It confirmed mother’s total of 257
points (residency 100; welfare 100; medical 50 and waiting time 7) and
the inclusion of medically recommended ground floor criterion. The letter reiterated the fact that others with fewer points had succeeded in acquiring comparable accommodation. A reference was found in the correspondence to the reasons why mother had not considered the accommodation viewed as suitable viz: the flat had been too small and the bathroom unsuitable for child E to take the medicated baths required for her skin condition. There is no evidence that bathing needs were discussed with or agreed by professionals at the time.

**TAC meeting 3**

2.2.36 Reference to a third ‘team around the child’ meeting on 28.07.11 was found in a supervision note. Because re-housing was by then the only outstanding issue, the DCT perceived there to be no further role for its staff. Thereafter its only involvement until early 2013 were the reviews of the family’s care package at routine Scrutiny Panels.

Comment: mother’s viewings of accommodation which satisfied the allocation criteria but which were believed by mother to be unsuitable, remained unknown to any outside of the Housing Service; mother’s reasons were never independently validated; the unintended consequence was that child E remained at what was viewed by all involved Health and Social Care professionals to be a significant level of risk.

2.2.37 An enquiry from the local MP was received by Housing on 05.08.11 and a prompt response (which was sought and seen) repeated the facts and explanation earlier provided to the elected Member. A later review of educational progress in October 2011 provided further confirmation that child E was doing well at school.

**Confusion over eligibility criteria**

2.2.38 The involved Legal Centre on 28.10.11, asked why she was not being short-listed for properties with internal stairs and was informed that the family had a ‘ground floor only’ recommendation.

Comment: the operational definition of ‘ground floor only’ was unhelpfully literal. Coupled with an absence of human mediation it meant a significant number of bids over several months had been ineligible for consideration; the current arrangements differ as described in section 4.

2.2.39 A powerfully expressed plea was submitted to Homes for Islington by advocate 1 on 21.12.11. She used the phrase that would later be repeated …‘it is not a case of if child E will fall, but a case of when’. Of potential significance is that advocate 1 expressed a view there would be no suitable properties in the borough and indicated in her letter that mother was ‘happy and willing to move into a property with two levels’.

Comment: in response to this contact a review of child E’s medical needs was triggered and completed as described below.
TAC meeting 4

2.2.40 According to the information provided by IANDS there was a fourth TAC meeting in January 2012 at which time a Centre 404 advocate agreed to refer mother to an agency called ‘Islington Families’ for support with housing issues.

Comment: the well-intentioned action of introducing an additional organisation risked reducing the level of commitment to re-housing across agencies with an existing appreciation of the family’s needs.

2.2.41 Though not referred to in the Housing report supplied, a reference exists in the integrated chronology to an unconfirmed meeting on 24.01.12 between advocate 1 and housing allocations manager. It seems likely that its purpose was to clarify why the family had not yet been transferred. Regrettably the results of this useful initiative do not appear in any material supplied to the serious case review.

FORMAL MEDICAL REVIEW OF HOUSING NEEDS

2.2.42 There was a formal review within Housing of the family’s medical needs on 27.01.12 and a recommendation made that any property to which the family moved would require window and door locks. A revised recommendation was made with respect to the required floor level so that it became ‘1st floor maximum with or without a lift. It is thought that for the first time, the recommendation also included the need for garden access.

Comment: ‘ground or first floor’ differs from the parameters suggested by the advocate in October 2011 viz:…’a property with two levels’; this lack of clarity created confusion about what child E’s mother might expect to be offered and what she could bid for.

2.2.43 Mother was advised in a letter dated 27.01.12 that she had by then accrued 257 points (the final 7 related to time spent on the waiting list) and had been assessed as requiring accommodation on ground or first floor (with or without a lift) and with garden access.

Comment: it is understood that an ‘auto-bid’ arrangement was used from this time (reportedly in an attempt to increase the choice of properties to be drawn to mother’s attention), though the above letter makes no reference to that.

2.2.44 In February 2012 in response to a request from mother’s solicitor copies of completed assessments of need were supplied. A further Scrutiny Panel was convened on 08.03.12 but focused on the costs of the personal budget previously put in place.
Fourth expression of concern by a local professional

2.2.45 As well as those agencies that helped to articulate or promote mother’s view, there were further professionally assessed reports of need and risk e.g. a further assessment report was sent to Housing on 23.04.12 by OT3 who again referred to the balcony as the main risk.

POTENTIAL TRANSFER 2

2.2.46 On 26.04.12 mother viewed a second potential property (a 3 bedroom house with a garden). She did not consider it to be suitable because the kitchen was not big enough and because there were too many (13) stairs. Mother confirmed to the author that she visited all the properties inspected, alone.

2.2.47 An OT report from school 3 was received by Housing on 08.05.12. It was nearly identical to the medical recommendations of January 2012 though it added (as well as ground or 1st floor accommodation) the need for a separate kitchen and living room. At this time, reflecting further elapsed time awaiting more suitable accommodation, further points were added to make a total of 264.

Mother’s description of child E’s world

2.2.48 In May 2012 Centre 404 noted an account by mother which captured well the ongoing confusion she (and others) were experiencing.

- ‘Missed out on bidding, very difficult, never would have found out - just wasn’t being called to even bid on properties as they had internal steps very confusing - if she says that child E is able to manage internal steps [she fears ??] the medical points [could] go down? [text in square brackets added to clarify what mother is thought to have meant]
- Child E not eating at school have to send food in; eats very well usually, goes through weekly phases
- The garden is a priority for child E who wants to be outside all the time; will run outside, climbing up the windows to get out so dangerous, is completely obsessive; will have to go out; family needs a ground floor with a garden and 3 bedrooms - this will still be difficult as child E is unable to share; she constantly wakes during the night waking everyone up and tries to escape
- Very worried that child E will fall, constant worry every day; not sure what to do to make the Council realise it has been years and is getting worse; child E is getting older and bigger more obsessed with getting out - terrified one day she will succeed
- Computer bidding has not worked with it changing the bids to up to the 2nd or 3rd floor with a lift; need a secure outside area; Housing- not moving forward at all'
2.2.49 Advocate 1 was planning to check whether the Legal Centre had been in touch recently and what had been happening with any progress. She also signposted mother to a law firm that had recently helped another family with a child at school 3 to achieve a transfer.

POTENTIAL TRANSFER 3, 4 & 5

2.2.50 A 3rd potential transfer arose on a date in May 2012 when mother viewed a 3 bedroom property with a garden. Though sought, the ‘refusal form’ has not been found (mother may or may not have been offered or completed one) and it is not possible to establish from records why this property was not considered to be suitable.

2.2.51 A 4th potential transfer occurred on 11.10.12 when mother viewed a further 3 bedroom house which had 21 internal stairs (mother thinks this was likely to be why she did not progress this possibility – the refusal form is though incomplete). On 20.12.12 mother also deemed unsuitable (because of 26 internal stairs) the 5th potential transfer - a 3 bedroom maisonette with a garden.

2.2.52 On 12.02.13 Islington Legal Services received a letter from solicitors acting for child E’s mother. The letter requested access to files, a copy of Housing’s allocation scheme, an assessment of her children’s needs and mother’s own needs as a carer, as well as an assessment of the need for what was described as a ‘ground floor property’. The author of the letter argued for the allocation of 100 ‘medical points’ on the grounds that a fall from the 11th storey would be fatal (mother had actually had 250 points since June 2011).

2.2.53 Legal Services responded on 18.03.13 in the following terms:

- Mother’s application has been assessed lawfully and in accordance with the Council scheme which has been published in accordance with the law
- A copy of the file would be provided in due course
- It was confirmed that mother was assessed as eligible for a 3 bed home; there was no evidence to support a ‘GG’ assessment (meaning no internal or external stairs) [from early 2011 mother, her then legal representative and OT2 had accepted the possibility of some internal stairs]
- Mother has been assessed as requiring ground or first floor with / without a lift; there was no medical evidence to support a need for a garden [the medical review of January 2012 had supported the desirability of a garden]
- Information was given regarding social services nominations; it is not unlawful to omit this from the published scheme
- Mother’s welfare points (100) and medical points (50) were confirmed
- Mother was invited to submit medical forms for all members of the household, following which a further assessment would be completed
Comment: mother’s view (shared by at least one doctor and OT) was that a garden was required for ‘sensory-seeking’ child E. Her preoccupation with climbing would also have required measures to ensure that any garden provided was made safe.

2.2.54 In response to the letter from mother’s legal representative, DCT’s SW2 completed a ‘core assessment’ between 20.02.13 and 26.04.13. She concluded the primary need was the challenge of keeping child E safe. SW2 noted Housing had recently provided locks for internal doors. Whilst acknowledging that this had helped, mother remained worried about the windows and still wanted to move. The author of the above assessment cited an occupational therapist as having recommended ‘ground floor flat with a garden’.

Comment: it has been deduced that inclusion of a garden in the search criteria first occurred on 27.01.12 when medical advice was reviewed and criteria widened to include ground or first floor. It was reinforced by the OT report of May 2012.

2.2.55 The view taken by SW2 (and she recalls this as mother’s preference) was that solicitors were already advocating for her, that mother was content with her personal budget (due for review in June) and there was no need for additional DCT action. Mother’s alternative memory is that she found it difficult to interest the social worker in the issue of re-housing. SW2 observed and recorded nothing to suggest mother was incapable of making informed decisions.

2.2.56 SW2 has reported no awareness of mother’s bidding or viewing history. SW2 had the impression that mother and her advocates believed that the family lacked sufficient points for re-housing in more suitable accommodation.

Comment: whilst in other respects a well completed document, the core assessment was not informed by liaison with the Housing Service and depended upon face to face contact with the family and some unspecified medical reports.

2.2.57 A comprehensive and independent ‘carer’s assessment’ had been initiated in March and (because of minor discrepancies) an addendum provided on 19.06.13 by ‘advocate 1’. The report provides a comprehensive account of an exhausted mother doing her best to manage a very demanding child E and her siblings. The author wrote ‘the family desperately need to move; the house is unsafe; it cannot be adapted to make it safer and there is a very real possibility of child E falling from the window. Mother is constantly stressed and fearful that child E will escape and will fall eleven floors which would be fatal…’

2.2.58 The independent assessor wrote …‘it is not a case of if child E will fall but when’. A core assessment completed by DCT’s SW2 was broadly consistent with that of Centre 404 and highlighted the at times almost impossible challenge for mother e.g. the fact that she was obliged to leave two young children unsupervised whilst she ensured child E’s safe transfer down eleven storeys for the school bus.
Comment: though not specified in the records of Scrutiny Panels latterly provided, mother’s ‘personal allowance’ could have been committed to arranging for supervision of child E’s siblings on school-day mornings; the advisability of making such an arrangement is included within the core assessment completed by SW2.

2.2.59 SW2 has confirmed that at her final visit on 18.04.13 she was unaware of the levels of concern amongst professional colleagues or of the alternatives that had been offered. By May 2013 Housing points were increased (for elapsed time) to 272.

SCHOOL MEDICAL, POTENTIAL TRANSFER 6 & FATAL FALL

2.2.60 At a consultation with a school doctor on 10.05.13 Melatonin use (which mimics normal physiological changes during sleep) had been discussed and a plan agreed with mother for a nocturnal dose, to be doubled in 2 weeks if there was clinical change to the child’s sleep, plus work with school and home about sleep protocols and ‘sleep meetings’ at school 3. It is thought that mother had not begun use of Melatonin by the time of a routine examination at school on 17.06.13 when she sought a sedative’ prescription’. Paediatric advice is that sedatives such as chloral hydrate or benzodiazepine have side effects that can add to risk e.g. a child may remain awake but be less steady on their feet. Use of Melatonin in combination with a behavioural approach is standard good practice.

2.2.61 Next day mother viewed and thought unsuitable a ground and basement 3 bedroom maisonette with 12 internal stairs and a large garden.

Comment: mother has described child E’s fear of going down into enclosed spaces thus, although not precluded in the established criteria, the inclusion of steep steps leading to a basement was why mother believed this accommodation was unsuitable.

2.2.62 Child E fell to her death 8 days later.
2.3 LOCAL AGENCIES’ RESPONSES FOLLOWING DEATH OF CHILD E

RAPID RESPONSE MEETINGS & TRANSFER

2.3.1 In accordance with regulation 6 of the Local Safeguarding Children Board Regulations 2006, ‘rapid response’ meetings were convened on 28.06.13 and 23.07.13. Housing, Disabled Children’s Team, Child Development Team, Centre 404, Schools, Police, Royal London Hospital and other agencies were present.

2.3.2 Mother’s account of how child E had managed to access and fall from the balcony was heard. According to the information presented to the meeting mother had viewed 6 properties out of a possible 11 and had found the last one (a ground floor maisonette) to be unsuitable due to it having 13 internal stairs.

2.3.3 Offers of temporary accommodation were made immediately after the death of child E but mother preferred to avoid a double move and remained at a relative’s home until she accepted the offer of address 3 and moved there on 31.07.13.

RECOMMENDATION ABOUT A SERIOUS CASE REVIEW

Criteria for convening a SCR

2.3.4 At the time of child E’s death the criteria for initiating a serious case review were that abuse or neglect of a child is known or suspected and that either a child has died, or alternatively been seriously harmed and there is cause for concern as to the way in which organisations or professionals worked together to safeguard the child.

2.3.5 It will always be possible that retrospective exploration of the totality of information held by agencies, when effectively collated and analysed, reveals previously unrecognised evidence of a child’s unintentional neglect e.g. an able, caring and committed parent whose capacity to make fully informed decisions is temporarily compromised by illness or stress. The independently authored carer’s assessment completed weeks before child E’s death came closest to that thought and illustrated the greatest sensitivity to the considerable ongoing pressure mother and her other children experienced living with child E.

2.3.6 This review, whilst acknowledging a number of occasions on which there could have been more effective multi-agency discussion has not identified indications that mother was at any point incapable of exercising her parental responsibility i.e. other than her decisions with respect to accommodation viewed (about which there was insufficient awareness across involved agencies) there were no indications of neglect or any insufficiency of parental co-operation such as could have justified enquiries under s.47 Children Act 1989 (reasonable grounds to suspect a child is or is likely to suffer significant harm).
Institutional / organisational neglect?

2.3.7 The lead reviewer’s understanding of the intent of the 2013 and current 2015, as well as all previous editions of *Working Together to Safeguard Children* is that the term ‘neglect’ used and defined within them refers to personal care e.g. that provided by a parent or carer.

2.3.8 At no point in any of the 20+ years since such guidance was developed has the notion of any alleged ‘corporate’ or ‘institutional’ neglect been understood amongst those undertaking serious case reviews to satisfy the criteria for initiating such a review. Thus the decision made in 2013 to undertake a multi-agency management review was a reasonable and proportionate one.

Opportunity for learning

2.3.9 The chairperson of any LSCB has the discretionary power and may determine there is potential learning to be derived from completion of a serious case review even when the criteria are not satisfied.

2.3.10 In this instance, given the inability of the national panel of independent experts to rule upon the precise lawful definition of neglect for the purpose of a serious case review, the decision in mid-2014 to re-visit and extend the work completed during the course of the earlier multi-agency management review by commissioning a serious case review was commendable.

2.3.11 The author has been informed that Islington now has a standing ‘case review group’ which routinely examines which cases might justify a formal review and may recommend to the independent chairperson of its Safeguarding Children Board that a serious case review be commissioned.

TRANSFER APPLICATION HISTORY

2.3.12 On the day after the death of child E records associated with bids and offers since eligibility had been confirmed in July 2010 were interrogated. Combining those records with the reports submitted for purposes of this review suggest a total of 82 bids, 57 since January 2012 when the criterion of ‘ground floor only’ was revised. From the latter date, 18 properties had been bid for and shortlisted i.e. mother was in the top 8 and invited to view. At least 5 were actually viewed and it is thought that the Housing Association property had also been viewed in January 2011. All other bids had ‘not been shortlisted’ i.e. they had not met the established criteria to meet this family’s needs.

2.3.13 Whilst Police investigated the circumstances of child E’s death, mother and her other children stayed with some friends. Mother could not recall receiving an invitation to view a property on 29.06.13 for which (according to Housing) she had already been short-listed.
3 ANALYSIS

3.1 ISSUES CONSIDERED

3.1.1 Reflecting the fact that the majority of required improvements had already been put in place as a result of the multi-agency management review completed in 2014, this section addresses a small number of additional issues that have emerged in the course of this serious case review. Section 4 provides some overarching conclusions and 2 further recommendations.

3.2 ALLOCATION OF 11TH STOREY ACCOMMODATION

3.2.1 The report supplied by Whittington Health Islington Additional Needs & Disability Service (IANDS) for the multi-agency management review completed in 2014 refers to the autism assessment completed by the Child Development Team (CDT) at the request of the Speech & Language Therapy Service.

3.2.2 The above assessment was undertaken between late June and September 2009 and within a month of its completion, the family had moved to address 2 where the fatal accident occurred. The family’s involvement with the Disabled Children’s Team of Children’s Social Care therefore pre-dates the transfer.

3.2.3 Thus, in the period prior to the family’s transfer to its 11th storey accommodation, whilst it was clear to those professionals who had met her that child E was very active, impulsive and sensory-seeking, neither these facts, nor their collation and analysis in the completed assessment by the child development team informed or influenced the offer of accommodation. The justification for the transfer had been ‘overcrowding’. It appears that at the unknown earlier date on which the family had submitted its application, the severity or chronicity of child E’s needs had not become sufficiently apparent within the local network of services to influence allocation of social housing.

3.3 SOCIAL HOUSING CONTEXT

3.3.1 The report provided by the Housing Service indicates that Islington is the most densely populated borough in the UK and has approximately 20,000 households on its housing register (those seeking social housing and those hoping for a transfer to more suitable accommodation). There are about 1,100 lettings each year which are allocated on the basis of need as set out in the borough’s ‘Housing Allocation Points Scheme & Definition of Categories’.

3.3.2 The majority of social housing in Islington consists of flats in blocks and only 12% of that is ground or first floor, including properties with basements. There is a particular scarcity of properties with gardens.
3.3.3 Relevant extracts from the borough’s then Housing Allocation System including the distinction and application of ‘welfare’ and ‘medical’ points were provided for this serious case review. Whilst complex, the system was clearly the result of a lot of thought and rightly sought to balance individual need with the limited amount of available resource.

3.3.4 Within the information reviewed, nothing was found to suggest that the above system was ineffective. The system was underpinned by the principle of ‘service user’ as opposed to ‘professional’ choice. In consequence there existed the possibility (as in this case) of there being no reconciliation of the professionally-advised formal allocation criteria and a mother’s view of what would actually work for her child.

3.3.5 Standard locks in this and similar blocks of flats were considered sufficient generally to provide good safety and security (lockable handles, plus restrictor preventing opening beyond 100mm [though this could be over-ridden]. As well as balcony door locks, there were additional robust window and internal door locks at the time of child E’s accident.

3.3.6 Ultimately, child E did not die because there were no locks. It is though regrettable that it proved so challenging to wholly reconcile memories of installation/s with formal records.

3.3.7 Unfortunately, opportunities to bring together and debate the system-generated offers of accommodation with professionally-assessed and parentally-supported assessments, of need and risk were not sufficiently exploited. Housing professionals were not involved in the individual and sometimes joint planning of service delivery by DCT (including Scrutiny Panel involvement) and OT staff. To a large extent the Services moved on parallel tracks instead of converging.

3.4 ACCOMMODATION VIEWED

3.4.1 As early as mid-2011 the family had accrued 250 points (well over the reported average 211 held by successful bidders that year) and the properties seen did satisfy the criteria established in early 2012 on the basis of medical and occupational therapy expertise.

3.4.2 There was some imprecision in the parameters established in Housing on the basis of Health (OT and medical) and Social Care-related advice. The chief underpinning reasons why child E’s family did not in fact move into any one of the properties offered reflected:

- An unmet need for a professional to intervene in the service user-led housing allocations system which was not designed to ‘case manage’ individual needs
- The absence of Housing Service representation at the team around the child meetings that were convened
In spite of a clear awareness of child E’s needs, insufficient recognition within the Disabled Children’s Team, Occupational Therapy and Housing of the need (rooted in the implications of the family not moving out of the 11th storey), to escalate protective responses

- Parental ‘choice’ (a legitimate exercise of parental responsibility though one arguably insufficiently informed by advice that could have been provided by Housing or perhaps others including advocates, to indicate the limited alternatives that realistically might be offered and to seek to reconcile what was desired with what was available)

3.5 **WHY PROFESSIONALS ACTED AS THEY DID**

**THE THINKING UNDERPINNING PROFESSIONAL RESPONSES**

3.5.1 The review group sought to appreciate why, in spite of a widespread acceptance that child E was at risk of harm, professionals did not initiate protective action e.g. invoking s.47 Children Act 1989 enquiries or escalating their concerns if they felt that protective action was not being taken by relevant others.

3.5.2 The most obvious obstacle to any professional initiating action was their ignorance of the fact that mother believed the alternative housing viewed was unsuitable. A second factor may have been a not uncommon belief that the conditions for triggering action under s.47 must relate to poor parental care. Growing levels of concern about child sexual exploitation or gang membership offer contemporary examples of a need to broaden thinking to embrace harm not necessarily linked to inadequate parental care.

3.5.3 There are also some essentially comparable psychological phenomena that may have unconsciously influenced professionals:

- ‘Group-think’ which occurs within a group where a desire for harmony or conformity results in an irrational or dysfunctional decision-making outcome
- ‘Cognitive dissonance’ - the mental stress / discomfort experienced by an individual holding two or more contradictory beliefs, ideas, or values performs an action that is contradictory to one or more of them, or is confronted by new information that conflicts with existing beliefs, ideas, or values
- ‘Mind-set’ - a set of assumptions held by one or more people or groups of people that is so established it creates a powerful incentive within these people or groups to continue to adopt or accept prior behaviours

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6 By virtue of s.47. local authorities have a duty to make enquiries if they suspect a child is suffering or is likely to suffer significant harm

7 The author has been assured that a current ‘escalation policy’ embraces the possibility of recognising and articulating risks to a child even if they are not a direct function of parental care – hence no recommendation has been made
3.5.4 Whichever of the above concepts one applies, the consensus amongst those who knew mother was that she was a loving and committed parent who would not knowingly do anything to harm a child. That shared view would make it difficult to ‘think the unthinkable’ and apply to her situation, the responses most often triggered by abusive or neglectful parenting.

**APPRECIATION OF MOTHER’S ABILITY TO MAKE RATIONAL CHOICES**

3.5.5 The review group has considered the question of the extent to which assessments of the needs of child E and how these should be met and the acceptance by the professionals of the mother’s exercise of her parental responsibility were appropriate. No one questioned whether the mother was able to make or to sustain making informed decisions in circumstances which were extreme. No one questioned whether it was rational or reasonable at that point for mother not to pursue an accommodation option which could have removed child E from the environment in which she was living.

3.5.6 The review group recognised the legal test on how to determine whether a parent has ‘capacity’ under the Mental Capacity Act 2005 but there had been no suggestion and is no suggestion from any source that child E’s mother lacked mental capacity at any time.

3.5.7 Legal advice received raised the question of the extent to which assessments of need and acceptance of mother’s exercise of her parental responsibility in not pursuing accommodation options were based on informed decisions by the mother. Recent case law has set out the required practice for those charged with the completion of an assessment of need under s.17 Children Act 1989.

3.5.8 The information relevant to a decision includes information about the reasonably foreseeable consequence of deciding one way or the other, or failing to make the decision.

3.5.9 Recent case law (post-dating child E’s death) has however emphasised that even if a parent has mental capacity the applicable challenge for those assessing the family’s need for support services is to ensure that mother’s consent with respect to the services received is fully informed:

- Did mother fully understand the consequences of consent?
- Did mother fully appreciate the range of choice available and the consequences of refusal as well as giving consent?
- Was mother in possession of all the facts and issues material to the giving of consent?

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8 See [http://www.bailii.org/ew/cases/EWCA/Civ/2015/1112.html](http://www.bailii.org/ew/cases/EWCA/Civ/2015/1112.html)
3.5.10 In order to be satisfied that parental decision-making is fully informed, there is a further stage which requires that giving of such consent (and any subsequent removal) is both fair and proportionate. In considering that, it might have been helpful and necessary to ask:

- What is the current physical and psychological state of mother (which might in turn have prompted enquiries of her GP)?
- Has she been encouraged to seek legal advice and/or advice from family or friends?

3.5.11 The level of rigour now required by the above 2015 Judgement was not applied to the situation of child E’s family. The otherwise comprehensive and sensitive carer’s assessment completed not long before child E’s death described mother’s level of stress but did not address the extent to which that could potentially reduce her ability to make fully informed decisions i.e. might she have been rendered ‘vulnerable’ by virtue of the ongoing responsibility for an increasingly challenging child E?
4 FINDINGS & CONCLUSIONS

4.1 FINDINGS

COMMISSIONING A SERIOUS CASE REVIEW

4.1.1 In the view of the author, the original view formed at the ‘rapid response meetings’ and ‘child death overview panel’ – that the criteria for a serious case review were not satisfied, was not irrational and was justifiable.

4.1.2 The decision that a multi-agency management review should be completed was made promptly and illustrated a welcome readiness amongst local agencies to identify any lessons arising from the tragic death of child E that might improve future service delivery.

4.1.3 The multi-agency management review of February 2014 was a well-written document based upon coherent material provided by most of the relevant local agencies.

4.1.4 The value of the management review was somewhat reduced because it:

- Failed to involve either of child E’s parents sufficiently
- Covered only the period after the family was transferred to the 11th storey flat – thus omitting the issue of how such an allocation was made in the first instance
- Made insufficient use of information about child E known to be available and of potential relevance in educational records
- Was unable to fully explain why (in spite of several potential alternatives) child E’s family had not completed a transfer
- Did not evaluate agencies’ responses to child E’s death e.g. the immediate identification and acceptance of alternative property and the decision that no serious case review was required

4.1.5 The attempt by mother’s legal representative to argue the term ‘neglect’ in the statutory child protection guidance ‘Working Together to Safeguard Children’ 2013 should be interpreted to cover neglect by a statutory agency was not decided upon by the High Court because of the decision to exercise the discretion to carry out an SCR after the issue of proceedings. Given the inability or unwillingness of the national panel of independent experts to form a view on the question of any obligation to initiate a serious case review, the decision by the independent chairperson of Islington’s Safeguarding Children Board to exercise his discretion and commission such an exercise was the correct decision.
4.1.6 As indicated in the introduction, the terms of reference sought to enhance the previous evaluation of services provided by:

- Inviting the involvement of mother and father from the outset [child E’s mother contributed directly to information-gathering and draft findings of this report were shared with her and child E’s father before it was finalised]
- Enlarging the scope of the review to consider why the family was placed in an 11th storey flat
- Broadening and deepening the evaluation of services provided
- Considering the organisational responses to the news of child E’s death
- Addressing the effectiveness of the follow-up and implementation of the recommendations agreed at the time of the 2014 review
- Recommending any further measures believed still to be necessary

4.2 CONCLUSIONS

4.2.1 Though this review has widened and deepened the areas explored and directly involved child E’s mother, it has not generated radically different results to that of its less formal predecessor. Child E’s death was predicted by more than one involved professional, some of whom were sufficiently concerned to make that fear explicit in formal records. The extent to which the death was preventable was a function of:

- An unmet parental need (in consequence of the exceptional needs of her child) for assistance in navigating the housing allocation system
- Insufficient inclusion of housing professionals in multi-agency planning by means of a team around the child (TAC) framework (itself weakened by a failure to keep / circulate minutes) where potentially the possibility of even temporary housing might usefully have been debated
- A lack of direct involvement of Housing or other professionals such as OT, social worker or advocate to accompany mother to viewings or explore the potential for adaptations in short-listed properties
- A focus across local agencies on advocating for more suitable accommodation rather than appreciating a growing and more urgent need to initiate protective responses whilst such accommodation was being sought (possibly influenced by the mind-set about the family amongst involved professionals)
- An absence of any shared understanding between the involved professionals and the mother of what would constitute ‘suitable’

4.2.2 As was apparent to the Coroner, the immediate human link to child E’s death was a momentary lapse of concentration by a devoted mother.
BEST PRACTICE v INSTITUTIONAL NEGLECT’?

4.2.3 The evidence that emerges from the multi-agency review of 2014 and this review is that child E’s death cannot be argued to have been preventable had any individual professional acted differently. It could have been rendered less likely if local arrangements (chiefly the Housing Allocation system and Children’s Social Care practice) had operated differently. The choice-based system (used by most local authorities) is understood to meet the needs of the vast majority. Child E presented highly challenging conduct requiring a different approach to that suiting more visible physical or tangible medical difficulties. There was:

- A general over-dependence upon an insufficiently understood housing allocation system
- Some confusion about criteria for the required property (definition of ‘ground floor’; was a garden an essential or a desirable feature?; absence within criteria of child E’s parentally-reported fear of steps leading to enclosed spaces)
- A failure by any of the involved professionals (including those advocating for the child) to explore with child E’s mother why she believed the accommodation viewed to be unsuitable, or to re-frame the unintended consequence as one that left a highly vulnerable child at risk of significant harm

4.2.4 ‘Best practice’ would have transcended formal roles and remits and recognised more clearly that child E’s immediate needs for protection outweighed them. It is tragic that systems and professional practice proved to be of insufficient sensitivity and rigour to meet her needs but the lead reviewer has found no signs of wilful or reckless misconduct by any professional and only some individual practice that did not meet expected standards.

IMPROVEMENTS ALREADY IN PLACE

4.2.5 Following the death of child E, the scope for more effective arrangements was readily recognised and a multi-agency protocol was recommended by the multi-agency management review in 2014. The reviewer was provided with a copy of a helpful protocol developed in response to the above recommendation. The Children’s Health and Social Care Services & Housing Needs’ protocol was introduced in November 2014: Protocol for meeting the housing needs of non-physically disabled children.

4.2.6 The reviewer has more recently been provided with a summary of an audit of cases relevant to the above protocol which was completed in August 2015 by suitably qualified and independent professionals. The summary indicates that the new arrangements were working well and that ten key standards relating to the recognition of, and multi-agency responses to high risk cases were being satisfied in cases audited.
5 RECOMMENDATIONS

5.1 FROM COMPLETED MULTI-AGENCY REVIEW

5.1.1 Recommendations of the 2013/14 management review were:

**All agencies**
- Create a ‘protocol’ for non-physically disabled children

**Housing**
- Review communications to the public & professionals to ensure understanding of the bidding system & availability of local housing stock
- Review policy in relation to ‘ground-floor only’ allocation
- Review the allocation scheme policy & associated publicity
- Change the medical assessment form

**Health & Social Care (Occupational therapists)**
- Provide refresher training for specialist staff on housing issues
- Visit properties with families classed as high risk to advise on suitability

5.1.2 The lead reviewer and serious case review group have received confirmation that all the above actions were accepted by respective agencies; that the required changes were introduced during 2014. It is understood that the protocol referred to in para. 4.2.5 has been further enhanced.

5.2 EMERGING FROM THIS SERIOUS CASE REVIEW

5.2.1 Two further recommendations are that the chairperson of Islington’s Safeguarding Children Board should:

- Via the Association of Independent Chairs of Local Safeguarding Children Boards, share Islington’s protocol for high risk cases and encourage other Boards to seek from their local Housing Services, assurances that the standards described in that protocol are being satisfied in the respective localities
- Seek to establish the policy of the Department for Education with respect to the contention that an allegation or evidence of institutional neglect by a local agency should be considered as satisfying the criterion for initiating a serious case review
### Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Agency Abbreviation / Meaning</th>
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<tbody>
<tr>
<td><strong>A&amp;E</strong> Accident and Emergency Department</td>
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<tr>
<td><strong>ASD</strong> Autistic Spectrum Disorder</td>
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<td><strong>CDOP</strong> Child Death Overview Panel</td>
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<td><strong>DCT</strong> Disabled Children’s Team</td>
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<tr>
<td><strong>IANDS</strong> Islington Additional Needs Disability Service</td>
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<tr>
<td><strong>LSCB</strong> Local Safeguarding Children Board</td>
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<td><strong>MAF</strong> Medical assessment form</td>
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<tr>
<td><strong>MAMR</strong> Multi-agency management review</td>
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<td><strong>NPIE</strong> National Panel of Independent Experts</td>
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<tr>
<td><strong>SCR</strong> Serious Case Review</td>
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<td><strong>TAC</strong> Team Around the Child</td>
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#### Centre 404

<table>
<thead>
<tr>
<th>Advocate 1</th>
<th>Centre 404</th>
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<tr>
<td>Advocate 2</td>
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#### Disabled Children’s Team

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<thead>
<tr>
<th>SW1</th>
<th>Social worker</th>
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<tr>
<td>SWM1</td>
<td>Social worker manager</td>
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#### Housing

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<tr>
<td>Housing allocations manager</td>
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</tr>
<tr>
<td>OT1</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>OT2</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>OT3</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>SALT 1</td>
<td>Speech &amp; language therapist</td>
</tr>
<tr>
<td>SALT 2</td>
<td>Speech &amp; language therapist</td>
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#### Whittington Health

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<th>Health visitor</th>
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#### Education Services

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#### Home addresses

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7 BIBLIOGRAPHY

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8 TERMS OF REFERENCE

Introduction:

A brief summary of why the decision to complete only a MAMR has latterly been reversed; purpose of a SCR; acknowledgement of the attempt to embrace ‘corporate neglect’ etc

Tasks:

To consider and report upon:

- The extent to which the MAMR was a lawful, proportionate and appropriate response to the death of child E
- The quality (objectivity and comprehensiveness) of its output
- Any further opportunities for learning that emerge from that management review or subsequent events or documents

Scope:

To consider the period from September 2009 (i.e. extended to address the question of initial choice of property when the behaviour, albeit not diagnosis, of child E was known) to a date beyond death so as to embrace RRM / CDOP responses.

Methodology:

Supported and informed by a SCR panel of suitable individuals / agencies, to:

- Invite parents’ involvement and agreement with terms of reference
- Share proposed terms of reference with professional stakeholders
- Commission an additional report that captures the early years / education services provided to child E
- Evaluate all available reports submitted to the LSCB, as well as verdicts / views of Coroner and High Court
- Invite contributing agencies to amend existing reports and/or address the specific questions of the extent to which the separated father was involved by providers & whether mother’s individual ability to keep her child safe was sufficiently assessed?
- Complete supplementary interviews deemed necessary
- Confirm the extent to which all previously agreed actions have been implemented and specify arrangements for ensuring implementation of any additional tasks agreed necessary
- Offer an opportunity to parents and to stakeholders to comment on provisional conclusions
- Provide a final version of the output to parents and to Islington's Safeguarding Children Board

Parental (mother’s) expectations of the SCR

Introducing improvements in local arrangements to ensure that acute risks to a child with special needs cannot in future be missed – by means of more effectively co-ordinated multi-agency work and by involvement of senior staff when systems or procedures appear ineffective
**Timeframe:**

SCR to be completed between December 2014 to April 2015'