



**Nottinghamshire**  
**SAFEGUARDING**  
**CHILDREN Board**

## **Overview Report**

### **Serious Case Review of the Circumstances**

#### **Concerning**

#### **'Peter'**

**Independent Author**

**Malcolm Ross M.Sc.**

**Date 19<sup>th</sup> October 2018**

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## **List of Abbreviations**

ADVIS	Adult Deaf and Visual Impairment Service
ASD	Autistic Spectrum Disorder
BTP	British Transport Police
CAIU	Child Abuse Investigation Unit (Police)
CATS	Police Child Abuse Tracking System
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CEOP	Child Exploitation and On Line Protection Command of National Crime Agency
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DfE	Department for Education
DNA	Deoxyribonucleic Acid
EHAF	Early Help Assessment Framework
EHCP	Education, Health and Care Plan
EMAS	East Midlands Ambulance Service
GP	General Practitioner
IMR	Individual Management Review
LSCB	Local Safeguarding Children Board
MASH	Multi Agency Safeguarding Hub
MISPER	Missing Person (Police form)
SCB	Safeguarding Children Board
SCR	Serious Case Review
SCRP	Serious Case Review Panel
SEIU	Sexual Exploitation Investigation Unit (Police)
SLSA	Senior Learning Support Assistant
WTSC	Working Together to Safeguard Children

**Overview Report of the**  
**Serious Case Review of the Circumstances Concerning**  
**'Peter'**

The Serious Case Review Panel offer their sincere condolences to the family of Peter (not his real name) in their sad loss and thanks them for their kind assistance in this review process which must have been difficult for them.

**1. Introduction**

- 1.1 Peter was a 16 year old boy who took his own life on 8<sup>th</sup> June 2017 by jumping in front of a moving train in Nottinghamshire. According to evidence gathered by British Transport Police who investigated the death, it appears to have been a deliberate act. The train driver had no chance of avoiding him as the train was travelling at approximately 80 m.p.h.
- 1.2 The review process has determined that there were issues identified with the emotional stability of Peter emanating from his family background, his chaotic family circumstances and he was known to mental health services as well as Children Social's Care, GP, School Nurse and CAMHS in relation to a range of concerns including self-harm, OCD, body image, eating disorder, his sexuality and possible CSE. These issues will be explored later in this report.
- 1.3 HM Coroner was notified of the death of Peter. H.M. Assistant Coroner for Nottingham, Dr. Elizabeth Didcock, held an Inquest into Peter's death on 13<sup>th</sup>, 14<sup>th</sup> and 21<sup>st</sup> September 2018. After hearing evidence from numerous witnesses, H.M. Assistant Coroner returned a determination of suicide adding:

'I do not think that even those who knew him very well, particularly his parents, could have predicted what he would do – what is not predictable is not preventable'.

**Serious Case Review process**

- 1.4 This Serious Case Review has been commissioned under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 which sets out the functions of Local Safeguarding Children's Boards (SCBs). This includes the requirement for SCBs to undertake reviews of serious cases in specified circumstances.
- 1.5 Regulation 5(1) (e) and (2) set out an SCB's function in relation to serious case reviews, namely:
- 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
- (2) For the purposes of paragraph (1) (e) a serious case is one where:
- (a) abuse or neglect of a child is known or suspected; and
- (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

“Seriously harmed” in the context of regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;
- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development

1.6 Cases which meet one of these criteria (i.e. regulation 5(2) (a) and (b) (i) or 5 (2) (a) and (b) (ii) above) must always trigger a Serious Case Review. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

1.7 The Terms of Reference and Scope of this review are detailed in Appendix No 1 to this report.

### **Local Safeguarding Children Board responsibilities**

1.8 Chapter 4 of Working Together 2015<sup>1</sup>, states:

‘The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB should let Ofsted, DfE and the national panel of independent experts know their decision within five working days of the Chair’s decision.’

1.9 The Chair of Nottinghamshire SCB was informed of this incident on 18<sup>th</sup> September 2017 and a decision to commission a Serious Case review (SCR) was made on that day.

### **Independent Reviewer**

1.10 Chapter 4 of Working Together to Safeguard Children (WTSC)<sup>2</sup> gives guidance on the appointment of an independent reviewer and states:

‘The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers’.

1.11 Nottinghamshire SCB has commissioned Mr. Malcolm Ross to undertake this review as author and chair of the Serious Case Review Panel (SCRCP). Mr Malcolm Ross was appointed at an early stage, to carry out this function. He is a former Detective Superintendent with West Midlands Police and has many years’ experience in writing over 80 Serious Case Reviews and chairing those reviews. He has also performed

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<sup>1</sup> Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children H.M. Government 2015 page 78

<sup>2</sup> Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children H.M. Government 2015 page 78

both functions in relation to over 30 Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies involved. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

### Serious Case Review Panel

1.12 WTSC guidance goes on to say:

‘The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.’

1.13 In order to satisfy this part of the guidance, Nottinghamshire SCB created a Serious Case Review Panel consisting of senior members of organisations concerned with the family together with the important element of independent members to give a neutral oversight to the proceedings and findings of the review. None of the panel members had any operational dealings with the family.

1.14 The panel members were:

Malcolm Ross	Lead Reviewer/Overview Report Author
Julie Gardner	Associate Director for Safeguarding and Social Care, Nottinghamshire Healthcare NHS Foundation Trust
Nicola Bramhall	Director of Nursing and Quality, Nottingham West Clinical Commissioning Group
Mel Bowden	D.C.I. in Public Protection, Nottinghamshire Police
Steve Edwards	Service Director, Youth, Families & Social Work, Nottinghamshire County Council
Marion Clay	Service Director, Education, Learning & Skills, Nottinghamshire County Council
Deputy Head Teacher	Deputy Head Teacher, Nottingham School
Bob Ross	NSCB Development Manager
Steve Baumber	Safeguarding, Assurance and Improvement, Nottinghamshire County Council
Carol Fowler	Child Death Administrator Nottinghamshire County Council

## **Individual Management Reviews**

1.15 WTSC suggests:

‘The SCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.’

1.16 In order to gather information for the review process, the following agencies were requested to provide an Individual Management Review (IMR):

- Nottinghamshire Police
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham West Clinical Commissioning Group
- Education
- Children’s Social Care

The below named agencies were asked to provide an Information Report;

- British Transport Police
- Nottingham University Hospital
- Nottinghamshire County Council Adult Social Care (Adult Deaf and Visual Impairment Service)
- Nottinghamshire County Council Adult Social Care (Community Mental Health Team)
- East Midlands Ambulance Service
- Cafcass

## **Timescales**

1.17 Guidance mentions Timescale for SCR completion:

‘The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action to implement improvements and disseminate learning.’

1.18 The National Panel was informed of the commencement of this review on 25<sup>th</sup> September 2017 and all efforts have been made to complete the review within the 6 months guidance.

1.19 The scope of this review and the parameters for IMRs was determined as being from 1<sup>st</sup> May 2014, the month when the first indication of suicidal ideations was brought to the attention of professionals, until the date of the ‘Child Death Initial Case Discussion Meeting’ on 12<sup>th</sup> June 2017.

## **Learning Model**

1.20 WTSC guidance states:

‘SCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro’.<sup>3</sup>

In this review Nottinghamshire SCB decided to use the traditional model of reviews.

### **Family Involvement**

1.21 Page 74 of the guidance deals with family involvement in the review process:

‘Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.’

1.22 To this end family members were written to indicating that a review is being undertaken and inviting them to engage. The Author and the NSCB Safeguarding Development Manager saw Peter’s mother at County Hall on 19<sup>th</sup> December 2017 and also visited his father at his home on 30<sup>th</sup> January 2018. There has also been considerable telephone contact between the Development Manager and the father during the remainder of this review period. Both parents have been consulted extensively and have engaged throughout with the review panel and process.

### **Subjects of this review**

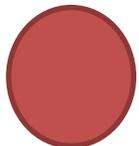
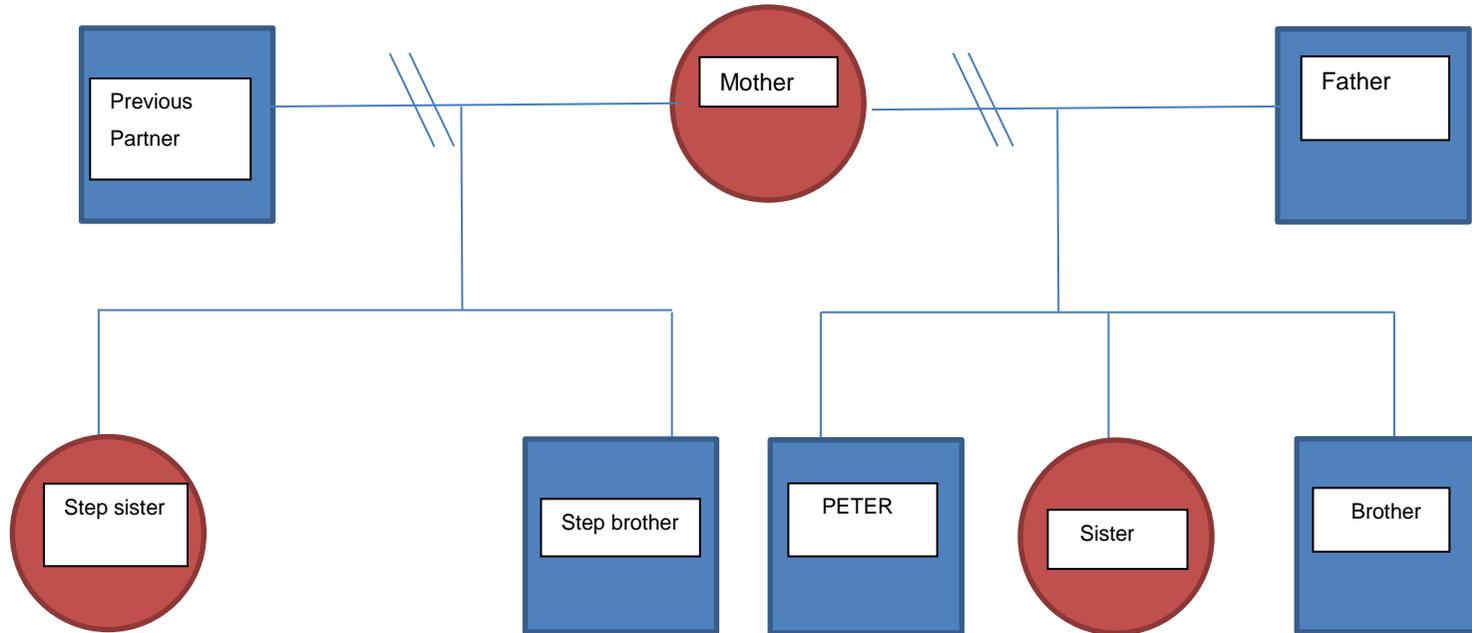
1.23 The below matrix indicates the principle people involved in this review and how the report refers each to them to protect their identity.

Mother	Mother of Peter and of S1, S2, S3, and S4
Father	Father of Peter and of S3 and S4
S1	Female Oldest sibling
S2	Male Second oldest sibling
S3	Female Third oldest sibling
Peter	Male Deceased Fourth oldest sibling
S4	Male Fifth oldest sibling

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<sup>3</sup> Department for Education The Munro Review of Child Protection: Final Report: A Child Centred System, Cm 8062, May 2011.

# Genogram



Female



Male



Divorced/separated

## 2. Sequence of Events leading to the death of Peter

- 2.1 Family structure and history.
- 2.2 Mother and Father separated years before the scope of this review. Mother had two children, S1 and S2 from a previous relationship. Mother and Father went on to have three other children, S3, Peter and S4.
- 2.3 Mother is registered with Nottinghamshire County Council as being Deaf with Speech. She has been known to Adult Social Care since December 1999 and remains known to the Adult Deaf and Visual Impairment Services (ADVIS). Mother's general health problem concerned her hearing that affected her communication, albeit she was able to adequately lip read. She had a full time job. She acknowledged that communication with Peter was sometimes difficult.
- 2.4 The father has a long history with mental health services dating from when he was a child. He developed a personality disorder and obsessive compulsive disorder. The impact of his mental health and the risk to his children was considered but there was no referral made to Children's Social Care (CSC). The children appeared well cared for and the father expressed 'the upmost concern for his children'. The father disclosed to various medical and mental health practitioners that he had suicidal ideation of killing himself at a local train station. His own grandmother had taken her own life 2 – 3 years before. Peter had to live through the suicide of his father's grandmother and his uncle.
- 2.5 Health Visiting records indicate that the older children remember an incident of domestic abuse while the mother was pregnant with Peter. There is evidence of social care intervention and some multi-agency information sharing. S3, Peter's older sister had been diagnosed with Autistic Spectrum Disorder (ASD) at the age of 14½ years and the mother was concerned that Peter was displaying similar behaviours.
- 2.6 Education records indicate that all of the children in the family attended local schools and Peter in particular, was described as being happy at school and making good progress. His attitude to learning was noted as being universally good or outstanding. One incident worthy of mention prior to the scoping dates of this review, occurred in 2013, when Child Exploitation and On Line Protection (CEOP), a National Police Unit, came across a video that Peter had posted of himself on line engaging in a sexual act. He was identified by the school blazer in the background of the video.
- 2.7 Peter was traced and interviewed stating that it was his own stupidity and no-one else was involved. He denied that he had been coerced or bullied into acting in this way. No further police action was taken and the matter closed, however details of the incident were not shared with CSC. CEOP's involvement was not shared with Nottinghamshire CSC.
- 2.8 Peter was described by his mother and family members as being the joker of the family. He liked to drink alcohol and attend parties and enjoyed sport and music festivals. He did not eat with the family but would binge eat and then make himself vomit. He was described as being overweight, something that Peter himself was concerned about but not long before his death, Peter had lost a considerable amount of weight, according to his mother, estimated to be around 9 stones. He was a goal keeper for a local football team for some years.
- 2.9 It is of interest that Peter's school indicate that by the end of year 8, (13 years of age) his attitude to learning was described as good or outstanding in all but 3 subjects where improvement was needed. At the end of year 9, (14 years of age) records indicate his attitude to learning was good or outstanding in all subjects apart from 5 subjects that required improvement. By the end of year 10, (15 years of age) his attitude to learning

was good or outstanding in all subjects. It is considered by his school that he would have achieved passes in his GCSE subjects with good grades.

- 2.10 At Secondary school, the Year Head became Peter's pastoral lead and would follow him through years 7 to 11. That Head of Year was interviewed by the Education IMR author during the process of this review and stated that he knew Peter well and Peter and other pupils would often join him at lunch time in general conversation. It is clear from what Peter's mother stated that Peter got on well with the Head of Year and confided in him about all sorts of issues. It is interesting to note that not long before his death, Peter wrote the Head of Year a letter, described by the IMR author as 'remarkable', making the case for Peter to be appointed a school prefect. Extracts of the letter state;

*'I feel that I have reclaimed a favourable relationship with certain subjects; along with a constructive relationship with teachers. However there is no hiding the fact that my attitude coming in to year seven was quite poor, reflected in my 'attitude to learning' scores. Nonetheless, after maturing throughout my time at [school], I have developed a whole new persona – having been supported thoroughly by the school in helping me achieve my full potential'*

*'My willingness for the school to succeed is distinctive as I am a frequent volunteer in after school clubs, parents' evenings and even in the classroom. These traits all give worthy reasoning that I am an enthusiastic individual ... with positivity amongst my fellow students and teachers and also my longing for success within the school. I am full committed (to) becoming a prefect with only the full intention of helping others. Despite my looming face I deem myself well-mannered, well-spoken and most (definitely) – collected.'*

- 2.11 This letter seems to indicate that at the time of writing, Peter had the intention to continue at school and indeed offered himself for a position of responsibility, perhaps even being content with his school life.

### **Events within the time period of the scope of this review**

- 2.12 On 27<sup>th</sup> May 2014, Peter's school sent an email to their local School Nursing Team saying that the mother had had a conversation where she suspected Peter was demonstrating similar behaviour to that of his older sister who had been diagnosed with ASD. The email referred to a suicide notes that Peter had written about a month prior. The mother was advised by the School Nurse to take Peter to see his GP as soon as possible and it was intended that the school would make a referral to CAMHS. The mother was offered support over the forthcoming school holiday.
- 2.13 The School Nurse met with the mother during the school holiday on 30<sup>th</sup> May 2014, where the mother expressed her concerns that Peter had low self-esteem around his weight and appearance, spending hours in the bathroom over his appearance, showering up to three times a day. She said that Peter became angry and inflexible. She had found an empty box of paracetamol tablets in his room and he had been in trouble at school for stealing a memory stick from a teacher. Mother reported that Peter had posted a photograph of himself on You Tube, although the content of the photograph was not recorded in Peter's health record. The School Nurse was told that the police were involved indicating that the nature of the photograph was probably inappropriate. Mother stated that she felt that Peter had become withdrawn since going to secondary school and that she had not noticed the changes in him due to her being preoccupied with the diagnosis of her daughter with ASD. She said that Peter wanted to be tall and skinny like his peers.

- 2.14 On 30<sup>th</sup> May 2014, the School Nurse suggested that the Early Help Assessment Framework (EHAF) would help to identify the family's needs and a plan could be devised to address them. It was acknowledged that the mother was a busy working single mother with her own disabilities that may well make communication at home with the children difficult. She also mentioned that her daughter had been diagnosed with Asperger's and a lot of time was being taken dealing with that. The School Nurse again discussed a CAMHS referral with the school. (However CAMHS were unable to attend the first meeting and did not engage any further in the early intervention stage.)
- 2.15 On 25<sup>th</sup> June 2014, a meeting took place with the School Nurse, the school and the mother to initiate the EHAF process. The School Nurse had documented that the CAMHS referral was, at that time, 'in process'. The mother stated that Peter's emotional health appeared calmer at this stage and not at risk of immediate harm to himself. The School Nurse suggested that Peter should be seen by his GP for a referral to a Community Paediatrician. The school would support this referral. However, when the report from the school was received by the School Nurse on 23<sup>rd</sup> September 2014, there was no evidence to suggest that the GP was made aware of the proposed referral to a Paediatrician as per the Concerning Behaviour Pathway.<sup>4</sup>
- 2.16 On 17<sup>th</sup> September 2014, the School Nurse met with mother. She had not yet taken Peter to see his GP and therefore the referral to the Community Paediatrician had not been made. The mother explained how Peter could talk to his father much better than he could communicate with her. The School Nurse planned to see Peter in school.
- 2.17 After that meeting the School Nurse had a meeting with the school where she was informed of the previous episodes of Peter posting a video of himself and the intervention of CEOP<sup>5</sup>. The school have no record of the CEOP incident but school do acknowledge that CEOP contacted the school. There does not appear to have been due regard to any safeguarding concerns or risk to Peter as a result of this information exchange.
- 2.18 On 1<sup>st</sup> October 2014, the School Nurse had a one-to-one conversation with Peter at school. He is reported to be open and honest in his views but the School Nurse could not decide if he was crying or sweating profusely. He denied crying. The suicide note was discussed and Peter stated that he did not feel like that anymore. He did however say that he thought his home circumstances lacked routine and he also lacked personal space. He was at variance with his mother over the statement she made to the effect that he could talk to his father better than his mother. He said that it would be his mother he would turn to if he ever felt suicidal again. The School Nurse's plan was to continue with the referral pathways to CAMHS or the Paediatrician. There is nothing recorded as to why she had not done that thus far.
- 2.19 On 30<sup>th</sup> October 2014, the School Nurse again saw Peter with his mother at the Health Centre. He was very weepy and stated that he felt more relaxed at his father's house where there was less pressure. He completed a 'mood diary' and the School Nurse suggested a referral to CAMHS. Peter declined the referral but did consent to half termly appointments with the School Nurse.

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<sup>4</sup> The role school nursing service is well documented due to the quality and consistency of the record keeping in line with the Trusts record keeping policy. It therefore has been noted that the day to day contact within the school is not recorded in this way. The role of the school nurse must be seen within the context of the school nursing services role, responsibilities and the proportion of the overall interaction between Peter and all agencies. In particular the school nursing service had not had active involvement with Peter for the year prior to his death which is in line with the service provided. The Concerning Behaviour Pathway was introduced in 2013

<sup>5</sup> CEOP – Child Exploitation and Online Protection Command of National Crime Agency

- 2.20 Peter met the School Nurse again on 30<sup>th</sup> December 2014, when he told her that some of the issues at home had been resolved and he was in a 'much better place'. He was spending more time with his mother and looking forward to going on holiday with the rest of the family.
- 2.21 On 13<sup>th</sup> March 2015, the School Nurse attended a meeting at school and was informed that Peter had self-harmed in school. He was very anxious about this and stated that he did not want his mother informed of what had happened. Consideration was again given to the school making a referral to CAMHS, a Paediatrician and also to Young Carers. In fact the School Nurse or the school could have made that referral. Mother thought that ASD may have contributed to this behaviour and decision making.
- 2.22 Later that day the School Nurse saw Peter at school. He said that he had used the blade from a pencil sharpener to cut himself because he was annoyed that he had been late for school and he had self-harmed to calm himself down. He said it was a 'one-off' incident and he would not do it again. He stressed that he didn't want his mother to know as this would worry her. The School Nurse also tried to discuss other concerns that had been raised at school about his sexuality but Peter would not engage with that conversation.
- 2.23 An appointment was made for the School Nurse to see Peter's mother on 18<sup>th</sup> March 2015. The School Nurse told the mother that she was leaving the School Nursing Service. The School Nurse told the mother that she had been seeing Peter at school and she had no concerns about him. Mother said that she knew Peter was self-harming albeit Peter had said that he had scratched his hands in football practice. Mother also stated that her daughter had overheard a telephone conversation between Peter and another male who was asking Peter out. Peter had been seeing less of his father and it was clear that mother required on-going support for herself. She was advised to seek help and guidance from her GP. The School Nurse in fact communicated her concerns to the mother's GP.
- 2.24 On 20<sup>th</sup> March 2015, the School Nurse met with school management and expressed concern that no-one seems to be taking the lead in supporting Peter at which the Head of Year agreed to take ownership of this and support Peter in school.
- 2.25 On 24<sup>th</sup> March 2015, the School Nurse had a conversation with the GP and informed the GP of Peter's low mood, low self-esteem and possible autistic traits. It was noted that there was still no referral to CAMHS despite the ongoing concerns raised by the school nurse. In addition Peter had been involved in an incident at school where he had threatened another student with a bottle opener. The school nurse saw Peter together with a teaching assistant and discussed this latest incident, he said he had been drinking alcohol and had acted out a scene from a computer game. He indicated that he regretted the incident and had self-harmed as a result.
- 2.26 The following day the teaching assistant met Peter's mother and had a conversation about Peter wearing a sports bra and that he is very sensitive regarding his weight and his 'man boobs'. The teaching assistant had been in a meeting with Mother regarding the sister who had ASD and during that conversation, Mother brought the subject of what Peter had been wearing. The sister had heard Peter on the phone to someone talking about a boy who had asked him out but during the telephone conversation Peter self-harmed. Mother confirmed that Peter had an appointment with the GP for 31<sup>st</sup> March 2015 but he refused to attend that appointment.
- 2.27 In May 2015 a new school nurse took over Peter's case, the previous nurse having left the service. The new school nurse (SN2) was informed by Peter's GP that he had not attended an appointment to discuss his breast size. SN2 attempted to meet with Peter

on 3 occasions but it was clear that Peter was starting to disengage from offers of support. SN2 gave Peter an open appointment should he wish to see SN2.

- 2.28 On 15<sup>th</sup> June 2015 Peter's mother saw the GP and was concerned that Peter was isolating himself and she was worried that he had similar traits to her daughter who had autism. She described Peter as being 'desperately unhappy'. The GP spoke to SN2 and it was agreed that a referral would be made to CAMHS and a comprehensive referral was made by the SN2. The GP's records were also highlighted with 'emotional problems' which would alert clinicians to ongoing problems.
- 2.29 On 24<sup>th</sup> June 2015 SN2 tackled Peter as to why he didn't attend to see his GP about his breast size problem. Peter denied ever having a GP appointment, he stated he was well and he didn't require any further input in school. He was eager to leave and get back to class.
- 2.30 On 5<sup>th</sup> August 2015 mother attended the local Police Station to report that Peter had bought alcohol at a local shop. She stated that he was asked for ID but he said that he had forgotten to bring it with him and the shop owner 'let him off on that occasion'. A Police Officer made enquiries at the shop and checked the CCTV but was unable to identify Peter with alcohol. The 'refusal book' which is a log of occasions of when the shop refuses to sell alcohol was in order and no further action was taken.
- 2.31 During the school holiday in August 2015 SN2 met with mother at a local health centre. Mother raised several issues about Peter, his self-harming had escalated during the school holidays, he had attempted to strangle himself on two occasions during a family holiday and he had threatened his sibling with a knife. There appeared to be an escalation in his obsessional behaviour and mother reported she had removed knives, blades and medication from the home. Peter was obsessed with showers and cleanliness and he had attempted to set fire to curtains in his bedroom with matches. Mother also disclosed that Peter's father misuses drugs and alcohol and she worries when her children stay there with him. SN2 advised mother to take Peter to the Accident and Emergency department if she felt he was at immediate risk and there is nothing to suggest that the safety of the others in the same household was considered.
- 2.32 The following day SN2 visited the family home to discuss the CAMHS referrals with Peter who agreed that he needed support and consented to the referral being made. The referral was made to CAMHS on 20<sup>th</sup> August 2015. Peter had been referred to CAMHS in October 2014 but had declined to attend.
- 2.33 On 27<sup>th</sup> August 2015 CAMHS accepted the referral and escalated Peter's case to Specialist CAMHS. Peter was offered an appointment on 15<sup>th</sup> September 2015.
- 2.34 On 9<sup>th</sup> September 2015 the Special Educational Needs Co-ordinator (SENCO) at Peter's school emailed the Head of Year to the effect that Peter had been accepted by CAMHS and that CAMHS were very concerned about his mental health particularly around his self-harming. The Head of Year recalls that he understood that Peter only attended one CAMHS meeting and then stopped going. The Head of Year thinks that it was Peter that wanted to stop, not his mother who had tried to get Peter to attend self-help groups for eating disorders which again he failed to attend. It is the opinion of the Head of Year when interviewed by the IMR author for education that;
- '[Peter] saw the weight loss as about a healthy body and a good look. Mother saw the weight loss as a link to [Peter's] interest in the gay community with associated concern with body image.'*
- 2.35 On 15<sup>th</sup> September 2015 Peter and his mother attended a CAMHS initial assessment appointment. A discussion took place about Peter's difficulties within family

relationships especially with his sister, the frustration with communicating with his mother and the fact that he had not had contact with his father for six weeks due to lack of transport. He described how he enjoyed staying with his father. He also disclosed self-harming recently and admitted he attempted to strangle himself in July 2015. He denied trying to set fire to his bedroom curtains. Notes indicate that Mother was seen first at this meeting which took a long time and the assessment with Peter was only half completed. Another appointment to complete the assessment was arranged.

- 2.36 At 22.19 hours the same day Peter was reported missing by family members. He had been seen last at 18.30 hours by family members and had left with his mobile which he was now not answering. He was wearing his school uniform.
- 2.37 At 22.27 hours the same day Peter's father phoned the Police as Peter was still missing. A note had been found at the family home indicating that he wanted to commit suicide as he was depressed. An officer was sent to the home but on arrival Peter returned having been found walking the streets by his mother. On being interviewed by the Police officer Peter stated he had been arguing with his mother and siblings, which had caused him to feel down. He had had the first session with CAMHS that morning and found it a positive experience.
- 2.38 On 17<sup>th</sup> September 2015, Peter's sister (S3) disclosed to the Senior Learning Support Assistant at school that her brother had been missing and the Police involved. She disclosed that;
- 'he has been suffering from depression and had been cutting himself on his arms.' She had seen him at home holding a knife to his neck and on holiday they had found him with a belt around his neck 3 times and he had marks on his neck from trying to strangle himself. Mother and Father were said to be both aware of this but didn't want [S3] to tell anyone'.
- 2.39 The Head Teacher (Senior Designated Safeguarding Person) contacted the Early Help Team who advised a referral to the Multi-Agency Safeguarding Hub (MASH). The referral stated that Peter was not in a good place at that time and needed significant support. It is noted that Peter went missing on the same day as his initial assessment with CAMHS.
- 2.40 On 25<sup>th</sup> September 2015 a social worker from CSC visited the mother at the home address, but the mother refused to allow her into the house saying that Peter was now engaging with CAMHS. Mother refused to sign the consent form to allow the SW to speak to other agencies and refused to allow the SW to speak to the other children. Children's Social Care closed the case and informed the school. Mother refused to cooperate. The Head Teacher emailed the mother confirming that the CSC referral had been closed and asking the mother's permission for CSC to undertake checks with CAMHS.
- 2.41 As a result of the mother's refusal to engage with CSC, Peter's case was closed as it was thought that he was engaging with CAMHS and had a good relationship with the Head of Year at school.
- 2.42 On 7<sup>th</sup> October 2015 Peter's GP spoke to CAMHS confirming Peter's attendance, an indication of the GP following up Peter's best interest.
- 2.43 On 19<sup>th</sup> October 2015 in an email communication between CAMHS and the mother, mother stated that Peter was refusing to attend any further CAMHS appointment. Mother had disclosed difficulties in managing Peter's behaviour in that he was displaying controlling behaviour towards her and he was struggling to show any

empathy and was again concerned about his obsessive cleanliness. With the CAMHS assessment only half complete, Peter was discharged from the service, unsupported. There was no further communication between CAMHS and the school nursing team. The GP's records indicate that whilst Peter had declined any further contact from CAMHS he and the family had been offered support from Young Carers or the Deaf Society. The Healthcare Trust IMR indicates that

'All Health Services failed to engage with [Peter] as he refused additional support offered by [SN2]. [Peter] was offered an open appointment with the school nursing service and advised to attend his GP if he required further support,' and;

'The CAMHS discharge left Peter without CAMHS support as there was no further communication between CAMHS and the School Nursing Team'

- 2.44 Peter was at this stage two weeks away from his 15<sup>th</sup> birthday. There is nothing to suggest what Peter's thoughts were, what his strengths were, what he liked and the details of the difficulties at home. He had been seen with a belt around his neck. He communicated at a distance at school and did not get involved with things going on at school. The barriers preventing him communicating did not appear to have been explored.
- 2.45 On 9<sup>th</sup> December 2015 Peter was seen by SN2 at school. He stated that he thought CAMHS to be a waste of time and would not engage further in any discussion other than to say he did not have any other concerns or worries at that time. He declined to engage with SN2 any further but was left with an open appointment.
- 2.46 According to the CCG IMR Peter was discussed between the GP and SN2 on 16<sup>th</sup> December 2015 at the practice safeguarding meeting. SN2 reported details of her last contact with Peter on 9<sup>th</sup> December 2015 and the CCG IMR concludes;
- 'At this meeting it was agreed that [Peter] would be monitored by [SN2] in partnership with the school.'
- 2.47 On 28<sup>th</sup> January 2016 Peter was discussed at a GP's Practice Safeguarding Meeting. It was reported by the School Nurse that Peter still did not wish to engage for support and he was removed from the list with a proviso that SN2 continued to monitor and liaise with the school on a 'watch and wait' basis. Over the next few months Peter engaged well at school. By the end of year 10 all of his subject teachers described his attitude to learning as either good or outstanding. In two subjects he had gone from a judgement of 'requires improvement' to 'outstanding'.
- 2.48 On 26<sup>th</sup> September 2016 Peter and his mother saw his GP. He had been sporadically vomiting for a month. He was examined but no clinical abnormalities could be found. The GP signposted Peter to Harmless<sup>6</sup>, Kooth<sup>7</sup> and Base<sup>8</sup>. Peter was encouraged to eat regular meals and stop taking laxatives to reduce his weight.

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<sup>6</sup> Harmless is a user led organisation that provides a range of services about self-harm including support, information, training and consultancy to people who self-harm, their friends and families and professionals.

<sup>7</sup> Kooth.com is an online service for young people aged 11-25 living in Nottinghamshire which provides free counselling, advice and support on-line. Staffed by fully trained and qualified counsellors and available Monday to Friday from 12 noon until 10pm each night, and weekends from 6pm to 10pm, 365 days per year, it provides confidential and instant access service.

<sup>8</sup> The Base 51 Counselling service offers short and longer term counselling and psychotherapy to young people aged 12-25. Counsellors are trained in a number of approaches and have experience of working with young people to work towards their aims.

- 2.49 Just after 23.00 hours on 2<sup>nd</sup> November 2016, mother's partner called the Police to say that Peter had not returned home after having an argument about his weight loss with his mother and brother. Within 30 minutes Peter had returned home safe and well. The matter was reported to CSC by the Police and the CSC note indicates that Peter stated he felt like an outsider within the family. Mother reported that Peter walked around the house saying 'it's nearly over'.
- 2.50 On 8<sup>th</sup> November 2016 a worker from Family Services made contact with the mother about Peter going missing and the school to request permission to meet Peter in order to complete the return interview following him being missing on 3<sup>rd</sup> November 2016. Mother initially agreed but then withdrew her consent after reading about how information would be shared between agencies stating that the family did not need any support. There is no compulsion to engage under these circumstances. This was done in line with the missing children protocol. Peter was not always keen to accept support, but it appeared that it was his mother who refused support.
- 2.51 On 20<sup>th</sup> January 2017 Peter saw his GP with pain in his chest and being concerned about the excess breast tissue he had as a result of extreme weight loss. His GP reassured him that a good diet and putting weight on would correct this. This was the last recorded contact between Peter and the GP.
- 2.52 On 6<sup>th</sup> February 2017 Peter's father contacted Peter's GP explaining Peter's anxiety and that fact that Peter said he might be gay and was possibly having sex with an older man. The GP advised the father to discuss this with Peter and his mother and if this older man is much older there would be safeguarding concerns that need referring to social care and the Police. The CCG IMR Author considered the dilemma the GP was placed in here as to making a referral based on speculative information is discussed in the analysis section of this report, but on the facts presented to the GP, the CCG Author considers her decision is seen as being appropriate in all of the circumstances.
- 2.53 On 8<sup>th</sup> February 2017 Peter had a meeting at school with the head of sixth form who had had no prior contact with Peter. Peter was concerned about his home circumstances and lacking in privacy. He wanted to know if he could attend the sixth form at this school if he moved to live with his father. It was pointed out to him that would be two bus rides to get to school making it difficult. Peter told the head of sixth form that;
- His father is an alcoholic and his current accommodation was unsuitable – mattress on the floor, beer cans all around. Dad was moving to where he thought the accommodation would be fine
  - his mother has started a new relationship 3 months ago, with a woman, they are due to be married in the next few weeks
  - they are 8 people living in a three bedroom house at the moment, this is why he needs to move out, he has no space
  - he can't talk to mum
  - he has slept rough in the past
- 2.54 The teacher reported this to the Head Teacher of the school and to the Head of Year, who knew Peter well and thought that the home situation was resolved.
- 2.55 On 21<sup>st</sup> April 2017 the mother went to the school to see the Head of Year concerned about Peter. She explained she was at the end of her tether and that Peter's behaviour was affecting home life. She said that Peter was in possession of money and she feared he may be a 'rent boy'. To support this she explained that on Boxing Day an older man visited the house with a gift for Peter and often when his phone rang he would go outside to answer it.

2.56 On the same day Peter went to see the Head of Year at school and made a series of disclosures which the Head of Year made a note of and on being interviewed by the Education IMR author the notes can be summarised as Peter telling the Head of Year that;

- Things started a long time ago, him alleging sexual abuse within the family
- Another pupil had been asking Peter 'to meet older guys...for money'
- At the last such meeting he had to pretend to be the other pupil and meet a man in a supermarket car park. The other pupil had been meeting older men through a phone app. A second pupil was also meeting up with guys for money as well.
- The first pupil was worried about this becoming known and keeps asking Peter if everything is OK ...squeezing his shoulder firmly and whispering 'I hope you keep your mouth shut.' A third pupil saw this happen
- other pupils were becoming aware of this and a fourth pupil had approached him because Peter 'knew ways to make some money'
- he had arranged to meet a man in the city...picked up in a black Mercedes and driven to the other side of the city...went in to the man's house...felt that the guy was a dealer...had protected intimate sex ...drove him back and Peter went straight to a fifth pupil's house and broke down in tears, told the fifth pupil what happened...couldn't stop shaking, eventually went home.

2.57 The Head of Year reassured Peter that he'd done the right thing in disclosing and explained that he'd have to share that information to which Peter said in that case he would deny it.

2.58 On interview with the IMR author, the Head of Year stated;

*'I left the meeting with [Peter] feeling that he had made a genuine disclosure. At the very end when I told him I'd need to share these concerns he said, very simply '...and I'll just deny them.' And that is what he did. I recall other 'clues' in things [he] had said previously that now fitted with the disclosure. After being found sleeping rough and sleeping on a tram [Peter] had said 'it's about what those bad men did to me.' This was not a sudden disclosure, [he] would come and chat several times a week and I felt he was leading up to something important. [Pupil 5] had also expressed concerns about [Peter] and some other pupils reported having sight of phone messages between [Peter] and older men that caused them concern. So when the disclosure came I was not totally surprised.'*

2.59 The Head of Year took the matter to the Head Teacher who met with Peter and went through the statement he had received from the Head of Year to which Peter said 'it's all a load of rubbish. I needed the attention'. The Head Teacher was of the opinion that what Peter said didn't make sense. Peter had mentioned a boy at school dealing in drugs, a statement the Head Teacher didn't believe. Despite any reservations the Head Teacher had about the disclosure the Head Teacher decided to make a referral. The allegation Peter made about intra-familial abuse was the area the Head Teacher doubted most.

2.60 The Head Teacher went to see the head of sixth form and told her of Peter's disclosures but also that he had retracted them. As the Head Teacher left the head of sixth form's office, Peter entered and said to the head of sixth form '[the Head Teacher] will tell you that things I said aren't true, but that is not true', meaning that the disclosure

he had made to the Head of Year were true and it was his retraction that was not true. He said;

*'The reason I said it was a lie is that it's too much bother, causing too much trouble but it's all true'*

- 2.61 The Deputy Head Teacher correctly made his referral to the MASH Officer. The Head Teacher delegated the role of completing the safeguarding referral form to the Deputy Head. The form gave a brief summary of Peter's disclosure;

*'On Friday 21<sup>st</sup> April 2017, Peter disclosed that he had met two men on separate occasions. The first meeting was with a man who drove a large black Mercedes. This man took Peter back to his house and he claimed that they had had penetrative and oral sex. This meeting was arranged through an unnamed app. The second meeting with a different man was in Tesco Beeston car park. Furthermore, he disclosed that he had been sexually abused [within the family].*

*'Following lengthy conversations with [Peter] by the Senior Child Protection officer (Head Teacher) it is believed much of his statement is fabrication, especially the [intra-familial abuse] meeting with older men and the use of an app to meet up with older men. However we are concerned that through the level of fabrication [Peter] is displaying features of low self-esteem, has lost a significant amount of weight, vomits regularly and is demonstrating hazardous substance abuse through alcohol. [Peter] freely admitted that much of the information he provided was a fabrication. However there is still much to be investigated.'*

- 2.62 The Head of Year recalls how after the disclosure Peter 'froze him out' and didn't communicate with him anymore. The Head of Year described how, a couple of days before Peter died he was very angry and stormed out of school.

- 2.63 On 10<sup>th</sup> May 2017, a Social Worker contacted the Head of Year and there was an exchange of information about Peter. The Education IMR quotes the conversation:

*'[The Head of Year] said that as a school they had spoken to other young people who confirmed that possibly those inappropriate contacts with older males had taken place. [The Head of Year] said that following the referral to Social Care (Peter) had said that he had made up the stories for attention seeking. [The Head of Year] said that [Peter] is a compulsive liar and dangerous in the process as things he could say could place someone's profession at risk. [The Head of Year] advised that when I [Social Worker] came to see [Peter] I sit with someone.'*

- 2.64 CSC files record a Family Assessment being carried out at school on 12<sup>th</sup> May 2017. Peter was seen and told the Social Worker that he had lied to the teacher about meeting up with older men. He was also seen at home with his mother but would not talk to the Social Worker. The main areas of concern were his weight, Mother described how she had taken Peter to the GP to discuss how Peter had lost 9 stone within one year due to starving himself, taking laxatives and forcing himself to vomit. From the school's view, Peter losing weight was seen as a positive step in his improvement of his health and appearance. He was taking care of his hair and clothes and looking smarter. Peter had lost weight in a very short time, nearly nine stone in one year. He was using his mother's make up, going out without telling her where he was going and being seen with unaccounted for money.

2.65 On 2<sup>nd</sup> June 2017, CSC saw the father at his home in preparation for the forthcoming CSE meeting. The father explained that he was concerned that Peter had a lot of unaccounted for money. He stated that the father's mother had taken her own life 8 years previously and her brother, Peter's uncle, had done the same in 2016 and this had had a significant impact of Peter's emotional well-being. He said that he did not want to attend the CSE meeting as he thought it would embarrass him. The father was uncertain if the meeting would achieve anything apart from causing Peter to feel embarrassed.

2.66 A Child Sexual Exploitation Multi-agency Strategy Meeting was convened five days later, on 7<sup>th</sup> June 2017. The meeting was attended by:

- A Child protection Co-ordinator acting as Independent Chair
- Two Social Workers
- Head Teacher from Peter's school
- Peter's mother and father and mother's then partner.

2.67 Apologies were received from Nottinghamshire Police, who were unable to attend due to resourcing problems. A report was submitted confirming that no incidents were recorded connecting Peter to their system. The police acknowledged that at that stage No Further Action was going to be taken regarding Peter's disclosures however, it was appreciated that he was 16 years of age and not considered a high risk by the police. Due to an administrative error the School Nurse did not receive an invitation to attend the meeting although the Social Worker had requested for her to be invited.

There is no record of an invitation being sent to CAMHS. Peter was invited but chose not to attend.

2.68 The Chair of the meeting commented about Peter being labelled as;

'a compulsive liar by a school representative in some of the contact with CSC and her concern was that his disclosures had been discounted.'

2.69 The Head Teacher explained that;

'that was not the case and the school has concerns about [Peter]. There are elements of the disclosure known to be wrong however where there is explicit detail, this cannot be discounted as fantasy.'

2.70 During the course of the review process, the Head of Year has been seen by the Education IMR author and concedes to the fact that the choice of words describing Peter as a compulsive liar was unfortunate and in hindsight an incorrect use of the words. He regrets using this phrase and explains that he was trying to demonstrate that Peter told him a story which the Head of Year believed and then Peter retracted on the events, which in itself was the lie. There is no suggestion that the Head of Year did not believe Peter's account of being sexually exploited. He apologises for any misunderstanding or distress his comments have caused. To clarify, Peter was saying that the disclosures he had made to the Head of Year were true and his retraction was not true. He told the Head of Year;

"The reason I said it was a lie is that it's too much bother, causing too much trouble but it's all true".

2.71 Actions that emanated from the meeting:

**For CSC**

- CSC to share the contents of school statement with the police and agree actions regarding [the four boys] Action for SW by 11.07.17
- CSC to explore the alleged historical incident [between the Perpetrator and two brothers] and discuss with the police and agree actions. Action for SW by 11.07.17
- CSC to check whether the 4 other boys are known to CSC. Action for SW by 11.07.17
- CSC to refer [Peter] to The Children's Society to increase his understanding of CSE. Action for SW by 11.07.17

**For the school:**

- School to sensitively explore the concerns relating to [the four boys] and liaise with CSC. Action for Head Teacher by 11.07.17
- School to continue to offer support to [Peter] and make a named person available to him. Action for Head Teacher immediately.

**For health:**

- School Nurse to arrange an appointment to see [Peter] regarding a possible eating disorder. Action for School Nurse by 11.7.17

**For parents:**

- Parents to work together to monitor [Peter's] movement and finances. Action for parents. Action for both parents – ongoing
- Disruption Plan. Parents to agree a curfew time with [Peter] and to report him missing to the police if he is not home within 30 minutes. Action for both parents – on going.

**For [Peter]:**

- [Peter] to tell parents where he is going
- [Peter] is to remain in mobile contact when out.

2.72 In line with the actions outlined, the Head Teacher spoke to four boys mentioned by Peter. The first said that he knew nothing about Peter meeting men for money but did recall an occasion when Peter tried to kiss him when Peter was drunk. The second stated he witnessed No 4 in this list, whispering to Peter that he hoped Peter could keep his mouth shut. He also said that Peter had told him that he had got into a car with someone he knew.

2.73 The third boy spoken to recalls the time when Peter disclosed to him that he had been taken to a house and engaged in sexual acts. He said 'He [Peter] burst into tears and was shaking' and that Peter had said, 'something bad had happened'.

- 2.74 The fourth boy, who was alleged to have made arrangements for Peter to meet a man, denied all knowledge of this and was described as being shocked at the suggestion that he did know.
- 2.75 The Head Teacher interviewed the four boys as described above as Head of Safeguarding for the school. However, he failed to keep any notes from the interview and had to rely on his memory of the events when interviewed by the Education IMR Author. The Head Teacher also interviewed Peter and Peter's younger brother.
- 2.76 The Head Teacher came to the view that much of the disclosures were not credible, which is reflected in the MASH referral:
- 'Following lengthy conversations with Peter by the Senior Child Protection Officer (Head Teacher) it is believed much of his statement is fabrication, especially the step-brother, meeting with older men and the use of an app to meet up with older men.'
- 2.77 The Head Teacher referred two of the boys to CSC on 12<sup>th</sup> June 2017, to the relevant Local Authorities. Additional reference to the Head Teacher interviewing all of these boys is made in the analysis section of this report.
- 2.78 On the morning of 8<sup>th</sup> June 2017, Peter went to see the Head Teacher and enquired how the CSE meeting had gone the previous day. On the basis that Peter had been invited and chose not to attend the meeting, the Head Teacher thought it proper to tell Peter what had occurred and the decisions that had been made. Peter asked the Head Teacher about the curfew that had been imposed by his mother the previous evening (following advice from the CSE meeting).
- 2.79 The Head Teacher told Peter to speak to his mother about that. He also explained that the meeting had agreed for him and the police to make further enquiries. Peter was agitated about this and the curfew and when the Head Teacher explained to Peter the options open to him for support regarding his sexuality, Peter stated that he was not gay.
- 2.80 Later that day CSC and the police held a strategy discussion about the allegations of intra-familial abuse and it was agreed that a Section 47 investigation should be commenced. The Social Worker planned to speak to Peter and his siblings and the parents. The mother stated that she was worried about the information being shared and explained that Peter had 'lost it' the previous night when he had been told about the meeting. Mother said that she did not believe the disclosure was true.
- 2.81 It would appear that there was no agreement or consistent message made at the CSE meeting as to how the decisions made were going to be communicated to Peter. In the event, it appears that this was left to the mother, who was going to be the first person to see him after the meeting, to inform Peter in a supportive and informative way as opposed to the curfew being seen as a punishment. She told Peter that a curfew had been imposed to which he reacted by becoming angry and moody, perhaps seeing that decision as a punishment of some kind, rather than a way of protecting him. The following day he saw the Head Teacher who told him about the decisions which would have included the Head Teacher speaking to the four boys. The Head Teacher referred Peter to speak to his mother about the curfew, which had been a decision made at the meeting.
- 2.82 On the morning of 8<sup>th</sup> June 2017, Peter had taken an examination at school. He returned home at lunch time and saw his older half-brother who had asked him how the examination had gone to which Peter replied it had gone well. Peter called his

father and after a short conversation he left the house. He was still wearing his school uniform.

- 2.83 At 15.22 hours that day, a call was received by British Transport Police to the effect that a person has been struck by a moving train near to a railway station in Nottingham. Peter was later identified by DNA.
- 2.84 Once Peter had been found on the railway line and agencies were informed, including the Rapid Response Team. On 12<sup>th</sup> June 2017 an Initial Child Death Strategy Meeting was held. CSC IMR records that the British Transport Police (BTP) visited the family without representatives from Health or CSC, which is not in line with the Nottinghamshire Child Death protocol. This is examined later in this report.
- 2.85 Later on 12<sup>th</sup> June 2017, the father of Peter sent text messages to the Social Worker involved with Peter blaming him and the CSE meeting for his son's death.

### **3. Views of the family**

- 3.1 On 19<sup>th</sup> December 2017, the report Author and the NSCB Development Manager met with mother at her request at County Hall. She described Peter as being a funny lad, always joking and carefree but once he started at the Secondary School from the age of 11 to 12 years, his personality changed. He became overweight and wanted to fit in and be 'one of the lads'. He had been a goal keeper for a local football team and always wanted to be everyone's friend. At home he engaged with social networks, his computer and mobile phone and played his music. He was fond of attending live 'gigs' and often travelled some distance to see various bands, sometimes without telling his mother where he was going. He would travel to Manchester and Birmingham on his own to see bands.
- 3.2 By the age of 13/14 years old, Peter became self-conscious about his weight. His mother described him as a 'big lad' overweight and well groomed. She illustrated how he would spend hours grooming himself in the bathroom and constantly showering. He was concerned about his 'man boobs' and considered asking his GP for surgery at one time. He turned to 'Weightwatchers' meals, then he went vegetarian, then vegan and then he started to self-harm. He slashed his wrists with a mirror, tied a rope around his neck marking himself and during a family holiday he was found with a belt around his neck which again marked his neck. The mother stated that she sought help from the School Nurse. The mother said that she wondered about his sexuality.
- 3.3 The mother stated that Peter did not attend an appointment with the GP and she found CAMHS of little use. He had been referred to CAMHS by the School Nurse. Peter got into the habit of eating, sometimes binge eating and then vomiting. Peter denied that he had a problem and he eventually saw his GP who gave him a web site to explore, but the mother said, 'He was so screwed up he was not interested'. She explained that Peter would tell the GP what he thought the GP wanted to hear but overall she did not think that GP was very helpful. The mother said that she arranged to go to First Steps with Peter, an eating disorder advice centre in Derby but they could not help him as he denied having a problem.
- 3.4 About CAMHS, the mother said that the first assessment for Peter was made a long time in the future and Peter couldn't keep other appointments. She found CAMHS to be inflexible and rigid in appointment making and eventually they closed the case, with Peter only having attended one appointment and his assessment incomplete. Mother also said that CAMHS would try to ring her but with her hearing disability she was not aware of that. She said CAMHS should have easily tried to email her.

- 3.5 The mother described Peter as buying boxes of laxatives in order to assist his weight loss. She said the GP did not speak to Peter much during consultations. She became concerned about his sexuality when Peter constantly showered and was using her make up. She was aware that he had been asked out by both boys and girls and this, she said, confused Peter. She knew about a suicide note that Peter had written in which he named the boy who had asked him out and that the notes also mentioned the Year Teacher with whom Peter confided about losing weight. She was aware that Peter had been speaking to that particular teacher for some time.
- 3.6 The mother expressed her frustration to the Author and the Development Manager that she perceived that she could not know everything from school, she perceived, because of confidentiality. With regard to the CSE meeting, she said that it was discussed that Peter was probably meeting men for money in exchange for sex and was suspected of being involved in sexual exploitation. She was aware that Peter would be in possession of quite a lot of money on occasions about which, Peter stated his father had given it to him. The mother was well aware that his father would not be able to give him the amounts of money he had, which aroused her suspicions.
- 3.7 The mother was upset that the police did not attend the CSE meeting and she thought the Social Worker's report was inadequate and missing pages. The only result she got from the meeting was the fact that a curfew was suggested. She imposed the curfew the night before Peter's death which upset Peter and made him angry. She told the British Transport Police in a statement that she felt that police had not attended the CSE meeting because Peter 'was not underage and had not known that other boys were involved'. She said that CAMHS was not present and neither was the School Nurse. She described the whole meeting as an appalling mess. She said the only thing that came out of the meeting was the curfew and she had told Peter that the meeting was 'a complete waste of time'.
- 3.8 On 30<sup>th</sup> January 2018, the report Author and the NSCB Development Manager saw Peter's father at his home. The father was mindful that the CSE meeting should not have taken place as he thought that Peter would be badly affected by it and that Peter was very nervous of the rumours that may be spreading at school if the meeting took place.
- 3.9 The father said that he was badly affected by the death of his son and has been referred for counselling and medical treatment as a result. The father told them that he would often tell Peter that he loved him and accepted him for what and who he was. He told his son he was his best friend and the father wanted Peter to move in with him. He refuted that he knew about the alleged intra-familial abuse Peter stated he was subjected to.

#### **4. Analysis and recommendations**

- 4.1 There are several areas worthy of mention and more detailed examination in the circumstances of this case.

##### **Referrals**

- 4.2 Peter and his siblings were known to NCC Education Authority for many years. His sister, S3, was known to the Educational Psychologist Service since 2005 regarding her diagnosis of ASD. There was contact between CSC and the Primary school in 2009 regarding concerns about the way the parents were caring for the children, but at that time there were no concerns whatsoever about the children whilst in school.

- 4.3 It is clear from the IMRs that home life for Peter was not particularly easy. His father and mother had separated years before and Peter still had contact with his father. The relationship between his mother and father was acrimonious. Mother is deaf and has to lip read, which caused her frustration when communicating with the children. Peter had to share a bedroom with a younger brother due to limited space in the household thereby restricting his privacy.
- 4.4 Peter was having problems with his body image, being concerned about the size of his breasts even to the point of considering surgery. He was partaking in risky behaviour situations and via the internet was visiting websites concerning meeting men for sex. He reported that he had met a man in a car park of a supermarket and had been taken to the man's house where sex had taken place; and another occasion when he had sat in a man's car on a car park for whatever reason. He had previously posted an indecent video of himself on YouTube.
- 4.5 Peter formed a bond with the Head of Year and confided in him about his weight loss and eventually disclosed to the Head of Year the sexual behaviour he was indulging in. It was the duty of the Head of Year to do something about that information which later resulted in the CSE meeting being held. Peter 'froze the Head of Year out' and Peter felt let down and feared that details of his behaviour would become common knowledge in school.
- 4.6 Research<sup>9</sup> shows barriers to disclosing are well known and include individuals who feel that they will not be believed, they will have no control over the information and events after disclosure leading to a feeling that they wish they had not disclosed in the first instance. Children try to identify a trusted adult who can help and who has the time and motivation to help. Peter found these qualities within the Head of Year. By disengaging with the Head of Year, Peter became more isolated.

#### **2014 CAMHS Referral**

- 4.7 In May 2014, Peter wrote a suicide note. This came to the attention of the School Nurse a couple of weeks later. She discussed this with the school who stated that they intended to make a referral to CAMHS. On 30<sup>th</sup> May 2014, the School Nurse saw Peter's mother and spoke with her about completing an Early Help Assessment Form (EHAF) and a possible referral to a paediatrician. The School Nurse discussed the pending CAMHS referral with the school and set about initiating some actions such as liaison with CAMHS and arranging meeting dates with the school. CAMHS were unable to attend and did not engage any further in the early intervention stages.
- 4.8 On 25<sup>th</sup> June 2014, another meeting was held with the School Nurse, the mother and the school. The School Nurse noted that the CAMHS referral was 'in process' and the school undertook to check the progress. The Healthcare Trust IMR indicates that the School Nurse took no action to follow up or complete the CAMHS referral which is considered as a missed opportunity by the School Nurse. The CAMHS referral had not been submitted after nearly a month.<sup>10</sup>

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<sup>9</sup> Nottinghamshire Serious Case Review DN11 December 2011 pages 53-55. This section of the SCR explains in detail the barriers to reporting sexual abuse especially by male children and within the Overview Report quotes from a variety of authors and literature.

<sup>10</sup> In 2014 informal conversations documented in School Nurse records about a possible referral to CAMHS would not be expected to go on a child's safeguarding file at school. School now have 'my concerns' software, which enables staff to log any issues about any student.

- 4.9 By 17<sup>th</sup> September 2014, the referral to CAMHS had still not been made because the school was waiting for the mother to take Peter to see his GP, which she had not yet done. Likewise the planned referral to the paediatrician had not been made.
- 4.10 On 1<sup>st</sup> October 2014, the School Nurse saw Peter at school. Peter was upset and had serious negative thoughts. Following this meeting, the School Nurse was to continue to consider the appropriate referral pathway, which was either CAMHS or a paediatrician. The IMR indicates that the reasons for the School Nurse not making the referral to CAMHS or the paediatrician may have been pursued at interview between the IMR author and the School Nurse. However, the School Nurse, who has since left the service, declined to be interviewed.<sup>11</sup>
- 4.11 On 30<sup>th</sup> October 2014, the School Nurse again spoke to Peter. He declined a CAMHS referral. It had now been 5 months since the involvement of CAMHS was first identified.
- 4.12 More recent Education Psychology Service guidance<sup>12</sup> indicates that the CAMHS Primary Mental Health Team are available for consultation with school staff regarding issues of self-harming, and goes on to say;
- ‘The CAMHS Single Point of Access (tel. no. provided) can be contacted to discuss the perceived level of risk and identify any potential role for the CAMHS Crisis Team’.
- 4.13 There were therefore plenty of opportunities for the School Nurse and the School to make contact with CAMHS and to follow up any referral that was made. The initial CAMHS appointment with Peter did not occur until 15<sup>th</sup> September 2015. The Healthcare Trust IMR Author comments:
- ‘This CAMHS referral was very comprehensive and clearly documented the chronology of events and risk factors leading up to the referral. However, it did not identify the safeguarding concerns and this referral came over a year after professionals first became aware of Peter’s suicide note’.

#### **2014 Referrals to Paediatrician**

- 4.14 During a meeting between the School Nurse and the Mother in May 2014, the School Nurse, whilst talking about making a referral to CAMHS, also mentioned the option of making a referral for Peter to see a Paediatrician. No referral was made at that stage and in June 2014, the School Nurse again stated that a referral to a Paediatrician via the GP would be completed and;
- ‘the school would do a report to support this referral’.
- 4.15 On 23<sup>rd</sup> June 2014 there is still no evidence of the referral to the Paediatrician being made. The Healthcare Trust IMR Author notes:
- ‘It appeared the [School Nurse] worked hard but with little effect. The lack of a clear plan with SMARTER actions means that the case showed significant drift. There is no evidence to suggest that any minutes to meetings were produced and circulated leaving discussions had within them open to interpretation’

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<sup>11</sup> There have since been changes in school referral process to CAMHS. Any child of concern is now discussed at a monthly consultation meeting with the Primary Mental Health Care Team and if necessary a referral is made.

<sup>12</sup> Young People and Self-harm: Guidance for Schools -Nottinghamshire County Council Educational Psychology Service September 2017 page 9

- 4.16 On 1<sup>st</sup> October 2014, the School Nurse had another meeting with Peter, where her plan was;
- ‘to continue to consider the most appropriate referral pathway; CAMHS or Paediatrician’
- 4.17 On 30<sup>th</sup> October 2014, the School Nurse again saw Peter. He refused a CAMHS referral but wanted half termly appointment with the School Nurse in order to discuss his low mood and how to cope with a busy household. There is no mention of the outstanding Paediatrician referral, which may have resulted in an appointment being offered.
- 4.18 On 13<sup>th</sup> March 2015, the School Nurse attended the school’s year leadership meeting where she advised the school to consider a CAMHS referral and a referral to a Paediatrician. It was at this meeting that the School Nurse informed Peter and his mother that she was leaving the service. It is also at this time that Peter’s anxiety and risky behaviour were escalating. The School Nurse’s analysis of the then current situation was that she would consider whether mother was able to respond appropriately to her son’s needs. No referrals were made or child protection risk assessment conducted, nor is there evidence that the School Nurse sought advice from her supervisors or senior management team.
- 4.19 The referral process for Peter to attend CAMHS and the Paediatrician was disjointed and without continuity. The School Nurse expressed the correct intentions but this was not followed through with timely referrals. There is nothing to indicate that her supervision addressed the problem. The Healthcare Trust IMR author states;
- ‘The school nurse took no action to follow up or complete the CAMHS referral, which amounts to a missed opportunity. Unfortunately it has not been possible to explore this further as the School Nurse declined the invitation to attend the interview [with the IMR Author].<sup>13</sup>
- 4.20 The School Nurse made decisions about the probability of mother being able to respond appropriately to Peter’s needs, despite the history of the contrary. This may have been seen as confirmation bias. Confirmation bias suggests that professionals (in this case) seek out information that confirms their existing opinions and ignore contrary information that refutes them. This psychological phenomenon occurs when decision makers filter out potentially useful facts and opinions that don’t coincide with their preconceived notions.
- 4.21 Research illustrated in the paper by the Behavioural Insights Team<sup>14</sup> into decision making by Social Workers, indicates that analysis suggested that there are a range of overarching behavioural factors that complicate or reduce the efficiency of social workers’ decision-making. The four which were identified as being of most significance are:
- a) Time and workload pressures increase the reliance upon social workers’ intuition to make decisions.

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<sup>13</sup> The School Nurse referred to here was the first school nurse, who had significant dealings with Peter. She left the service and initially declined to be interviewed by the Healthcare Trust IMR Author. She has now been interviewed - see page 46.

<sup>14</sup> Clinical Judgement and Decision-Making in Children’s Social Work: An analysis of the ‘front door’ system Research Report by Elspeth Kirkman and Karen Melrose - The Behavioural Insights Team Department for Education April 2014

b) A range of behavioural biases affect social workers' ability to make objective judgements.

c) The complexity of social workers' decision-making is increased further by the fact that many sequential decisions have to be made through the course of a single day, which engenders depletion or 'decision fatigue'.

d) The information provided to social workers is often of relatively low quality. This means that significant energy is expended piecing together a full picture of the relevant information, leaving less time for analysis of each case.

4.22 This research can equally be applied to other professionals.

### **2015 Referrals**

4.23 On 13<sup>th</sup> March 2015, the School Nurse was informed that Peter had self-harmed in school and he was insistent that he did not want his mother told. He had used a blade from a pencil sharpener to cut his arm. Consideration was given to informing CAMHS but Peter insisted he didn't want that done. The School Nurse spoke to Peter about his self-harming and his sexuality but again Peter declined to discuss either issue, other than to say that he regretted doing what he had done and would not do it again.

4.24 At this time, the self-harming was not the first time that Peter had engaged in this behaviour. He had written a suicide note prior to this incident and had displayed many of the identified risks research informs about suicide.

4.25 More recent NCC's Educational Psychology Service 'Young People and Self-harm Guidance for Schools'<sup>15</sup> states;

'Young people aged 16 or over are presumed to have capacity to consent to withhold information from others including parents, unless it is assessed that they do not have capacity. They may consent to having treatment and be happy for parents/carers to be involved – this would be best practice.

If young people do not want their parents to be involved then this right to confidentiality has to be weighed up against risk. For example, the confidentiality of a young person may be honoured in the case of self-harm e.g., superficial cutting (where there may be no immediate/significant risk). However, if the young person is deemed to be a high risk of suicide then, despite treatment compliance, risk management may over-rule rights to confidentiality and parents/carers would be informed.'

4.26 Nottinghamshire SCR NN15<sup>16</sup> report quotes recognised overlapping risk factors of both self-harm and suicide as being;

- mental health problems including depression
- family issues
- disruptive upbringing
- physical or sexual abuse
- having worries about sexual orientation
- family relationship problems

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<sup>15</sup> Young People and Self-harm: Guidance for Schools -Nottinghamshire County Council Educational Psychology Service September 2017 page 8

<sup>16</sup> Nottinghamshire Safeguarding Children Board Serious Case Review NN15 2016

- self-harm in a family member
- low self-image and low self esteem

- 4.27 The above risks are confirmed in the Child Sexual Exploitation (CSE) Multi-Agency Pathway.<sup>17</sup> All of the above traits were demonstrated by Peter. The School Nurse advised the school to consider a CAMHS and a paediatric referral and also a referral to young carers was considered but none of the referrals were made. The School Nurse could have made a referral to CAMHS herself despite Peter expressing the wish that he wanted no-one informed of his self-harming episode. With hindsight, there were indicators of suggestive suicide at that time and Peter was a high risk of suicide at that time based on the evidence on suicide in young people. There was a further missed opportunity to contact CAMHS or any other support organisation for Peter.
- 4.28 The risks associated with young people threatening to take their own lives is well documented in a significant amount of literature including 'Suicide by children and young people in England'<sup>18</sup> This study of 145 children and young people found that 13% had suffered physical emotional or sexual abuse, 36% had suffered bereavement, 22% had been victims of bullying, 13% felt they had been socially isolated, 23% had used the internet in connection with suicide, 3% were struggling with their sexuality and 53% had suffered with academic pressures. Peter had experienced most, if not all of those issues and was clearly a very vulnerable person.
- 4.29 Further research<sup>19</sup> indicates that in cases where there may have been a lot of risk factors present as with Peter, on a national level available statistics show that very few young people go on to take their own life. Suicide in young people is a very rare event. Of those aged 15 to 19 years, figures show that male teenagers in this age group are more likely to commit suicide than females but only 7.5 young men out of 100,000 across the UK are likely to commit suicide, which in proportion of all suicides is very low.
- 4.30 On 18<sup>th</sup> March 2015, the School Nurse met with the mother and told the mother that she was leaving her post. She said that she had been working with Peter and had no concerns about him, yet it was only 5 days prior that Peter had self-harmed. This together with the known history of suicidal ideations and self-harm that the School Nurse was aware of, made her comment to the mother that she had no concerns about Peter appear contrary to the concerns she had showed about Peter for some time. The School Nurse highlighted the fact that no-one in school appeared to be taking the lead with regard to supporting Peter at which point, the Head of Year took the lead.
- 4.31 In March 2015, there was an opportunity for either the School Nurse or the School to complete an Early Help Assessment Form (EHAF) as per Nottinghamshire's Children's Services Pathway to Provision.<sup>20</sup> This guidance indicates that when a child fulfils the criteria for a level 2 Threshold, the practitioner should complete an EHAF. This can be used by all agencies working with a child and their families and is used to identify a child's needs, strengths and goals and where there are worries, concerns or conflicts over an extended period.
- 4.32 The Level 2 Threshold illustrates the child's needs as including having sexual relationships, alcohol abuse, being involved in anti-social behaviour, insecurities

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<sup>17</sup> Nottinghamshire County Council Child Sexual Abuse Multi-agency Pathway 2017

<sup>18</sup> Suicide by children and young people in England National Confidential Inquiry into Suicide and Homicide by people with Mental illness. University of Manchester May 2016

<sup>19</sup> Office of National Statistics Statistical bulletin: Suicides in the UK: 2016 registrations

<sup>20</sup> Pathway to Provision Multi-Agency Thresholds Guidance for Nottinghamshire Children's Services Version7 February 2018

around identity and sexuality, having difficulty in maintaining relationships and being exposed to dangerous situation in the home or in the community. Most of these issues were present in Peter's life at that time. Whilst it is appreciated that before an EHAF is completed consent should be obtained from the child or the parent. The EHAF form was not completed for whatever reason although professionals did discuss the submission of such a form<sup>21</sup>.

### **Recommendation 1**

NSCB to promote the increased use of the EHAF by agencies and explore the barriers which prevent professionals from completing them.

- 4.33 The original School Nurse had left the service and a new School Nurse took over Peter's case in May 2015. Despite attempting to meet with Peter, the new School Nurse was unable to engage with him. The new School Nurse did however make a referral to CAMHS with Peter's agreement after another incident of setting fire to the bedroom curtains. The referral was made on 20<sup>th</sup> August 2015. A comment in the Healthcare Trust report from the IMR author about that referral reads;

'It is my opinion that this CAMHS referral was very comprehensive and clearly documented the chronology of events and risk factors leading up to the referral. However, it did not identify the safeguarding concerns and this referral came over a year after the professionals first became aware of [Peter's] suicide note'

- 4.34 In September 2015, school were made aware, through Peter's sister, that Peter was self-harming and going missing from home which involved the police. His sister told the Senior Learning Support Assistant (SLSA) at school that Peter;

'had been suffering from depression and had been cutting himself on his arms'.

- 4.35 S3 also stated that Peter had been found with a belt round his neck. She added that the mother and father were aware of this but didn't want her, S3, to tell anyone. This could be seen as casting doubt on mother and father's ability to act as positive factors acting in the best interests of Peter.

- 4.36 The Head Teacher, as the designated safeguarding person at the school made a referral to MASH on the same day and wrote to Peter's mother telling her what he had done and to expect CSC to arrange an assessment of Peter. The Head Teacher's view was that Peter was not in a good place at that time. On 22<sup>nd</sup> September 2015, the Head Teacher received confirmation that the assessment would be undertaken but on 30<sup>th</sup> September 2015, the Head Teacher learned that Peter's mother had refused to engage with the assessment and the CSC case had been closed. CSC made a request for the school to follow this up with the mother and seek permission from her to provide support to Peter should he feel the need. On 6<sup>th</sup> October 2015, the Head Teacher wrote to the mother asking permission for CSC to undertake agency checks with CAMHS. There is no record of any reply to this letter.

- 4.37 The Head Teacher spoke to Peter who stated he did not want to engage with CAMHS and it was left that the school would KIV (Keep in View) the situation with Peter. The Head Teacher was aware that Peter had a good relationship with the Head of Year and saw that as positive signs. It was thought that the reluctance not to engage with the assessment was Peter's choice as opposed to any obstruction from the mother.

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<sup>21</sup> At the end of 2017, an audit of the EHAF form was conducted and the form revised. The revised form has now been adopted.

4.38 It was clear that for some time no-one had taken the lead to make referrals to CAMHS and the Paediatrician.

4.39 The Healthcare Trust IMR comments regarding the half completed CAMHS assessment in November 2015 and Peter being discharged from the CAMHS service due to a failure to engage. The Author makes the following observation;

‘Given the amount of previous involvement from the School Nursing service and the level of concerns raised it would be reasonable to assume that [School Nurse] would have enquired about Peter’s wellbeing in school, or that school or mother would have re-referred him back to the team given the on-going concerns highlighted by the social worker following the MASH referral in May 2017. However, there is no evidence in the health records that Peter was ever discussed, re-referred or seen by health services after he was discharged in November 2015. [School Nurse] confirmed at interview that she did not have contact with Peter or his mother after this point and that she left the School Nursing service in September 2016.

4.40 The CAMHS visit to Peter in September 2015, resulted in the mother being spoken to first and not enough time was left for the assessment to be fully completed. During the course of this review questions were raised with the Healthcare Trust asking if this was the usual practice to see the parent/carer before the child. The response received indicated that this was not usual practice and clinicians will usually see the family together initially and explain about the assessment process. They would then offer the young person the opportunity to be seen on their own initially and then the parents and family together at the end. It will depend on the wishes of the child/young person. Clinicians offer young people and families the opportunity to contact them after the assessment should they think of something they want to talk about or if there was something they did not feel comfortable speaking about during the assessment.

4.41 Asked why this did not happen in this case the IMR author stated the worker had since left the service but was asked about this in interview and was unable to provide a rationale for seeing the mother first.

4.42 The IMR Author is content that this this appears to be a one off incident and there are no recommendations for the Healthcare Trust linked to this issue. The importance of seeing the young person first to validate their voice is to be re-iterated when the learning from this review is shared, which is usual practice for staff currently. There are ‘minimum clinical standards for assessment’ which state that:

‘The clinician should ensure that they spend time with the young person and where possible with the carers too. The young person should be offered time alone with the assessing clinician to discuss anything privately’.

### **2017 Referrals**

4.43 In February 2017, Peter’s father telephoned the family GP concerned that Peter had intimated that he was gay and the father wondered if his son was having sex with older men. The details the father could give were only scant and the GP advised that he should speak to Peter and his mother. If there were partners much older than Peter, and the father had safeguarding concerns then a referral to social care or the police may be needed.

4.44 It could be considered whether at this point the GP could have made a referral to children’s social care in light of Peter’s comment. The CCG IMR Author’s view concerns the difficulty that the GP faced was lack of any specific information to include

in a referral and whether this would have met the threshold for further response. With the benefit of hindsight it would appear significant, but at the time the GP was faced with the dilemma of the possibility of making a referral to the Local Authority based on tenuous non-specific information without the knowledge or consent of the young person concerned.

- 4.45 The CCG IMR Author's view is GPs have to weigh up the public interest of maintaining the public confidence in a confidential medical service, with the responsibility to act in the best interests to safeguard children. Disclosure of tenuous and apparently speculative information without the knowledge of the young man concerned could have resulted in both Peter and his father losing confidence in the GP patient relationship and subsequently not accessing help when needed in future. It would also have very likely affected Peter's relationship with his father and put Peter at risk.
- 4.46 The IMR Author is content that the advice to the father to find out more from Peter and his mother was appropriate. The GP was aware that the father in particular, with his disclosures of historical child sexual abuse, was acutely aware of this issue and appeared keen to safeguard his children from similar abuse.
- 4.47 With hindsight the GP could have taken this information to the Practice Safeguarding multi-disciplinary meeting or daily team meeting to identify whether there was any additional information known by other GPs or the School nurse which would have checked out any additional concerns known in relation to risks of sexual abuse. Peter was taken off the Red Flag meeting after the relationship between him and the School Nurse collapsed.
- 4.48 It is noteworthy that the GP had no information in relation to Peter or his siblings being at risk of sexual exploitation until June 2017.
- 4.49 It could be argued that a more proactive decision could have been taken by the GP. Peter had a history with the GP and the School Nurse about his weight loss, his dissatisfaction about his appearance.
- 4.50 In November 2016, after Peter went missing, mother told the police that she had taken Peter to the GP as he seemed detached from the family and walked around the house saying, 'Its nearly all over'. However there is nothing recorded in the GP's records of an appointment for Peter in November 2016. The GP was unaware of the missing episode and the extent of mothers concerns for her son at this time.
- 4.51 In January 2017, the GP was aware that Peter had disengaged from CAMHS and this was discussed at the GP's Practice Safeguarding Meeting. However, the recent concerns around the suicide note and the missing episodes were not known by the GP.
- 4.52 There is variance among the panel members about this point. Whilst there is an appreciation of the dilemma the GP faced (as outlined in the IMR) with the degree of information supplied by the father about his worries that his son *may* be engaging in sexual activity with older men, the Overview Author considers that all of the circumstances of Peter's history should have warranted a more positive response than to advise the father to speak to his son and the mother.
- 4.53 The Overview Author considers an enquiry should have been made to Children's Social Care via the MASH. If the enquiry reached the threshold for a referral, police and Children's Social Care would have had an opportunity to establish if the allegations made by the father had any truth to them. It was not the role of the GP to determine this. The facts as presented by the father constituted a possible safeguarding concern irrespective if the circumstances were vague. The Pathway to Provision is clear on this.

- 4.54 On 21<sup>st</sup> April 2017, the Deputy Head Teacher from school telephoned the MASH to report that Peter had been meeting older men via an app. on his mobile telephone. A conversation took place between the MASH operative and the Deputy Head Teacher that stated that Peter had disclosed that he had been seeing older men, he had been sitting in a car with one man and had been paid money for that. On another occasion had been taken to a house where consensual protective sex had taken place. The MASH operative asked if Peter's parents had been informed and the Deputy Head Teacher said at that stage they had not. The operative suggested that the Deputy Head Teacher inform Peter's parents. The panel consider that this was not wise advice and should have been left to CSC or the police to inform parents of the disclosure.
- 4.55 A written referral was sent to the MASH by the same member of staff. This contained information about incidents of intra-familial abuse that Peter had allegedly been subjected to sometime before and had only just disclosed to the school. This information was not passed to the MASH during the telephone referral. The alleged intra-familial abuse was disclosed at the same time as the 'prostitution' concerns.
- 4.56 It appears that once the written referral had arrived at the MASH the information about the alleged intra-familial abuse was missed by a social worker and supervisor. An examination of the written MASH referral form indicates that there was one line about the alleged abuse on the front page of the form but a more detailed entry, including mention of the four boys, on pages near to the back of the form. The referral resulted in a Child Sexual Exploitation meeting being held on 7<sup>th</sup> June 2017. Following the initial disclosure by Peter, to the Head of Year, the Head Teacher chose to re-interview Peter.

#### **Peter's response to referrals and agency involvement**

- 4.57 Agency involvement with Peter and his family was significant over a number of years. As can be seen by the sequence of events, Peter's behaviour and reaction to intervention by agencies escalated as time went by. Much of his reaction resulted in 'risky behaviour'. He went missing on two occasions and again on the day of his death. Both the Police and the Social Worker followed their respective procedures regarding missing people especially with the 'return interviews'.
- 4.58 Peter often self-harmed, became anxious and was seen with a belt around his neck. In March 2015, he self-harmed with a sharp instrument. His mother raised concerns that he may have ASD as his sister does. On another occasion she suggested he might have a personality disorder. He had already written a suicide note and had been investigated by Nottinghamshire Police for posting an indecent image of himself on social media as a result of a referral from CEOP.
- 4.59 The first reported incident of him going missing was in September 2015 It transpired that he had been depressed in the previous weeks and had attempted suicide before and self-harmed 3 weeks previously. A note had been found at his address indicating his wish to take his own life. In addition he had recently been referred to CAMHS as outlined above. Police informed CSC of the circumstances.
- 4.60 The next missing episode was in November 2016, when police were informed but Peter arrived at his father's house before the police could find him. His mother had taken him to see his GP due to him walking around the house saying "it's nearly over". A worker from the Family Services made arrangement to see Peter for a return interview but Mother changed her mind after seeing the information sharing agreement. Albeit Peter had returned before the police had found him, the officers still completed the necessary MISPER forms to properly record the incident. On each occasion of his being reported

missing and then returning CSC conducted a 'return interview' to ascertain from Peter the reason for him going missing and to enquire into his general safety.

- 4.61 The third missing report was on the day of Peter's death, when his family reported him missing at 22.15 hours on 8<sup>th</sup> June 2017. The day before there had been the CSE meeting to discuss Peter and it is thought that he was concerned that information about his sexuality and his behaviour would become common knowledge among his peers. He had been told that he was under a curfew and the Head Teacher had explained to him the outcome of the CSE meeting. He was found on the railway line after colliding with the train.
- 4.62 Peter reacted to stressful occurrences in his life. He was a very vulnerable person. The pattern of his likely reactions and the possibility of him harming himself were not identified and therefore it was difficult to manage his reaction to events that occurred in his life. It was clear that there was lots done for Peter by various professionals but he had no control over what was happening to him. Once he had disclosed he was aware that he had exposed some of his family members, friends and men he had possibly been associating with, to questioning and investigation. He had lost his trust in the Head of Year and there was no consideration as to how anyone was going to keep Peter safe or what his wishes and feelings were now that his issues had been exposed.

#### **Record keeping within school**

- 4.63 During the course of this review there are several instances that have come to notice regarding the lack of record keeping of significant events at school. The first was the visit to the school by the CEOP after Peter had posted images of himself on social media. He had been identified by his blazer shown in the background of the video and the matter dealt with accordingly as set out above. Later enquiries with the school indicate that there were no written records of this occurrence although some members of staff could remember the incident.
- 4.64 The submission of the referral to the MASH when Peter disclosed involved three members of staff at the school. The first was the Head of Year who had received the disclosure. The second was the Head Teacher who instructed that a referral be completed and the third was the Deputy Head Teacher who actually completed and submitted the written referral form. In doing so information about alleged intra-familial abuse was not communicated during the initial telephone referral and missed at the MASH when the written referral arrived. Consequently the alleged intra-familial abuse was not recognised or investigated.
- 4.65 There were no records made immediately after the conversation that the Head Teacher had with Peter following Peter's disclosure to the Head of Year. The Review Author considers this interview was unnecessary and improper when dealing with reported allegations of child abuse especially when the Head of Year had made copious notes of the disclosure from Peter himself. Similarly, the Head Teacher was left with the responsibility of speaking to the four boys named at the CSE meeting by the Chair. This he did in relation an immediate assessment of any possible risk, but again there are no notes made immediately after the interviews

**Learning Point:** Professionals are reminded for the need to make notes of disclosures made by children as soon as possible after the conversation and the conversation must not include leading questions. The notes must be suitable for disclosure to any future enquiry or investigation.

## MASH referral, 21<sup>st</sup> April 2017

4.66 The referral into the MASH on 21st April 2017, emanated from disclosures Peter made to the Head of Year Teacher. Those disclosures involved:

- Meeting men in car parks (possibly for money)
- Meeting one man in particular, a man, who took him to a house and had penetrative and oral sex with him
- Meeting men on a mobile phone app.
- His actions being known to other boys at school
- There had been intra-familial sexual abuse.
- Peter had previously disclosed he had been sleeping rough
- It was known that he had anxiety about his weight, low self-esteem and other emotional problems

4.67 There was no indication that consideration was given to recording this as a Section 47 investigation; that Peter was in danger of significant harm and therefore would have warranted the multi-agency response that a Section 47 investigation deserves.

4.68 When asked to clarify this CSC stated:

‘A decision about sec 47 was given consideration, it was decided that a CSE risk assessment together with a child and family assessment, would be undertaken to gather further information about Peter and his family. This work started and Peter was seen in school on the 12<sup>th</sup> May 2017 by his social worker.

Had a sec 47 investigation been completed it is unlikely that there would have been a different outcome, the Police have indicated that because of Peter’s age they would not be involved and the Police did not attend the strategy meeting when it was held. CSC would have undertaken a child and family assessment and completed a CSE risk assessment to gather information about Peter and his family.

It is important to say that risk to Peter was recognised. On the day of the telephone referral the MASH SW phoned Peter’s mother as follows; *mother is deaf so I spoke to (sibling aged 19 in the same house) to ring the police if he leaves and family is not sure where he goes. [Sibling] confirmed he will ring police himself.*

4.69 The Police had not in fact said they would not be involved because of Peter’s age, comment from the police was;

‘[Peter] is 16 and whilst this does not stop him being subject of CSE it does allow him to legally engage in sex with older males’.

4.70 The referral form to MASH contained information about Peter being abused within the family which had not been communicated by telephone at the time of the original referral.

4.71 When asked to clarify the fact that this information was missed by MASH workers, CSC stated:

The written referral has the additional information at the very end of the report, i.e. after “page 7 of 7” and follows a Blank page. It is completely understandable that this information was missed. The Social Worker contacted the school on the 10<sup>th</sup> May 2017 to discuss Peter and arrange a visit to the school. A new “online” referral form is about to be introduced.

## Recommendation 2

NSCB needs assurance from MASH that written referrals are being used and that they add value to the process.

- 4.72 The fact is that the information about alleged intra-familial abuse was also contained on the first page in line 5 of a narrative description of the disclosures Peter was making. A more detailed account of that part of the disclosure is contained on pages after page 7. Whoever read the report did not read the whole document and information about alleged intra-familial abuse was missed and did not come to light until the CSE meeting. That would have added weight to the decision to hold a Section 47 investigation as the alleged perpetrator of that abuse was still in the family setting. H.M. Coroner commented:

'I find that the failure to understand the disclosure in full, was made not just by the individual social worker, but also by the Team Managers in the MASH'

- 4.73 Regarding the seven week delay in calling the CSE meeting, when asked to expand CSC stated:

Peter and his family were seen during the seven week period between the referral and the CSE meeting, a CSE risk assessment and a child and family assessment were both completed by the 30<sup>th</sup> May, this is within statutory timescales. The NSCB policy re child sexual exploitation states that;

*Comprehensive Interagency assessments that are conducted at an early stage are essential in the support and protection of children and young people who are, or are at risk of becoming, sexually exploited. The immediate presenting problems need to be considered in the context of the care that the young person is receiving at that time taking into account the family history, the child's background and any previous harm or neglect experienced.*

- 4.74 Following assessment a strategy meeting was then convened. Had the strategy meeting been held before the child and family assessment and the CSE risk assessment it would not have been able to consider this information.
- 4.75 The information about the alleged intra-familial abuse came to light during the CSE meeting, seven weeks after the MASH referral. During that time, according to CSC, two significant assessments took place, the Child and Family Assessment and completion of the CSE risk assessment tool. Both processes involved discussion with partner agencies but in neither assessment was the issue of alleged intra-familial abuse (as detailed in the written MASH referral) apparently discussed. Had it been it is likely serious consideration would have been given to initiating S47 enquiries. In the event this opportunity was missed.

### **Child Sexual Exploitation Multi-agency Strategy Meeting, 7<sup>th</sup> June 2017, and Nottinghamshire Police response**

- 4.76 This meeting was convened as a result of the referral made by the school on 21<sup>st</sup> April 2017, following the disclosure by Peter that he had been associating with older men for sexual purposes. The information was passed to CSC but when Peter was told that CSC would have to be made aware, he stated that he would deny the disclosure was true. CSC conducted a CSE Risk Assessment and concluded that he was at high risk of sexual exploitation.

- 4.77 The referral resulted in the CSE meeting being held on 7<sup>th</sup> June. It was chaired by an Independent Child Protection Coordinator and attended by two Social Workers, the Head Teacher from Peter's school, Peter's mother and her partner and also Peter's father. There was no representative from the police, CAMHS or the school nursing service. Peter was invited but declined to attend.
- 4.78 The Chair heard an overview from the agencies present and also about the allegation of intra-familial abuse, which had not been included in the verbal referral from the school, but had been included in the written version submitted the next working day. CSC had not yet investigated this disclosure by Peter because the alleged intra-familial abuse had not been picked up by CSC until the Head Teacher raised it verbally at the CSE meeting. The meeting also heard from a Social Worker that there were fears over Peter having suicidal thoughts and that there had been previous suicides within the family.
- 4.79 The Chair read from an email received from the police giving their apologies and stating that they had no information on Peter on their systems. The report stated that the police were to take no further action regarding the disclosures, and whilst they acknowledged that Peter was vulnerable, he was 16 years of age and the police did not consider him to be a high risk. The Chair commented that the police could be contacted if more information was required
- 4.80 Further examination of the police records indicated that the check that was made resulting in the CSE meeting being told there was no information on police records was not thorough enough. The Police CATS<sup>22</sup> system and safeguarding systems were not checked and a more detailed examination of the Compact system would have revealed details of the two missing episodes involving Peter.
- 4.81 The Police did not attend the CSE meeting due to resourcing problems and other pre-arranged commitments. The decision not to attend was a subjective decision to make and the police report that based on the facts that they had been given, which of course did not include the allegation of intra-familial abuse, did not appear to indicate a high risk referral. An Officer from the Sexual Exploitation Investigation Unit (SEIU) stated that not attending the meeting was simply a resourcing issue and even if the alleged intra-familial abuse was known about, it was unlikely to have led to police attendance at the CSE meeting on 7<sup>th</sup> June 2017. The Officer noted;

'[Peter] is 16 and whilst this does not stop him being subject of CSE it does allow him to legally engage in sex with older males'.

- 4.82 When asked to clarify the reasons for not attending the CSE meeting, Nottinghamshire Police stated:

The reason for non-attendance was purely resourcing given the number of CSE meetings the same department were being asked to attend at the same time on the same day.

The research issue only affected attendance in that, having found (incorrectly) no record of Peter on Police systems, the meeting was considered to be a lower priority than the others. It is doubtful that had the officer identified the previous MFH episode, it would have changed the position (i.e. made the meeting a higher priority than those elsewhere).

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<sup>22</sup> CATS Police Child Abuse Tracking System

The researching error is attributable to the officer not checking the MFH system. This was an error and communications have gone out to rectify that.

### **Recommendation 3**

NSCB to review the interagency CSE procedures to ensure that when there are sufficient concerns to support a section 47 enquiry that the appropriate multi-agency response is triggered.

### **Recommendation 4**

NSCB to disseminate the learning from this review.

- 4.83 Previous contact with Peter by the Police had been missing from home reports, the earlier investigation into him posting indecent images of himself on social media and a minor incident where Peter had purchased alcohol whilst being under age. The Police had not been made aware of his disclosures at school. The allegations of intra-familial abuse were only realised at the CSE meeting from the written referral.
- 4.84 The Chair also commented about the note made in the referral to the effect that Peter was a compulsive liar. The Chair said;
- ‘[Peter] had been labelled a compulsive liar by a school representative in some of the contact with CSC and my concern is that his disclosure has been discounted.’
- 4.85 Father stated that Peter told him about that 2 years previously but father didn’t believe Peter. Father now disputes that he had known about this before. CSC made the point that they had not been told about that allegation and therefore nothing had been done about it at the time of disclosure.
- 4.86 The conclusion of the meeting was that Peter was at high risk of being sexually exploited and the actions outlined earlier in this report decided upon.
- 4.87 Because Peter did not attend the CSE meeting, it was left to his Mother to inform him of the conclusions, part of which was the details of the curfew that was to be imposed. She told Peter about the curfew later that evening and she described him as ‘losing it’. He was annoyed and had nothing more to do with her that evening. Whether he saw that decision as some form of punishment will never be known, save to say he was upset about the CSE meeting.
- 4.88 The following day Peter went to see the Head Teacher and asked what had happened at the CSE meeting. The Head Teacher felt obliged to tell Peter of the result and what action had been decided upon including the fact that the four boys would be spoken to.
- 4.89 It appears that there was no thought given as to how the result of the meeting was to be conveyed to Peter in a managed and structured way. It would have been wiser for a strategy to be agreed for someone to sit down with Peter and talk through the results of the meeting immediately after the meeting and probably someone who was not close to Peter, perhaps even the Chair of the meeting. The way the outcome of the meeting was disseminated to Peter could have been managed better. His reactions to sensitive issues in his life were well known, self-harming, going missing and suicidal ideations. The minutes of the CSE meeting do not indicate that there was an understanding or consideration of the impact the meeting may have had on Peter. HM Assistant Coroner concurred with this finding at the inquest and expressed her concern that the NSCB inter-agency CSE guidance had not been followed in this regard.

4.90 Calling the CSE meeting should have been earlier when concerns were identified and the result of the CSE meeting should have been a joint Section 47 investigation led by the police. That would have been even more relevant as there were the four other boys to interview. The CSC IMR author states;

‘Upon hindsight it would have been more appropriate for this to have been a joint agency investigation due to the information about [Peter] meeting with older men for money alongside the allegation of intra-familial abuse.’

4.91 The minutes of the CSE meeting indicate that references were made to Peter’s self-harm and suicidal ideations.

- [Head Teacher] said he had concerns about Peter’s emotional wellbeing and the previous incidents of self-harming’
- ‘[Mother] said that his diet is a type of self-harm and he is still losing weight’
- ‘In [Father’s] opinion, Peter is suffering from depression and he is worried about his son’s mental health
- [Social Worker] said there was some concern regarding Peter’s suicidal thoughts.’
- [Mother’s partner] mentioned that Mother’s brother had committed suicide.

4.92 However it does not appear from the minutes as if self-harm, suicide or Peter’s general well-being were explicitly identified as current risks and none of the actions in the action plan appear to be designed to directly address those risks.

4.93 The actions regarding the other four boys who may have been either witnesses or potential victims, to corroborate Peter’s disclosures of sexual exploitation were left to the Head Teacher to ‘investigate’. The fifth point within the action plan states that the school should sensitively explore the concerns with the named boys and liaise with social care. This action was not appropriate as any further communication with these boys should have been agreed with the police.

4.94 The Chair of the meeting had not intended the school to have any further conversations with the boys but had instead wanted school to share the information gathered to date with the social worker. The wording of the action was unhelpful and led to confusion about further discussions with the named boys. The Education IMR Author comments about this and the fact that the Head Teacher also interviewed Peter after he had disclosed to the Head of Year, possibly unintentionally conveying the impression that Peter was not to be believed. The IMR Author quotes from the school’s Child Protection Policy of 2017; (which was not in place at the time and therefore the Head teacher was not in breach of this guidance. The following quote was not contained in the 2016 guidance).

- ‘Staff should never attempt to carry out an investigation of suspected child abuse by interviewing the child or any others involved. The only people who should investigate child abuse and harm are Social Care, Police or the NSPCC.’

4.95 The Education IMR Author also points out that the Head Teacher (also the Designated Safeguarding Officer at the school) attended the CSE meeting, yet the person with whom Peter had had most dealing with at school and had supported him throughout his troubles, was the Head of Year. The Head of Year started off the referral process by informing the Head Teacher of Peter’s disclosures. The Head Teacher then

interviewed Peter as stated above and then the Deputy Head Teacher, firstly telephoned through the referral which did not include the alleged intra-familial abuse, and then submitted a written referral that did include the alleged intra-familial abuse.

- 4.96 During the course of panel meetings dealing with this review, clarification was sought as to the Head Teacher's purpose in interviewing the four boys and in addition what did the Head himself understand his role to be.
- 4.97 The Head Teacher explained that his view of the purpose of the meetings with the boys was to further clarify any risk factors and clarify the views of the four students and ensure they themselves were not at risk. This was based on the Head Teacher's five years of knowing the boys and none of them having ever demonstrated behaviour that had raised safeguarding concerns. He had seen three of the boys both before and after the CSE meeting, but before the minutes of the meeting were received.
- 4.98 The Head Teacher was of the view that the purpose of the meetings was to ascertain the veracity of some of Peter's claims relative to the individual and to also assess risk. During a conversation with the Education IMR Author the Head Teacher stated:
- 'It would be fair to note that advice to the school prior to the CSE meeting would have been more than welcome. In the period between our submission and the CSE meeting all students presented no further issues within school of a safeguarding nature. We maintained a high level of monitoring.'
- 4.99 It appears from the Head Teachers answers to the questions posed by the panel that his understanding of his role was to ensure that no other child at his school was at risk in a similar way as Peter had been placed at risk. None the less, as stated before in this report, the Head Teacher did obtain information from the four boys that related to what may have been considered evidence. The directions from the CSE meeting as to what was expected of the Head Teacher were unclear and the Head Teacher had rightly, acted before the minutes were produced and circulated. The specific expectations of the outcome of the CSE meeting should have been made clear by the Chair before the meeting ended.
- 4.100 The Chair of the CSE meeting picked up on the reference to Peter being described as a 'compulsive liar' and raised it with the Head Teacher. It would have been better for the Head of Year to attend and present to the meeting the benefit of his experience and extensive knowledge of Peter. The Head of Year when interviewed stated that he expected to go to the CSE meeting but was told that he wouldn't be going as the Head Teacher, being the Designated Safeguarding Lead for the school, would be attending.
- 4.101 Because police were not able to attend the CSE meeting, it is considered that the relevance of the other four boys named by Peter in the overall possible exploitation of Peter was not realised. The four boys named during the CSE meeting were spoken to by the Head Teacher and the police had dealings with only one of these boys
- 4.102 The police did however trace one of the adults that Peter had been contacting, who stated he could not recall Peter personally or their interaction in June 2017. He used 'Grindr' to meet gay men and this was most probably where he had met Peter and exchanged messages. Peter's number was in his phone as 'XnX' and he said that he would have got this from one of his online profiles. It was not established whether he actually had sex with Peter.
- 4.103 The Police IMR Author is content that given the information known at the time of the police involvement there was nothing more that could have been done to improve their dealings with Peter. Their absence from the CSE meeting was unfortunate.

- 4.104 With regard to the actions from the CSE meeting concerning the four boys, CSC opened a Section 47 joint agency investigation on all four boys. One lived in a neighbouring county and was seen with by agencies in that county. With regard to the remaining three boys that resided in Nottinghamshire, they were all seen by social workers and by the Head Teacher. Information gathered by the social workers and the Head Teacher was passed onto the police. The Head Teacher expressed the view that only one of the boys he had spoken to was worthy of further police attention with regard to his knowledge of events. Officers saw this boy and obtained a witness statement from him and a forensic examination of Peter's telephone was conducted as a result. The police were content with the Head Teacher speaking to the boys as he was acting under the provisions of a section 47 joint investigation.
- 4.105 When asked for specific clarification on this matter, Nottinghamshire Police responded:
- By the time the Police became involved the Head Teacher had already spoken to a number of boys. A more accurate observation is that the Police considered the view of the Head Teacher in determining who needed to be spoken to by Police to identify whether any of the boys were victims of crime.
- It is considered this position to be appropriate in the same way that the Police consider the views of social workers in establishing next steps. Had the boys been spoken to by somebody with no grounding in child protection or safeguarding then I would perhaps have a different view but a head teacher (who is also Child Protection lead for the school) does not fall into this category.
- 4.106 In Nottinghamshire the practice of a joint investigation will often involve one agency conducting enquiries and sharing information with other agencies to decide the next steps. However this is a subjective decision and consideration has to be given as to whether the people concerned could be witnesses to criminal activity and if the purpose of the contact by agencies is safeguarding, a trawl for witnesses or both. In an ideal situation police officers should have considered speaking to all four boys.
- 4.107 Immediately after the CSE meeting a Section 47 multi-agency investigation was opened in respect of the other siblings in Peter's family but not Peter.
- 4.108 The man who sent Peter explicit texts in the days before his death was traced by the police and he was interviewed. He admitted using a gay app. on his phone to meet others and that is how he contacted Peter. There was no reason to suspect that he knew Peter's age or identity before the contact. Police were satisfied that their investigation found no evidence that this man posed a risk to children and there was nothing to indicate that he used the app. to specifically seek out children.
- 4.109 There was no sharing of information in 2013 when the CEOP investigation took place. That concentrated on determining if any criminal offences had been committed or whether Peter was being exploited. It did not necessarily consider the wider issues of safeguarding of Peter, his family circumstances and any safeguarding needs of his siblings. That may have uncovered the issues of sexual abuse reported much later by Peter.

### **Recommendation 5**

NSCB to undertake an audit of Child Sexual Exploitation (CSE) meetings.

## British Transport Police response

- 4.110 British Transport Police (BTP) are responsible for policing incidents that occur on Network Rail Property and therefore have primacy when dealing with deaths on railways, be they suicide or other causes of deaths such as criminal actions and accidents.
- 4.111 During the year 2017, nationally, BTP dealt with 23 child fatal incidents. Five were classed as accidents, 11 were recorded as suspected suicides and there were 7 child homicides as a result of the terrorist attack in Manchester.
- 4.112 BTP had no prior contact with Peter before his death on 8<sup>th</sup> June 2017. BTP officers were called to the scene and dealt with the initial investigations as per their policy and procedures. Part of their investigation was to inform Peter's father of his son's death. During that contact the father disclosed allegations of intra-familial abuse that Peter had made to him sometime previous. This information was passed to Nottinghamshire Police.
- 4.113 BTP Suicide Prevention and Mental Health Team supported the father. Due to his understandable reaction to the news of the death of his son, BPT officers from this unit arranged for an ambulance to take him to hospital for a mental health assessment.
- 4.114 Working Together to Safeguard Children 2015<sup>23</sup> chapter 5 deals with the responsibility of each Local Safeguarding Children Board to ensure a review of the death of each child via the Child Death Overview Panel (CDOP) process. The CDOP has a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.
- 4.115 Page 91 Working Together to Safeguard Children illustrates by way of a flow chart the 'Rapid Response' process in the event of a child death. Beside the initial police response to the scene, the guidance requires a police officer to attend at the hospital and liaise with the duty Paediatrician. BTP Officers were in attendance and liaised with the designated nurse for child death that was an acceptable alternative to the Paediatrician.
- 4.116 The flow chart goes on to indicate that there should follow a joint home visit by the police and a designated paediatrician. This emanates from guidance issued in 2016 by Section 5 of the guidance, Sudden Unexpected Death in Infancy and Childhood<sup>24</sup> (SUDIC), which states:

'As soon as possible after the infant's death, the lead health professional (designated paediatrician, specialist nurse or on-call paediatrician) and police investigator, accompanied by the family's GP or health visitor if possible, should visit the family at home or at the site of the infant's collapse or death. The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the infant died, and to provide the family with information and support.'

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<sup>23</sup> Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children March 2015 HM Government

<sup>24</sup> Sudden unexpected death in infancy and childhood - Multi-agency guidelines for care and investigation. The report of a working group convened by The Royal College of Pathologists and endorsed by The Royal College of Paediatrics and Child Health Chair: The Baroness Helena Kennedy QC. Royal College of Paediatrics and Child Health 2016

- 4.117 The officer from BTP that attended the family home was a family liaison/ support officer who stated himself that he was not aware of the rapid response process and he was the wrong officer to attend the home for that purpose as he was there to support the family and not satisfy the requirements of the Helena Kennedy guidance. However the action taken did satisfy the requirement of the BTP guidance 'Fatality Management Policy'<sup>25</sup> regarding interaction with SUDIC and CDOP processes.
- 4.118 The Nottingham University Hospital IMR comments about the Rapid Response process following the death of a child or young person. It states that the Rapid Response was appropriately initiated at the hospital following the death of Peter. In cases where the family do not attend the hospital, the IMR points out that there is no opportunity for a history to be taken by the paediatrician. At this point it is expected that a joint agency discussion will take place to agree the next steps. This would include whether a joint home visit was to be made and who should attend. The IMR states that a joint home visit is useful in order to obtain background information and to explain about the child death review process and identify who is best to support the family. A report of this visit is usually sent to the Coroner and information shared at the initial joint agency meeting.
- 4.119 The Author identifies that a home visit was undertaken by a BTP officer followed by a separate visit by CSC and health, and that the BTP visit had a separate purpose. The IMR concludes that it appeared that the BTP officer had little knowledge of the Child Death Review process. Equally it is identified that neither CSC nor Heath had an understanding of BTP responsibilities in these circumstances. The joint decision making would have been based not only on the circumstances of Peter's death but also taken into account his full social history as it was then known, including his safeguarding and complex social background.
- 4.120 BTP IMR Author states that all officers have training on the requirements of the rapid response guidance and the guidance should have been followed regarding the home visit. This matter has been addressed in the BTP recommendations which require a review of the training to ensure that all officers are reminded of the need to conform to the guidance.

'BTP will refresh and reinforce the guidance set out in the Fatality Management Policy regarding interaction with SUDIC and CDOP processes to relevant staff to ensure that they are fully aware of their responsibilities' and;

'BTP will also review what training is given to officers regarding the specific requirements in child fatalities to ensure that that remains relevant and up to date.'

### **School Nurse 1**

- 4.121 SN1 has subsequently been interviewed by the commissioner of the Healthcare Trust IMR.
- 4.122 The death of Peter had a significant impact on SN1. She openly shared her work with Peter in the period August 2013 – April 2015 and her commitment to supporting him and his family. It was clear from the interview that SN1 worked hard with Peter and his family and was a consistent source of support for them.
- 4.123 SN1 recalled that at the time she faced a number of challenges – including covering a vacant caseload and the competing demands of her role and her own caseload.

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<sup>25</sup> British Transport Police Fatality Management Guidance 2013.

Despite this, she was able to reflect that she was committed to providing a good service to Peter, his family and the school.

- 4.124 SN1 shared her reflections on the issue of the EHAF not being completed. She was open and honest that she could not, from memory, provide a rationale for this. She confirmed that she has confidence in the EHAF as a process and that if she had felt the completion of the EHAF would have made a significant difference in supporting Peter, she would have prioritised this, irrespective of competing demands. However she does not recall this as being the case at any time in her work with Peter.

## **Summary of agency conclusions and recommendations**

### **Children's Social Care**

- 4.125 The conclusions in the Children's Social Care IMR concentrate on the efforts professionals took to encourage Peter to engage and how often his mother declined to allow that until the time of the last referral but by that time Peter was finding it difficult to openly engage with his social worker. He was also angry with school making a referral and was distressed about the amount of information being shared about him.
- 4.126 As stated above, CSC is of the opinion that a Section 47 joint investigation would have been a better way of managing his disclosures.
- 4.127 The CSC IMR makes two recommendations;
- When CSE issues have been identified when working with a young person, discussions should always be held with the chair and the team manager to carefully consider the timing, format and participation in all proposed CSE meetings. When it has been agreed that a CSE meeting should be held then this meeting should take place as early as possible.
  - Written referrals should always be read alongside the information contained within the MASH referral.

### **Nottingham West Clinical Commissioning Group**

- 4.128 The CCG IMR makes one recommendation
- Outcomes of the Practice Untoward Event Analysis will be shared with the CCG Designated Doctor for Safeguarding Children to identify whether further learning can be cascaded to other GP practices across the CCG

and illustrates contact with the GP practice has highlighted some areas of good practice;

- Holding safeguarding reviews regularly enabling peer review of children of concern.
- Learning from previous SCRs: young members of this family were offered appropriate confidential consultation and signposted to local services to suit their needs.
- The identification of a safeguarding lead who can attend learning events.
- The GP recognising that Peter may have underlying emotional needs, signposted him to self-help and on-line resources.
- Offering flexible consultations to vulnerable adults in the family, i.e. Peter's mother and father.

## Nottinghamshire Healthcare NHS Foundation Trust

- 4.129 The IMR from the Healthcare Trust makes an interesting comment about the reasons why Peter declined to engage with services especially around his sexuality and the suggestion that he was being exploited. In March 2015 Peter was in conversation with the School Nurse, with whom he had had significant dealings, but once the conversation erred on the subject of his sexuality he disengaged. Other women that he had dealings with, for example CAMHS etc., were identified as being significantly older than he was, meaning that he may not have been comfortable talking to them about his sexuality and the potential abuse he was suffering. This is somewhat supported by the fact that he spoke openly to the Head of Year about his abusive relationships with men, the alleged intra-familial abuse, his sexuality and concerns over his weight and then his 'man boobs' after losing a great deal of weight.
- 4.130 Conversely, it is suggested that female members of staff may not have felt comfortable talking to Peter about sexual issues and he may have picked up on that and decided not to engage with them. The truth about that area of Peter's life will never be known.
- 4.131 Another useful insight mentioned in the Healthcare Trust IMR is the area which has been identified in previous SCRs, that of confirmatory bias. The IMR considers that it is apparent in this case that professionals were seen to be looking for more comfortable explanations for Peter's presenting behaviours rather than considering child protection concerns. Peter could have spoken for himself in the meetings that were held and the IMR begs the question of, 'Whose needs were being met at the meetings as the voice of the child was not heard?'
- 4.132 The subject of supervision was examined in the Healthcare Trust IMR with a CAMHS professional who was of the view that cases would only be taken to supervision if there were concerns. As Peter's case was not taken to supervision, it has to be assumed that there were no concerns. However, the Author was told that this case would have been discussed at the multi-disciplinary team meeting both before and after seeing Peter and any risks or concerns would have been discussed then. The point is made that has supervision been accessed, and the appropriate supervision was available to be accessed, the case may have been formulated and a plan made around how to minimise the risks involved.
- 4.133 During an interview with School Nurse 2, the IMR author was told that at the time of dealing with Peter, her caseload was very high and a number of staff were off sick. There was a feeling of exhaustion among staff, with management making changes that made the situation worse, and caseload numbers rising. However the IMR indicates that the supervision framework is being embedded in practice across the Trust and staff with supervisory responsibilities are being trained in safeguarding supervision skills, to respond immediately if safeguarding issues are raised within teams.
- 4.134 In addition and in conclusion the Healthcare Trust IMR considers whilst both school nurses worked hard to engage with Peter and to understand the family's individual needs, it is unfortunate that the assessment tools available at the time such as EHAF were not used effectively resulting in plans not being robust enough to prevent significant drift of the case. The new Healthy Family Teams introduced since this case will enable children, young people and families to have their mental health needs addressed more effectively. This, together with the Primary Mental Health Teams, ensures that specialist mental health advice for universal service is now available for the Healthy Family Teams and school and is being offered in consultations on a regular basis.

- 4.135 The 'did not attend' policy has been re-visited and a 'was not brought' policy introduced in its stead. This will include following up those who do not attend for appointments rather than closing the case after so many times of failure.
- 4.136 Since March 2015 and the publication of Future in Mind<sup>26</sup>, CAMHS has attempted to move away from a culture where the responsibility was on families to go to the service and engage with them, to one which is a more community based approach with improved accessibility.
- 4.137 The IMR does however identify good interagency working between the school nursing service and the GP. This ensured that concerns were kept active and agencies were kept up to date.
- 4.138 Following the Coroner's inquest the Healthcare Trust have provided an addendum to their IMR giving additional information and assurances in the following areas:-
- School Nursing Service
  - CSE training
  - Safeguarding supervision
  - 'Think Family'
  - CAMHS, including
    - Assessment of suicide risk and,
    - Discharge arrangements
- 4.139 In particular, in terms of discharge from community CAMHS due to non-engagement, the process in place at the time and which was followed in this case, is that the referrer is notified of the failure to engage and informed that a re-referral can be made. There would be an expectation that, if efforts to engage the young person in CAMHS services have failed, then the referrer should take primary responsibility for trying to facilitate engagement via a re-referral or referring to alternative services.

### **Education**

- 4.140 Peter's school became aware of concerns of Peter's self-harm and suicidal thoughts in September 2015 and the IMR state that the school's response was timely and in accordance with school and NCC guidance and policy. However the Head Teacher's decision to determine Peter as a 'Keep in View' pupil and to remain vigilant for other signs causing concern, would have had more significance if there had been formal opportunities for a review process among teachers which there was not. In view of that the school make two recommendations;
- School should consider ways in which their good pastoral support could be further strengthened by the addition of more formal and recorded 'plan and review' processes for pupils causing high levels of concern.
  - NCC have recently developed and launched a suite of guidance and advice on self-harm and suicide. This school have resolved to make use of this new material in their future training and guidance for staff.
- 4.141 The Education IMR points out that the CSE strategy meeting minutes do not appear to include self-harm and suicide explicitly as current risks and none of the actions in the

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<sup>26</sup> Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing HM Government March 2015

action plan appear to be designed to directly address those risks. Accordingly the following IMR recommendation is made;

- All staff involved in multi-agency planning meetings where self-harm and suicidal ideation are a factor should ensure that the action plan from the meeting takes account of those risks and puts in place actions to mitigate them.

4.142 The Education IMR discusses the schools 'Whole School Policy for Child Protection 2016' which states that recognising signs of sexual abuse can be difficult for any child unless the child disclosed and is believed. This is in reference to Peter being described as labelled as a compulsive liar by a school representative. The IMR author points out that such guidance is not contained in the current 2017 version of the policy;

- School should review its School Policy for Child Protection to ensure through its training and guidance to staff that when a pupil discloses abuse the young person feels that their voice is being heard and take seriously.
- Nottinghamshire County Council should ensure that their 'School Child Protection Policy' template provides similar advice.

4.143 The IMR comments about the wisdom of the Head Teacher interviewing the four boys named in the CSE Strategy meeting against the school's 2017 Child Protection Policy;

- School should ensure through its training and guidance to staff, that staff understand, in line with the school's updated policy that it is not the role of staff to investigate disclosures by interviewing the child or others involved, unless asked to do so by Police, CSC or the NSPCC.

4.144 In line with this recommendation from Education, the Overview Author considers that there is a role for NSCB:

#### **Recommendation 6**

NSCB should ensure through its training and guidance to staff, that staff understand, in line with the school's updated policy that it is not the role of staff to investigate disclosures by interviewing the child or others involved, unless asked to do so by police, CSC or NSPCC.

4.145 Regarding the attendance of the relevant member of staff to the CSE Strategy meeting, the IMR makes this recommendation;

- In complex cases (such as this) senior designated person for safeguarding and the teacher who knows the child best, or who hear the original disclosures, should attend multi-agency meetings.

4.146 Finally, the IMR discusses how Peter 'froze out' the Head of Year after it was determined that details of the disclosure would be shared. This left Peter isolated and without his trusted point of support. The IMR makes the following recommendation;

- Nottinghamshire County Council should review guidance to all staff regarding support for children and young people following a disclosure. If the disclosure leads to a breaking of important sources of support (either because the young person chooses to do so, or because of a

subsequent move) there should be careful planning to ensure that a new supportive framework is created for the young person.

## 5. Conclusions

- 5.1 The reason why Peter came to the decision to end his life in the way he did and at the particular time he did is not known. As a result, whilst this review has identified learning for agencies, it is not possible to say that had agencies done things differently Peter would not have taken his own life.
- 5.2 There is substantial evidence to show that Peter and his mother received significant agency support from May 2014 onwards when agencies were first made aware of the suicide note that he had written approximately one month earlier.
- 5.3 There were two School Nurses involved with Peter. With the first, SN1, Peter built a long and trusted relationship. SN1 also had a good relationship with Peter's mother meeting her on a number of occasions to discuss her concerns about Peter and considerable personal support was offered. H.M. Assistant Coroner for Nottinghamshire comments during her determination:
- 'It is clear that [School Nurse 1] tried hard to support [mother] with both children'.
- 5.4 There is also evidence to suggest that there was a good working relationship between both School Nurses and the school as well as the family GP. Information was shared by the School Nurses and Peter was flagged at the GP surgery for their monthly 'Red Card' meetings. However, when SN1 left and SN2 took over, the relationship between SN2 and Peter broke down despite best efforts of SN2 to maintain the relationship at the level SN1 had been able to do. When Peter did not engage with SN2, she made an appropriate referral to CAMHS and advised the school to put measures in place to provide pastoral support for Peter. School followed this advice in the form of the Head of Year teacher with whom Peter established a good relationship for a considerable amount of time.
- 5.5 The option of referring Peter to CAMHS was first mentioned in May 2014, but there was a delay in making the referral and he was finally seen by CAMHS in September 2015. After only one appointment, with the assessment being only half completed, both mother and Peter disengaged and CAMHS discharged him from the service. CAMHS procedures have since been changed where monthly liaison meetings are held between school and CAMHS, where concerns about children are discussed and reviewed regularly and Healthy Family Teams now provide specialist mental health advice.
- 5.6 In 2015 when Peter was reported as missing from home, school, social care and the police had numerous contacts with him and offered support in doing so. Agencies worked hard to engage with Peter and his mother, sometimes that support was accepted but on other occasions neither Peter nor his mother engaged with agencies.
- 5.7 There were two reports made when Peter went missing. The police dealt with those incidents appropriately and speedily. They shared information with CSC and the follow up by CSC was timely and in line with inter-agency procedures. During the first 'missing from home' return interview a Family Service worker was able to spend time with Peter and he established a good rapport. Attempts by the same worker to conduct the second return interview did not succeed as the mother declined to consent to the interview taking place. The Review considered whether there was sufficient

information for the Family Service worker to lawfully override the wishes of Peter's mother and concluded there were not at that time.

- 5.8 Examining the early support Peter was offered, the Review concluded that the use of an EHAF may have helped professionals working with Peter obtain a fuller understanding of the issues impacting on him and his family. It is disappointing that no professional working with Peter took responsibility for completing the Early Help Assessment which may have led to improved identification and coordination of services required to address his needs.
- 5.9 Peter found a great deal of stability at school, he made satisfactory educational progress and was expected to pass his GCSEs with good grades. His attitude to learning improved as he grew older and this is reflected in the letter he wrote applying to be a school prefect which is referred to earlier in this report.. He lost weight, improved his appearance, and took pride in the way he looked and presented himself. He had good support at school and school was a positive influence in his life. He took an examination at school on the morning of his death. He had good relationships with staff at school, mainly with the Head of Year teacher with whom he formed a bond. Peter trusted the Head of Year however when he told the Head Teacher the details of Peter's disclosures Peter felt that trust had been breached.
- 5.10 The Head of Year made the correct decision by reporting Peter's disclosure in April 2017. Peter had disclosed information in relation to child sexual exploitation and alleged intra-familial abuse which suggested he was likely to suffer significant harm. School were well aware of his history of other concerns in relation to self-harm, suicidal ideation, extreme weight loss, OCD tendencies and poor self-image. The Head of Year would have been in contravention of guidance and procedures if he had not done so. It is unfortunate that this caused a breakdown in the relationship between Peter and the Head of Year. What Peter saw as a breach of confidentiality was the Head of Year acting with his best interests at heart and complying fully with the Nottinghamshire Safeguarding Children Board inter-agency procedures.
- 5.11 Following Peter's disclosure the Head of Year made a detailed written record of what had been said. This is good practice and in line with procedures. He correctly reported the disclosure to the Head Teacher. The Head Teacher re-interviewed Peter which was unnecessary and not good practice, as the full disclosure had been obtained by the Head of Year; a referral to statutory agencies via MASH was the next step to take.
- 5.12 The Head Teacher delegated the Deputy Head Teacher to make the MASH referral, which initially was by telephone. It mentioned that Peter had disclosed behaviour described as 'prostitution with older men' and it was clear from the call made that the school recognised this as a serious safeguarding issue. The details were recorded by the MASH Officer and a written referral was requested which was submitted the next working day by the Deputy Head Teacher.
- 5.13 The written referral contained additional information not passed to the MASH Officer as part of the telephone referral. It contained detailed information taken from the Head of Years notes of the disclosure made by Peter. It included further information in relation to 'male prostitution' and the names of four other boys who may have been able to provide additional information and/ or who may themselves have been at risk from CSE. The written referral also contained information about alleged intra-familial abuse not provided in the telephone referral. It is regrettable that MASH did not consider the information in the written referral as part of its decision making and the Social Worker allocated to the enquiry based his investigations on the information contained in the verbal referral and missed the additional information provided in the written one. This

error was not picked up until the CSE meeting seven weeks after the initial referral. It is accepted that this was an individual error rather than a systems failure.

- 5.14 The MASH referral eventually led to a CSE meeting, held on 7<sup>th</sup> June 2017. Several agencies could not attend for a variety of reasons meaning that the meeting was less effective. Given the serious disclosures made by Peter the MASH referral should have led to a more timely multi-agency response. Due to the lack of attendees, roles, responsibilities and actions that followed were less clear. Plans for communicating with Peter could have been more explicit. Communication was via mother and head teacher but was not part of a considered and agreed plan devised in the child's best interests. H.M. Assistant Coroner commented in her determination:

'I find that the guidance was not followed in respect of Peter. The outcomes from the CSE meeting should have been carefully and sensitively shared with him, with thought given as to how the impact on Peter, of these, such difficult issues, could be minimised. There was no consideration given as to who might share the outcomes with him, and how this might be done. I find, and the safeguarding Board accept, that this should have been the social worker, likely with a parent present and this should have been done immediately after the meeting on 7<sup>th</sup> June 17'.

- 5.15 The information about alleged familial abuse was missed by the Social Worker and also the Team manager in the MASH. The delay in holding the CSE meeting was because a decision was made to complete a Child and Family Assessment before completing the CSE risk assessment tool which triggered the CSE meeting. It may have been better practice to have completed the CSE risk assessment tool based on the information known at the time of referral. This would have indicated a CSE meeting was necessary and so avoided some of the delay.
- 5.16 With the benefit of hindsight it may be viewed that Peter's disclosure to the Head of Year of child sexual exploitation was a sign that he wanted to talk to somebody about what was happening to him but had not thought through what should happen next. Once he was informed by the Head of Year that the information had to be shared his immediate retraction was an indication that he was not happy with others being involved. His disclosure led to a number of consequences, which appeared to be both unforeseen and unwanted by him. This included questions being asked of him and his peers and a course of action culminating in the CSE meeting. It illustrates a potential conflict between our statutory duty to protect children and the need to take into account the child/young person's wishes and feelings. It may be that Peter felt he had lost control of events and this was troubling him.
- 5.17 The information known through the disclosure by Peter and other indicators of sexual exploitation was such that a multi-agency response was required and the CSE meeting was an appropriate means of coordinating those efforts. It was also good practice to invite the family and young person to be part of the work to reduce the risks to Peter. It is important to acknowledge the difficulties and sensitivities involved and how best to engage with young people at risk of sexual exploitation. An individual response focused on the specific needs and circumstances of the child/young person is needed.
- 5.18 Peter displayed a number of risk factors for self-harm and suicide and considerable efforts were made to provide support to him in a number of ways. Unfortunately the level of engagement with Peter that practitioners were able to achieve did not allow for these risks to be fully assessed. HM Assistant Coroner concluded that even those who knew him very well, particularly his parents, could not have predicted what he would do and observed that - 'what is not predictable is not preventable'.

## Recommendations

### Recommendation 1

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NSCB to promote the increased use of the EHAF by agencies and explore the barriers which prevent professionals from completing them.

### Recommendation 2

Page 36

NSCB needs assurance from MASH that written referrals are being used and that they add value to the process

### Recommendation 3

Page 38

NSCB to review the interagency CSE procedures to ensure that when there are sufficient concerns to support a section 47 enquiry that the appropriate multi-agency response is triggered.

### Recommendation 4

Page 38

NSCB to disseminate the learning from this review.

### Recommendation 5

Page 41

NSCB to undertake an audit of Child Sexual Exploitation (CSE) meetings.

### Recommendation 6

Page 47

NSCB should ensure through its training and guidance to staff, that staff understand, in line with the school's updated policy that it is not the role of staff to investigate disclosures by interviewing the child or others involved, unless asked to do so by police, CSC or NSPCC.

### Learning Point

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Professionals are reminded for the need to make notes of disclosures made by children as soon as possible after the conversation and the conversation must not include leading questions. The notes must be suitable for disclosure to any future enquiry or investigation.

## Bibliography

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**Pathway to Provision Multi-Agency Thresholds Guidance for Nottinghamshire Children's Services** Version7 February 2018

**Sudden unexpected death in infancy and childhood - Multi-agency guidelines for care and investigation.** The Royal College of Pathologists and endorsed by The Royal College of Paediatrics and Child Health Chair: The Baroness Helena Kennedy QC. Royal College of Paediatrics and Child Health 2016

**Fatality Management Guidance** British Transport Police 2013.

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### Scope and Terms of Reference

#### Decision to hold a SCR

##### Background

Towards the end of April 17 Nottinghamshire Children's Social Care (CSC) received a referral from school which raised concerns in relation to Peter being a victim of child sexual exploitation (CSE) and historical sexual abuse by a family member.

Given the nature of the concerns a CSE Risk Assessment was undertaken and completed at the end of May 17 which concluded that Peter was a "high risk". This led to a CSE Meeting being convened during the first week in June 17 and an action plan being devised. Both parents attended the CSE Meeting but Peter declined the invitation.

During the CSE meeting it became apparent that the disclosure in relation to sexual abuse by the family member had not been picked up from the initial referral.

In addition to providing further information in relation to the CSE the meeting also established that there were a number of other concerns in relation to Peter including incidents of self-harm, suicidal ideation, excessive alcohol consumption, issues regarding his sexual identity, a potential eating disorder OCD traits and general concerns around his emotional well-being.

Following the CSE Meeting Peter's mother informed him that he was on a curfew and that if he was not home by 10.00pm then she would be reporting him to the police (this was an action for mother from the CSE meeting). That evening Peter did not go out as he was reported to be revising for an exam the following day.

The following morning mother briefly saw Peter as he left for school. Between 11.30am - 12.00pm he returned home after his exam and briefly spoke to his older half-sibling to say that he thought his exam went well. He then left the property and called his father at approximately 12.30pm. It is known Peter exchanged sexually explicit text messages with a person not yet identified.

At 3.18pm that day there was a report to the transport police that a person had been hit on the local train line. Peter was reported missing at 10.00pm that evening. British Transport Police investigated the death and linked Peter's missing report to the person who had walked in front of the train earlier in the day. Peter was subsequently positively identified through DNA.

## **Decision making process**

This case was considered by the SIR sub group on 13<sup>th</sup> September 2017 when a decision was made to recommend a SCR be carried out. A summary of the recommendation was passed to the independent chair of Nottinghamshire Safeguarding Children Board and on 18<sup>th</sup> September the Chair confirmed his decision to carry out a SCR. On 25<sup>th</sup> September 2017 Ofsted and the National Panel of Independent Experts were notified of this decision.

The review will be conducted in line with the principles set out in Working Together 2015 and NSCB/NCSCB Interagency Procedures to safeguard Children.

## **Period to be covered by the review**

### **Chronology**

Agencies will be required to provide a chronology of their involvement with the subjects of the review from 1<sup>st</sup> May 2014, the month when the first indication of suicidal ideation was brought to the attention of professionals, until the date of the child death Initial Case Discussion meeting on 12<sup>th</sup> June 2017.

Chronologies must use the Chronology template. The chronology should cover only the period identified within the scope of the review. Only **relevant and significant** information which was known to the agency **at the time** should be included.

### **Individual Management Reviews**

In addition to providing a detailed narrative and analysis of events during the scope period detailed above, Individual Management Reviews should provide a summary of any relevant information prior to this period which may help assist in understanding subsequent events and be relevant to the key issues for the review.

Details of immediate actions following the incident to safeguard Peter's siblings and other children considered at risk of Child Sexual Exploitation should also be included within the agency report in summary form. Include in this section a summary of how the death of Peter impacted on the response to CSE.

Individual Management Reviews may be subject of requests for disclosure by other parallel processes e.g. Coroner, Criminal etc.

## **Focus / key issues for the review**

### **All agencies**

IMR authors are required to produce an IMR on the template provided which will address the key issues listed below. Examine and analyse the response of **your organisation** to the following issues in accordance with individual agency and multi-agency safeguarding procedures.

1. Consider the response to any known reports and concerns in relation to sexual abuse and child sexual exploitation.
2. Examine how your organisation identified and responded to any known concerns around suicidal ideation and self-harm.
3. Explore your organisations engagement with Peter and his family and consider its response to any known reluctance to work with services.
4. Did your organisation identify issues around parental mental health, alcohol and substance misuse and if so how did it assess the impact on the children within the family and respond to any risks identified.
5. Did agencies hear the voice of the child and was it acted upon by agencies working with the family? If not, what were the barriers to them doing so?
6. Were there any racial, cultural, linguistic, faith, disability, or sexual identity issues that needed to be taken into account in the assessment and provision of services? How were these issues managed by each agency?
7. Did professionals working with the family receive appropriate supervision and support? Was there appropriate management oversight in this case?
8. Were there issues in relation to capacity or resources in any agency that impacted on the provision of services?

(It is particularly important to identify any actions that could have led to a different outcome for the children).

### **Police only (in addition to the above)**

1. Examine the response to the referral from CEOP in November 2013

## **Methodology for the Review**

Working Together to Safeguard Children 2015 (WT2015) allows local safeguarding children Boards flexibility around the methodology to be adopted for serious case reviews. This review will adhere to the principles laid out in WT2015 and the NSCB local procedures.

In view of the period of time covered by this review it is proposed that the methodology to be adopted for this review is as follows: -

- Briefing event for authors. Commissioners will also be invited to attend the briefing event should they be available to do so.
- Chronologies will be prepared by agencies on the approved template and integrated.
- Individual Management Reviews/Information Reports as appropriate.
- Involvement of practitioners in the review will be via IMR authors. Should the Lead Reviewer consider further contact with practitioners is desirable this will be considered by the SCR Panel at that point
- SCR Panel meetings, as required, to consider the IMRs and the SCR report.
- SCR Panel meeting to agree the learning from the review and the appropriate response.
- Extraordinary meeting of the NSCB to sign off the SCR report.

## **Interviewing of staff**

Agencies should seek to immediately identify staff they would wish to interview as part of completion of their Individual Management Review. The Police have indicated that there is no barrier to staff being interviewed.

## **Involvement of Family**

Peter's mother and father are separated and each was notified of the review by letter on 10th October 2017. The Lead Reviewer and the NSCB Development Manager will consider how Mother and Father can best be supported to contribute to the review in order to gain an understanding of any learning they can provide.

Consideration will be given by the SCR panel as to how engagement with the siblings in the review process will be managed.

A further meeting/communication will be undertaken prior to publication to share the learning with the family.

### **Expert opinion**

The Panel will explore whether additional expert involvement in the area of self-harm and suicide in young people would aid the review.

### **Other parallel reviews**

A Coroner will hold an inquest into Peter's death. NSCB are not aware of any other reviews in connection with this death.

### **Organisations to be involved in the SCR**

The following organisations are required to provide chronologies and individual management reviews.

- Nottinghamshire Healthcare NHS Foundation Trust (school nurse, adult mental health, CAMHS)
- Nottingham West Clinical Commissioning Group (GP contracted services)
- Nottinghamshire Police
- NCC Children's Social Care
- NCC Education

The following organisation is required to provide an information report only

- CAFCASS
- Nottingham University Hospitals NHS Trust
- NCC Adult Social Care
- British Transport Police (BTP)
- East Midlands Ambulance Service (EMAS)

Peter's School will be invited to nominate a suitable senior member of staff to sit on the SCR Panel.

### **Involvement of agencies in other LSCB areas**

There are no agencies from other LSCB areas required to take part in this review. The NSCB Development Manager will link in with Nottingham City Safeguarding Children Board to ensure any cross authority issues are identified.

### **Coroner's inquiries / criminal investigations**

The death is scheduled for inquest in Nottingham Coroner's Court. The Assistant Coroner has indicated that the inquest will take place after the serious case review is completed. The NSCB Development Manager will be responsible for liaison with the Coroner. The Coroner has been notified that a serious case review is being undertaken.

### **Media coverage**

There has been some local media coverage of this incident. The media have not been notified of the decision by NSCB to carry out a serious case review in this case. Should agencies become aware of any media interest they are to notify the NSCB Development Manager. All media enquiries should be directed to the Nottinghamshire County Council (NCC) Communications Department.

### **Legal advice**

There is no requirement for independent legal advice at this stage however should this become necessary it will be provided by the NCC Legal Department.

### **SCR timescales**

The target date for completion is 6 months from the decision of the independent Chair to carry out this Serious Case Review which is 18<sup>th</sup> March 2018.

### **Commissioning of an Independent Author and Independent chair for the SCR**

In accordance with Working Together 2015 an independent person will be appointed to lead the review and author the overview report. A suitable chair will be appointed to manage the SCR panel meetings.

### **Implementation of IMR recommendations and feedback to staff**

Agencies which are required to produce IMRs will be responsible for producing internal recommendations to improve practice and for the implementation of associated action plans. Agencies should not wait until the end of the review process to implement any learning identified. Agencies are required to provide feedback to their own staff who were involved in the review.

Agencies are required to disseminate any learning that is specific to their organisation and the NSCB will facilitate the dissemination of any broader multi-agency learning through the NSCB Learning and Improvement Framework.

### **Liaison with Ofsted and DfE**

Liaison with Ofsted and the DfE will be the responsibility of the NSCB Development Manager

### Individual Management Reviews Recommendations

#### Nottingham West Clinical Commissioning Group

1. Outcomes of the Practice Untoward Event Analysis will be shared with the CCG Designated Doctor for Safeguarding Children to identify whether further learning can be cascaded to other GP practices across the CCG

#### Children's Social Care

1. Child Sexual Exploitation meetings to be held as early as possible.
2. Written referrals should always be read alongside the information contained within the MASH referral.

#### British Transport Police

1. British Transport Police will refresh and reinforce guidance set out in the Fatality Management Policy regarding interaction with SUDUIC and CDOP processes to relevant staff to ensure that they are fully aware of their responsibilities.
2. British Transport Police will review what training is given to officers regarding the specific requirements in child fatalities to ensure that it remains relevant and up to date.

#### Education

1. [The School] will consider ways in which their good pastoral support could be further strengthened by the addition of more formal and recorded 'plan and review' processes for pupils causing high levels of concern.
2. NCC have recently developed and launched a suite of guidance and advice on self-harm and suicide. [The School] will make use of this new material in their future training and guidance for staff.
3. All staff involved in multi-agency planning meetings where self-harm and suicidal ideation are a factor should ensure that the action plan from the meeting takes account of those risks and puts in place actions to mitigate them.
4. a) [The School] should review its School Policy for Child Protection to ensure through its training and guidance to staff that when a pupil discloses abuse the young person feels that their voice has been heard and taken seriously.  
b) Nottinghamshire County Council should ensure that their 'school child protection policy template' provides similar advice.
5. [The School] should ensure through its training and guidance to staff that staff understand, in line with the school's updated policy, that it is not the role of staff to investigate disclosures by interviewing the child or others involved, unless asked to do so by Police, CSC or NSPCC.

6. In complex cases such as this the school should consider sending both the senior designated person for safeguarding and the teacher who knows the child best, or who heard the original disclosures, to initial multi-agency meetings.
7. Nottinghamshire County Council should review guidance to all staff regarding support for children and young people following a disclosure. If the disclosure leads to the breaking of important sources of support (either because the young person chooses to do so, or because of a subsequent move) there should be careful planning to ensure that a new supportive framework is created for the young person.