Luton Safeguarding Children/Adult Board

Report of the Serious Case Review Regarding Child Hasan, Sibling Jila and Sibling Rahima.

(all the names have been changed to protect confidentiality**)**

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1. Introduction

1.1 Why this case was chosen to be reviewed?

This Serious Case Review was commissioned by Luton Safeguarding Children Board (LSCB) in conjunction with Luton Safeguarding Adults Board in respect of Hasan and his two elder sisters Jila and Rahima.

Hasan was 16 at the time of his death, he committed suicide at home. The Police investigation undertaken on behalf of the Coroner concluded that there were no suspicious circumstances and Hasan had taken his own life. At the inquest, HM Coroner gave Hasan's cause of death as 'suicide'.

This report considers the services provided to Hasan and his siblings from November 1994 until his sad death in the summer of 2000[1], including any relevant background history prior to this date.

Hasan had two elder siblings who were adults at the time of his death. Both sisters had a history of domestic violence, relationship difficulties, mental health problems, self-harm and reported Honour Based Violence[2]. As determined by the combined chronology, all three siblings had experienced adverse childhood experiences, complex and abusive family relationships, and the two sisters had problematic and difficult transitions into adulthood.

The (LSCB) considered carefully the circumstances surrounding Hasan's death and concluded that the case met the statutory criteria in place at the time, for a Serious Case Review. In that, under the Local Safeguarding Children Board Regulations 2006, for the purposes of Regulation 5(1) e under Regulation 5(2):

(a) abuse or neglect of a child is known or suspected; and
(b) the child has died.

Information that came to light regarding Hasan's siblings led the Luton Safeguarding Adults Review Group to consider whether the case met the Care Act Criteria for an Adult Safeguarding Review. This provides that the Board must arrange a Safeguarding Adults Review (SAR), in line with Section 44 of the Care Act 2014 where:

The Board has "*reasonable concern*" about how Luton Safeguarding Adults Board (LSAB) members worked together to safeguard the adult at risk and/or; the adult has died because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The LSAB concluded that the criteria had been met for an Adult Serious Case Review.

The joint Independent Chair of LSCB and LSAB, endorsed the decision to conduct a Serious Case Review in accordance with the above regulations and statutory guidance provided by Working Together to Safeguard Children

[1] All names and dates have been changed to maintain confidentiality
[2] Honour Based Violence is a collective of practices used to control behaviour within families in order to protect perceived cultural and religious beliefs and/or honour.

2015, and agreed that the criteria had been met for a joint adult and child review which would include the two vulnerable adults -Jila and Rahima.

1.2 Succinct summary of case.

The focus of this review concerns responses by service providers to Hasan, his two older female siblings Jila and Rahima, and both his parents. Hasan came to the attention of support staff in school because of his presentation of anger. The school reports that he was engaged in 'some minor contact with gangs', was emotionally vulnerable, he was not academic, found school work difficult and studying a challenge. He was also reported to be concerned about his father's response if he did not 'do well' in his exams.

The family are of South Asian background and their migration history is not known to services in Luton. The family background, culture and the response of agencies to their cultural context is a key feature of this review. This key finding highlights that potentially the professional's understanding and expectations of culture informed their service responses and therefore any improvements in professional's understanding of culture is likely to improve practice with diverse families.

All three siblings were known to services from hospital, education, GP, police, mental health services and to a lesser extent there was some contact with adult and children's social care. Hasan attended school in a different Local Authority Area. This added to the complexity of this case in that there are different practices in each Local Authority Area. Sharing of information and intelligence across different Local Authority Areas is sometimes difficult as is presentation at MARAC. It is also the case that no-one agency carried out on going safeguarding intervention with any of the three siblings.

1.3 Family composition.

Anonymised Name	**Relationship to subject (if applicable)**	**Ethnicity.**	**Age at time of SCR/SAR referral**
Hasan	Subject	Asian – Bangladesh	16
Jila	Subject	Asian – Bangladesh	21
Rahima	Subject	Asian – Bangladesh	19
Father	Father	Asian – Bangladesh	47
Mother	Mother	Asian – Bangladesh	40

1.4 Time frame.

The time frame for the review was from when Hasan was 11years old till his death. Agencies completed Independent Management Reviews and provided chronologies. They were asked to consider any significant events relating to all three siblings prior to 2011.

1.5 Organisational learning and improvement.

Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice.

LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'. [3]

The LSCB identified that this serious case review had similarities with some previous reviews, and reviews conducted concurrently to this review. There are some parallels to the SCR - Child J Serious Case Review (2017) in respect of information sharing.

In considering what happened to Hasan, Jila and Rahima, the LSCB, LSAB and lead reviewer agreed that the following areas should be considered in this review:

- Analyse the communication, procedures and discussions which took place within and between agencies to safeguard the three siblings.
- Analyse the co-operation between different agencies involved with Hasan, Jila and Rahima (and wider family).
- Analyse the opportunity for agencies to identify and assess risk of suicide.
- Analyse agency responses to any identification of suicides amongst Muslim young men.
- Analyse organisations' access to specialist services for young men (and especially from Muslim faith).
- Analyse policies, procedures and training available to the agencies involved in suicides amongst young men (and especially from Muslim faith).
- What are the key areas of learning in work with young people including young adults' suicidal ideation and self-harm?
- What changes have taken place in response to incidents of domestic violence and support to victims, including honour based violence?
- What work has been carried out in working with perpetrators of domestic violence to disrupt their activities?
- How has practice changed in implementation of Luton LSCB threshold document for children, and what practice changes have taken place in adult safeguarding?
- How does what happened to Hasan, Jila and Rahima, give us a mirror into understanding work carried out by professionals with South Asian families?

[3] Working Together 2015, 4:7 http://www.workingtogetheronline.co.uk/chapters/chapter_four.html

2. Methodology

Statutory guidance requires SCRs to be conducted in such a way which:

- 'recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- makes use of relevant research and case evidence to inform the findings'[4].

2.1 Reviewing expertise and independence

This review has been led by Kanchan Jadeja Managing Director of Spiritus Safeguarding and Reena Bali an independent safeguarding consultant with extensive experience of Serious Case Reviews in local, regional and national context. The Lead Reviewer has had no previous or direct involvement with the case under review. Reena Bali is a freelance consultant in education and safeguarding and also works for the NSPCC school service.

2.2 Acronyms used and terminology

Statutory guidance requires that SCR reports: '*be written in plain English and in a manner that can be easily understood by professionals and the public alike*'[5]. Writing any Serious Case Review poses a challenge and the language used can be specialist and complicated. To ensure the widest access to this review, a section with an explanation on the language used in safeguarding children and adults is in the Appendix.

2.3 Methodological comment and limitations

The methodology employed in carrying out this review has been based primarily on the professional participation and their perspectives about what happened and why? Records held in the respective agencies engaged with the siblings, were reviewed and critically assessed by professionals themselves providing Independent Management Reviews of their involvement. However, it is important to note that no-one agency working within safeguarding had on going involvement with any of the three siblings. Involvement was episodic with the school as they were the only consistent and universal service and made provision for Hasan in response to his behavioural challenges and anger management.

The lead reviewer has therefore formatted the report to reflect the information provided by agencies in the key practice episodes, and analysed

[4] WT 2015, 4:11http://www.workingtogetheronline.co.uk/chapters/chapter_four.html
[5] Local Safeguarding Children Board Serious Case Reviews and Individual Management Reviews. Home Office.

the results based on the information provided and based on very helpful discussions with key professionals involved with the three siblings.

2.4 Participation of professionals

The lead reviewer is grateful to all professionals involved in this case. They have been impressive in their engagement, and have been open, transparent and rigorous in their evaluation of their own practice. They have contributed to the review positively, and their willingness to reflect upon and challenge their work has been invaluable in this case.

2.5 Comment on Participation of family U

It has not been possible to involve Jila, Rahima or Hasan's parents in this review. The Lead Reviewer was informed by the professional who knew them well that they are too distressed to explore what happened to their son and brother, to contribute to this review. Contact was made with the family through a letter. As there was no response, their decision not to participate was respected and no further contact was made with them to engage them in this review.

3. Practice Episodes

The complexity about '*what happened to the three siblings'* is set out in six 'key episodes' below. The time frame for the key practice episodes is from 1996 -2000.

- The first key episode is period 1996-1997. In this episode Jila experienced domestic violence, assaults, had missing episodes and was stalked. This key episode sets out the abuse she experienced and her response to abuse, including suicide ideation.

- The second key episode relates primarily to Hasan – covering the period between 1997-1998. He has behavioural difficulties at school, presentation of peer violence and some concerns were raised about minor gang involvement and drug misuse.

- The third key episode is the period between February 1999 to September 1999, and relates to Jila and Rahima, both of whom experienced domestic violence, honour based violence, took multiple overdoses and had trauma of unwanted pregnancies. In this eight month period, there were numerous incidents of concern for all three siblings.

- The fourth key episode is the period between September 1999 and October 1999, and relates primarily to Hasan. He is assaulted at school and there is an allegation of sexual assault against him.

- The fifth key episode relates to the period between October 1999 – February 2000. This episode relates primarily to Jila, who experienced domestic violence, trauma as a result of unwanted pregnancy, and accounts for the fifth recorded overdose within the family.

- The sixth key episode relates to the period between May 2000 and September 2000, and to the death of Hasan from suicide. There is also suicide ideation presentation in both of his siblings Jila and Rahima. This final episode highlights the prevalence of suicide attempts within the family. The key practice episodes are detailed, but provide critically relevant information about what happened to all three siblings in this case.

3.1 Period 1: 1996 to 1997

Jila: Evidence of Domestic Abuse, Stalking, Assault, Missing Episodes.

Period	Key Information	Comment
11/03/96	**Jila** Aged 17 disclosed physical abuse from a boyfriend who tried to break her arm the previous week. She was assaulted by her father physically a few months ago, she had '*run away'* for two days.	**Management Systems** A referral was made by Education Services to Children Services. The 16+ Team was contacted, and advice given to her mother and school to report Jila as a missing person. This is an inappropriate response, because age should not be a barrier to safeguarding responses - that is the referral could have been progressed to S47 and single assessment.
24/03/96	**Jila** Police were called regarding a Stalking Offence involving Jila (aged 17) and her former boyfriend. Following the break-up, she has been followed, and threats made to send pictures of them together to her parents.	**Policy, Procedures and Practice** This incident demonstrates good practice, the former boyfriend was arrested and a referral was made to MARAC, In addition, a Stalking, Assault and restraining order was made to protect her.
23/10/96	**Jila** Jila, (aged 18), and her then boyfriend, were assaulted by her cousin. She reported to the Police, both declined to make a complaint. On 27/10/96 Jila said she wanted to make a complaint. Her cousin was arrested and interviewed but not for two months, there is no explanation for this.	**Management Systems** Further work is required to understand the reason for this delay and whether this is an isolated delay or system wide. Jila did not attend court, it is not clear whether she was supported, to attend court. Currently Police report that all victims are offered support by the witness care and witness support. The delay in arresting Jila's cousin for the offence was due to not being able to find them, numerous addresses where checked with no success and then we finally caught up with him, The reason for Jila not attending is not given however the statistics currently from HMICTS shows that a vast amount of witnesses and victims fail to attend court, this is an area of concern and requires further consideration by police and victim support organisations.
06/02/97	**Jila** Jila aged 18 left the family home at 4:00 am and was reported missing to Police by her father. The Police deemed her to be a medium risk. The Police commenced missing person enquiry and found a note to her then boyfriend that she was going to commit suicide. Consequently, the risk was upgraded to high. She returned home. A referral was made to Social Services by police.	**Management Systems** A SOVA referral was submitted on the 6th Feb 1997 for support to be provided to Jila and the family.
13/02/97	**Jila** A referral was received by Children's Social Care Beds regarding the above incident. She returned home the next day. It was agreed that a Return Home Interview was required but there is no record of it being undertaken.	**Management Systems** This highlights the importance of return interviews in providing information about Hasan's voice and lived experience about 'the why' in their actions. It is unclear whether this is systemic or whether return interviews are carried out consistently following missing episodes.
05/03/97	**Jila and Rahima** Two '999' calls were received from a distressed female. The Police attended and recorded that a non-crime domestic incident had occurred between Jila (aged 18) and Rahima (aged 16). Both had left the home before police arrival. Jila was recorded as the victim and Rahima was the suspect in the incident. Jila advised that she was receiving regular counselling. The Police were aware of previous incidents at the home address. Jila was not spoken to until 09/03/97 and	**Management Systems** It is not clear why there was this delay. A DASH assessment was completed for Jila as 'low risk'. The Domestic Abuse Incident Support Unit tried to contact Jila by telephone but none of the calls were answered. Police spoke to the mother when visiting the family home. This is confusing because in other records from police, there is an indication that mother does not speak English.

Period	Key Information	Comment
	Jila and Rahima Rahima was not spoken to at all.	**Management Systems** Further review of police records indicate that this incident was not on the crime report or the notes made by the officer that they tried to speak to the mother of the Jila or Rahima. The record indicates that at 1152 hours, the officers attended the address the suspect had left the location.
13/03/97	**Rahima** The Police referred Rahima to the Children's Social Care who sent a letter of advice to the family.	**Management Systems** There is no indication whether there was triangulation of the information and if lateral checks were made with other agencies such as the GP. Police IMR appropriately highlights the importance of having a discussion with Rahima, but this did not happen.
20/05/97	**Jila** Jila (aged 19) contacted the Police regarding threats made by the cousin who assaulted her on 23/10/96. The case went to court but dismissed due to Jila not attending court on the correct day as she mixed up the court dates. These threats were made through other family members and relayed to her by her mother. The Police interviewed her on 21/05/1997 and arrested her cousin on 25/05/1997. The incident was reviewed and deemed as non-crime, it was a one-off incident and the threats were made through a third party. The threat from this cousin was a one off incident.	**Management Systems** It is not known how Witness Support engaged with her to support and potentially secure her attendance. However, there was also no DASH completed or consideration of support from services such Victim Support or domestic abuse services. Although the cousin was arrested and interviewed there was no apparent consideration of any cultural issues within this incident such as Honour Based Violence.

3.2 Period 2: 1997 to 1998

Hasan: Incidents of violence in School, Gang & Drug Concerns.

Period	Key Information	Comment
04/09/97	**Hasan** Hasan aged 13 moved to a new school into year 9. In line with expectations, documents were transferred from the previous school including an Individual Education Plan dated 1996. The transfer was due to his previous school closing due to falling numbers as well as a 'Requires Improvement' Ofsted inspection outcome. Hasan was noted as '*high probability of having dyslexia'* (2013).	**Management Systems** It is unclear as to whether there was any formal assessment, or any other needs considered at that time. There were no safeguarding concerns transferred from either school in relation to Hasan suggesting that none had been identified despite there being known relationship issues within the family.
01/12/97	**Hasan** Hasan aged 14 received a fixed term exclusion from school due to persistent disruptive behaviour in class. A pastoral support programme put in place following return to school. At this time, the school had been placed in '*Special Measures'*.	**Management Systems** There was a failure in the system to follow through the educational and emotional needs. Later, it was found that his additional needs were not assessed. This was a missed opportunity.
03/02/98	**Hasan** Hasan aged 14 was involved in a physical assault on another pupil in school this resulted in a 3-day exclusion.	**Management Systems.** Example of Peer violence further analysed in Findings section.
10/05/98	**Hasan** An incident involving Hasan aged 14 and his peer group took place at school which resulted in a 4-day exclusion.	**Management Systems** It is unclear from the records what occurred. Hasan was offered anger management sessions by school as part of reinstating him into school. It is not known whether there was any engagement with his parents.
23/05/98	**Hasan**	**Management Systems**

Period	Key Information	Comment
	Hasan aged 14 'strangles' another pupil at school which resulted in a 5-day exclusion. **Hasan** The Senior Leadership Team agreed that upon returning to school Hasan will receive a final warning. He was closely monitored by senior pastoral lead and given a mentor in school.	This is another example of Peer violence; this is further analysed in Findings section. **Management Systems** At this point, there have been previous incidents. The expectation would be that a referral is made to Children's Social Care or Early Help.
04/06/98	**Rahima** Rahima aged 18 attended the emergency department following a minor head injury after being pushed by Hasan.	**Management Systems** This incident could have been referred to the (L&D Hospital) Safeguarding Team to explore if there was a role for other services such as Early Help or the involvement of School Nursing. There is no consideration that this met threshold for single assessment due to the number of incidents of anger and violent behaviour.
17/06/98	**Hasan** Hasan aged 14 was unusually quiet and disclosed to a teacher that there was going to be a fight and he would get stabbed. Records indicate that Hasan was involved in several incidents of violent attacks on other students. A referral was made by the school to Children's Services raising concerns about him being in a gang and the Police and Hasan's parents were made aware of this.	**Management Systems** There was no strategy discussion or single assessment in line with the Pan Bedfordshire Policy Safeguarding Children Vulnerable to Gang Activity as it was a one-off incident and his father advised this was because of a misunderstanding, rather than his son being involved in the incident. Father's response was accepted without question. This chronology sets out a pattern of behaviour which is concerning with Hasan presenting with anger issues. His father had assured professionals that he would talk to his child.
30/09/98	**Hasan** Hasan aged 15, punched a wall at school and grazed his knuckles he is seen in the school medical room.	**Management Systems** This was not seen as a part of a pattern of distressed behaviour that may need additional support from his GP, educational psychology or to be referred to the School Nursing Team for further advice.
16/11/98	**Hasan** Hasan aged 15 became unwell while at school due to smoking an unknown substance. He was violently sick, extremely agitated, scratching his face and pulling at his hair. A pupil alleged he had taken Spice. At this point, there had been a behaviour incident logged by the school since his admission. An ambulance was called by school, who then made a referral to Children Services.	**Management Systems** There is no referral by the school. The referral to Children's Social Care was made by the ambulance, given the likelihood of harm, this would have warranted a referral by the school.
01/12/98	**Hasan** The MASH contacted Hasan's father and the Designated Safeguarding Lead at school to establish what happened. Father stated that '*everything was fine*', and he felt that Hasan had learnt his lesson. Father was offered additional information on community resources that may be able to support Hasan, which he declined.	**Management Systems** Despite the pattern of concerns in school there is no early help assessment undertaken by the school or suggested by the MASH. It is not known why there was a two-week delay is contacting Hasan's father; and why there was no contact with Hasan himself to explore what was happening for him. Hasan's voice and lived experience was not reviewed and considered by professionals. Father's view that he would manage the situation, was accepted without question. A more robust approach from the school would have been warranted and an escalation to Children's Social Care.

3.3 Period 3: February to September 1999

Jila: 2nd Overdose, Concerns re: Exploitation, 3rd Overdose, Assault, Honour Based Violence, Refuge placement, 4th Overdose, Domestic Abuse incidents, Referral to Adults MASH, Pregnancy.
Rahima: 1st Overdose, Pregnancy, 2nd and 3rd Overdose, Missing Episodes.

Period	Key Information	Comment
27/04/99	**Jila** An ambulance was called following Jila '*having a fit'*. Jila was taken to hospital where she was diagnosed with low mood and depression. Jila declined a safeguarding referral as a vulnerable adult at the hospital.	**Management Systems** No other referrals were recorded; it is not known what the GP input or response was to this incident. After hospital attendance, there would be an expectation that Jila received follow on care. It is not known whether this was offered or provided.
02/05/99	**Rahima** Rahima (aged 18) attended the emergency department at 8.10pm with friends and her sister following an anxiety or panic attack after father had been verbally abusive to her when she returned home late. Her father was present and continued to be verbally abusive to her. She was admitted to the EAU for psychiatric assessment.	**Management Systems** The assessor did not identify any safeguarding concerns despite her stating she was afraid of her father. This is the one of the key findings where both Rahima and Jila were given information about support (in this case - information was given regarding self-referring to the Wellbeing Service IAPT service for support with her generalised anxiety), but it is not clear whether any follow up discussion was held to encourage her to attend. In addition, she was discharged back to her GP. It is not known what the GP input or response was to this incident.
07/05/99	**Jila** Jila called Police stating there was a man in the house, she was scared, and Hasan had a stick. Police attended and the house was found to be secure, and it was finalised as a suspicious incident. It is not clear what Hasan was doing with the stick or whether he intended or did harm anyone with the stick.	**Management Systems** Police attended and responded well to the incident.
10/05/99	**Jila and Rahima** Jila called the Police at 10:02pm stating that her parents were refusing to let her out of the house and had locked her in her room. **Jila and Rahima** She had left before police arrived. Police tried to contact her, Rahima and Hasan (aged 15 - at the time) went to help with the search. Father called the control room from 4:00 am onwards several times stating that both daughters had not returned home. He was told both were safe and well. Rahima advised Police that both she and her sister liked to go out drinking which had caused the argument. Jila did not engage with any follow up by the Police. The incident was deemed a non-crime domestic dispute by the Police.	**Management Systems** One of the key findings in this case is the different lifestyle choices of the children against the expectations of their parents. This is a good example of Police not disclosing where the sisters were but assuring parents that they are safe and well.
11/05/99	Jila An ambulance was called to Jila (aged 20) at '*an unkempt flat'*. There were two men in the bedroom but neither of them knew any details about her apart from her name. Jila smelt of alcohol and her behaviour made the crew think she had either taken or been given drugs. She was taken to the Emergency Department where a medical review was completed. The Police were informed by the Emergency Department staff and attended the department to complete the vulnerable adult incident details.	**Management Systems** There was a provider led enquiry regarding claims of a poor discharge from hospital at midnight without any support being offered or Jila being spoken to in relation to the concerns. Good practice was demonstrated by ambulance crew in making an adult safeguarding referral. Professionals in both the (ASC) Adult Safeguarding and Hospital Teams do not appear to have engaged with Jila adequately to assess her background of chaotic lifestyle and marked lifestyle problems.

Period	Key Information	Comment
	Jila Staff appropriately escalated to the Adult Safeguarding Team. The Ambulance Service made a referral which was received on 12/05/1999. A Section 42 enquiry was progressed and undertaken. She was deemed to have capacity in relation to the safeguarding enquiry. 19/05/1999 A follow up call was made to Jila by L&D Hospital. She told them was staying with a friend and she was provided with advice and support about whom to contact if she needed support.	Jila was deemed to have capacity and while she disclosed poor family dynamics, no abuse was said to have occurred. This outcome appears to overlook Jila being exposed to coercion, modern slavery or sexual exploitation. The males were not questioned further. The identity of the males who were in the flat was not questioned by the ambulance service. It is not known which one of the males called the ambulance. The men did not attend the hospital or provide their details. The expectation is that the details about the identity of the males would have been recorded by professionals who attended the scene and this information was shared with the police. This information was not collected; therefore it was not passed onto the hospital safeguarding team or ASC safeguarding team and those teams would therefore not have opportunity to question them. There is a systemic issue here which starts with the first attenders to gather information and then subsequent agencies to follow up as appropriate.
06/06/99	**Rahima, Hasan** Rahima (aged 19) attended the Emergency Department following an overdose. An allegation was made that she is at risk of Honour Based Violence and Forced Marriage. She has a boyfriend and her family do not like him. She denied assault and threats of violence by family but alleged being prevented from going to university. She was admitted to Emergency Assessment Unit for psychiatric assessment. She was deemed to have capacity, no mental disorder and discharged home on the same day. Children's Social Care Notification was made informing that there was a younger brother within the household. Family history was taken but there is no evidence that any questions about Hasan were asked. The (L&D hospital) Adult Safeguarding Team completed a referral, this was reviewed by Adult Social Care but did not progress to Section 42 enquiry The Police attended the Emergency Department and completed an Honour Based Violence Pack with a high-risk assessment. No further action was taken due to lack of support by Rahima. However, options were discussed with her regarding support post discharge and she was discharged to a safe address.	**Management Systems** This is the first overdose recorded for Rahima and third for the family. It is not known whether she was seen for follow up by her GP to this incident. Further analysis of this issues is included in the findings section. The impact for Hasan living within the home environment was not adequately considered by the PLS team.
24/06/99	**Jila** At 3.57pm Jila, arrived at Police Station. She had been assaulted by her mother and father whilst getting clothes together for Rahima who had run away from home. She stated that her father had punched her in the head and kicked her in the chest until she passed out. She had a panic attack at the police station, was hyperventilating and passed out. **Jila** Her boyfriend was also present and tried to calm her down. An ambulance was called.	**Management Systems** The process for prosecution problematic because there is no clear evidence that this was discussed with Jila providing her with information about the support she would have to make the prosecution. If she wanted to go home, especially as she was reported to be pregnant, follow up safety plan should have been in place. **Management Systems** Police report that current practice has evolved since this incident in 1999, there is now a designated adult and child

Period	Key Information	Comment
	Jila attended the Emergency Department, following the alleged assault. She was referred to as vulnerable adult and reviewed by Adult Safeguarding Team. Police completed a DASH Assessment with a medium risk. The Police Honour Based Abuse Unit notified Victim Support and Luton Social Services. A MARAC referral was also made following the completion of the Honour Based Abuse pack and was heard on 08/08/1999. She was offered woman's refuge or admission to hospital as a place of safety and as there was no space in refuge she went to stay in a hotel. A domestic violence meeting was held in the MASH; actions were that Early Help Domestic Worker should contact Jila and refer her to the Honour Based Abuse Unit. There is a reference to Baby U in the records, it is likely that Jila was pregnant at the time.	SPOC and they work closely with Local Authority Children and Adult services. There is insufficient information about the impact of Honour Based Violence against Jila, nor any detailed consideration about the pattern of domestic violence and abuse. The injuries sustained by Jila were significant and warranted a more robust approach. A Children's Social Care referral was made in respect of Hasan, this was not progressed. No lateral checks or a single assessment completed. This is less than expected practice.
25/06/99	**Jila** Domestic incident involving Jila as she had returned to the home address to retrieve her belongings. The Police were called and spoke to Jila and her parents. A DASH assessment was completed for Jila with a medium risk outcome.	**Management Systems** This incident reflects Jila as vulnerable because against advice, she attended the address to retrieve her belongings. Further information is required about who assaulted her and what action police were going to take as follow up of another incident of domestic violence.
26/06/99	**Jila** Jila attended the emergency department with her boyfriend following an taking an overdose. Jila had been physically and financially abused by her parents. She was kicked and slapped by both parents, who restrained her. For support, she rang her uncle in Bangladesh who reportedly told her that abuse is acceptable. Jila was seen by the Psychiatry Team and advised to self-refer to the well-being service then discharged home. She was also advised to consider contacting the local Women's Centre for support.	**Management Systems** This is the third overdose for Jila and the fourth for the family. There is also an emerging pattern of self-referral, without follow through. The expectation would be that there is a broader discussion about the third overdose by Jila. It is concerning that mental health services were not more proactive in their approach. Consideration could have been given to engaging with her with to provide protection and support.
27/06/99	**Jila** Jila's case was heard at the Domestic Abuse Multi-Agency meeting, the decision was to refer to the Honour Based Violence Unit to Jila. Victim Support made a referral to the unit. At the time, domestic abuse cases were dealt with by the Domestic Abuse Hub (workers seconded into the MASH by Victim Support). The Hub is part of Early Help, although based in the MASH. This is the first domestic abuse notification that alleges that Hasan was also a perpetrator of abuse.	**Management Systems** Social work intervention was not offered despite evidence that Jila was presenting frequently at A& E. The response to this referral does not consider the needs of Hasan, as a victim or a perpetrator of domestic abuse. The response appropriately prioritises the risks to Jila in relation to potential Honour Based Violence. This is a missed opportunity to refer Hasan to Children's Social Care and potentially to provide services to Hasan and his family.
04/07/99	**Jila** Jila is accommodated in out of county Refuge but is under pressure from the family to return home.	**Management Systems** This is an on-going theme where Jila experiences violence and returns home, records highlight the support provided immediately after an incident of violence, but there is less evidence of any support for the underlying and persistent violence she has experienced.
16/07/99	**Rahima**	**Management Systems**

Period	Key Information	Comment
	Rahima aged 19, attended the emergency department stating she was seven weeks pregnant.	This is significant information due to the previous history and potential of Honour Based Violence in the family; however, no action was taken. The question is why was a Multi-Disciplinary Team (MDT) response or meeting not convened?
21/07/99	**Jila** Jila returns to the home address from the refuge; police had a discussion with her. She told them that the family was supportive regarding her boyfriend and everything was normal at home. Issues regarding self-harm were discussed. Her response being she did not feel like that now and that "*she was ok".* She had been advised by the police not to return home. The Police expressed their concerns at her returning home but were of the opinion she had capacity to make her own decisions.	**Management Systems** Jila's return home is likely to put her at risk. Although police records indicate that she had capacity and they had advised her not to return, a safety plan could have been agreed with her should she face further violence and abuse.
08/08/99	**Jila, Hasan.** MARAC notification was made stating that Jila had been assaulted. The perpetrators were named as Hasan (aged 16) and her mother and father. MARAC contacted (L&D hospital) Adult Safeguarding informing that Jila was not engaging and had returned to her family home. It was Flagged on Emergency Department records.	**Management Systems** No referral was made in respect of Hasan as potentially violent towards siblings. This was a missed opportunity.
12/08/99	**Jila** Jila rang the ambulance service stating she was suicidal and had taken an overdose. The Ambulance Service attended and brought her into the Emergency Department. The Ambulance service contacted Mental Health Street Triage Team (MHST), she was triaged over the phone. She was admitted to Emergency Assessment Unit for treatment for overdose also seen by Psychiatric team and offered was admission to the Mental Health Unit which was declined. She was discharged on 15/08/99 and Adult Mental Health Service involvement was noted. Jila declined a counselling offer but accepted CRHT support.	**Management Systems** This is fourth overdose for Jila and the fifth for the family. It is not known whether she saw her GP for follow up or other support such as medication for depression or anxiety. The prevalence of self-harm and suicide ideation are of concern and a more assertive intervention to provide support would have been appropriate.
16/08/99	**Jila** Jila was discharge from the Crisis (CHRT) service with a self-referral to wellbeing service. During the assessment Jila requested that she did not want to share her clinical records with the GP. As he had previously made comments about culture and behaviour which made her feel uncomfortable about sensitive information being disclosed to her G.P	**Management Systems** This is the third occasion where the outcome is for Jila to self-refer to the wellbeing team. Concerns about clinical records not being shared were not escalated to the hospital safeguarding team. Nor was support explored or offered regarding the cultural issues she referred to. This is a concern and it is not known whether this is an issue that is wider than for Jila.
16/08/99	**Jila, Rahima and Hasan** Following discharge from hospital (of Jila) there is a domestic incident involving Jila, Rahima and Hasan. Jila and Rahima had an argument about letting Hasan smoke cigarettes. Jila went to her bedroom and started cutting her wrist with a razor blade. She was taken to hospital by ambulance and admitted to the Emergency Department where she self-discharged, the GP was notified.	**Management Systems** Considering the ongoing domestic violence in the family, intervention could have been considered at a systemic level, even though the section 42 threshold was not met. That is, a referral for additional services in the community to support Jila. However, given the history of self-harm and suicide ideation, and domestic abuse it is surprising that the threshold (for referral) was not met.

Period	Key Information	Comment
	The Police attended and spoke to Jila and established that no crime had occurred, but they were concerned about her welfare. She told the police she wanted to end her life. A DASH assessment was completed as 'medium risk'. It was recorded that she intended to self-refer to the 'Freedom Programme'. A Domestic Violence risk assessment was completed by (L&D hospital) Adult Safeguarding and it was concluded that the threshold for referral for Adult Safeguarding referral was not met. The decision was made not to progress to a Section 42 enquiry.	Hasan was referred to Children Services, it appears this was not received until 12.09.99, the reason for the delay is unknown. However, yet again the contact was not progressed to a referral. This was a missed opportunity. The pattern of these incidents is concerning given that this incident occurred the day that Jila was discharged from CHRT. This incident happened on the same day that Jila was discharged from CHRT.
23/08/99	**Rahima.** Rahima (aged 19) attended the emergency department, following an overdose and was admitted to the Emergency Assessment Unit. She disclosed having a termination of pregnancy the previous week. A safety plan was discussed. Support was agreed from the Wellbeing Service Increasing Access to Psychological Therapies (IAPT) Team and University of Bedfordshire Mental Health Advisor. She was discharged to a temporary address. The GP response to these multiple attendances at hospital is unknown. The pressures on the family were significant. There is no evidence of a 'Think Family' approach.	**Management Systems** This was the second overdose for Rahima and sixth for the family. However, these appear to be seen in isolation with no triangulation of the lived experience of Hasan or other family members.
26/08/99	**Rahima** Rahima attended the emergency department following an overdose. Rahima was medically reviewed and discharged home. It is not known whether she was seen by mental health services on this occasion. This is three days after her last overdose. It is her third overdose and the seventh for the family.	**Management Systems** There is no evidence that this was considered as a pattern within this family, and therefore a review of the needs of the children in this family and a potential package of integrated support for the family was required. Chronology and records of incident indicate that responses to the increasing number of suicide attempts in the family had been reactive without robust responses to provide services.

3.4 Period 4: September to October 1999

Hasan: Assault at School on Hasan aged 16 and Sexual Assault Allegation.

Period	Key Information	Comment
12/09/99	**Jila, Hasan** A police referral was received by MASH about an incident on 16.08.99 for Hasan. Jila was referred to MARAC and (Hospital) Adult Safeguarding Team. A Domestic Violence Risk Assessment was completed by Safeguarding (hospital team) and it was agreed the threshold for making a Section 42 referral and enquiries was not met. **Hasan** Hasan's case was signposted to Early Help Services as a decision was made that the threshold had not been met for Children's Social Care intervention.	**Management Systems** Given the pattern of incidents within the family, the rationale for these decisions is unclear. According to the Luton Threshold document, the threshold for a child in need and statutory assessment was met. Further consideration should therefore have been given to the impact on Hasan of the domestic abuse, suicide attempt and self-harming which all happened in the space of 24 hours. **Management Systems** The focus appears to be on the adult siblings and no conversation was had with Hasan in relation to his views and feelings wishes and feelings about this incident or his lived experience in the family home and school. This is less than expected practice.
18/09/99	**Hasan**	**Management Systems**

	Hasan incurred injures to his fourth finger while at school. He said a door banged into his hand. He was seen in the school medical room and advised to go to the Emergency Department. He attended the Emergency Department, no treatment was required, and was discharged home.	It is not known whether there is any professional curiosity as to whether this was an accident, or a self-inflicted injury, given Hasan was previously known to punch walls and doors.
18/09/99	**Rahima, Hasan.** Father contacted police and informed that Rahima (aged 19) was missing person. A subsequent call was also made by Hasan who reported he had been advised by friends she was in a Watford Hospital but was not located when he rang the hospital. Police called Rahima leaving a message. She returned the call and informed them that she was safe and living in a hostel. Father was notified that she is safe.	**Management Systems** Police took appropriate action – good practice to inform father that she is safe and well. The report of Rahima missing by her father is interesting as she was not residing at the home address at the time. This relates to a key theme in findings about Honour Based Violence and coercive control by the father within the household.

3.5 Period 5: October 1999 to February 2000

Jila: 6th Domestic Violence incident, 2nd Pregnancy, 5th Overdose.

Period	Key Information	Comment
21/09/99	**Hasan** The school recorded an after-school incident involving dangerous behaviour by Hasan on the school drive. Hasan was confronted by an unknown parent who pushed and grabbed him by the throat. The School Head intervened and referred the matter to Police. The School notified police and parents.	**Management Systems** The parent who confronted Hasan was not spoken to. On 22/09/19, the police review the intelligence form but despite the headteacher witnessing the incident and having the perpetrator's name, no one is spoken to and no further police action is taken.
30/09/99	**Hasan** Hasan was also brought into the Emergency Department, following a punch injury to his right hand and an X-ray was completed. This was the second injury to his hand.	**Management Systems** There was no strategy discussion held to explore the reasons for physical harm and why the injury occurred. Police made a referral to Children's Social Care. This is good practice.
02/10/99	**Hasan** The referral was triaged on and signposted to Early Help Services. The decision was made that threshold had not been met for Social care intervention.	**Management Systems** This was the sixth referral into the MASH for Hasan and the third regarding his violent behaviour in the home. However, there is no strategy discussion, and the application of threshold is questionable because of history of violence, incidents at school and family dynamics. This is less than expected practice.
03/10/99	**Jila** Jila is pregnant; the family is unaware. Victim Support contacted the Police Honour Based Abuse Unit informing them that Jila is six weeks pregnant and they were concerned for her safety. She was due to have a termination. **Jila** Victim Support made a referral to MARAC. The Police confirm the domestic violence between siblings and potential for Honour Based Violence if the family become aware of the pregnancy. The case was considered by MARAC on 17/10/99.	**Management Systems** Appropriate safety response. However, given Jila's vulnerability, her mental health needs were not discussed nor was a referral made for additional support, this is less than expected practice.

Period	Key Information	Comment
03/10/99	**Hasan** Hasan aged 16, completed an assessment for exam support. The Assessor advised that he needed extra support. Hasan became very concerned and distressed that school would contact home. Hasan said he did not want anyone to know and he did not want support. The Safeguarding Team at school spoke to Hasan about his safety at home. Hasan said there was nothing to worry about. The school referred him to 0 - 19 team who informed school that there was a concern around Honour Based Violence at home, as Hasan's sister had recently been in hospital.	**Management Systems** The school response was good practice and this incident highlights Hasan as a victim of parental expectations. This is the first time that the school become aware of Honour Based Violence relating to Hasan's siblings. The Luton MASH was informed but there is no corresponding entry in their chronology or IMR.
17/10/99	**Hassan** Family heard at MARAC for the second time.	**Management Systems** The outcome plan still did not address referral for Hasan to Children's Social Care. That is either as a potential perpetrator of violence as well as a vulnerable young man who needs support to manage his anger and regulate his emotions.
20/10/99	**Hasan** Hasan aged 16, was reported for a serious sexual assault on another student. This was reported to police and a referral was made by the school to Luton MASH and BROOK. **Hasan** Police advised school not to discuss the incident with him.	**Management Systems** The outcome of the referral to the MASH was no further action. There was also no referral by Police into Luton Borough Council for a strategy meeting for Hasan under the Children Using Sexual Harmful Behaviours guidance in place at the time, under the Pan Bedfordshire Harmful Sexual Behaviour procedures. There was also no consideration of the possible cultural implications for him, of this allegation becoming known to the family. For reasons that are not apparent Luton Children's Services were not invited to take part in the strategy meeting convened in Central Bedfordshire where the alleged offence took place. It is not known whether Hasan was discussed at this meeting. Luton Children's Services should have made attempts to obtain copies of the minutes of that strategy meeting to review if Hasan was discussed, and any actions agreed. This did not happen. Luton Children's Services should have convened their own strategy meeting. Hasan had expressed that he would kill himself following this incident and this threat has not been taken seriously. This is less than expected practice.
27/10/99	**Hasan** Hasan was involved in a physical assault on another pupil at school. Resulting in a 5-day fixed exclusion. On return to school further support was offered.	**Management Systems** The school response was appropriate. However, a referral could have been made to Children's Social Care and psychological services for Hasan to receive support.
31/10/99	**Hasan** Hasan posted on social media saying he wanted to kill himself as he had been accused of a crime by another student and if the police get involved, he will kill himself. This related to the sexual assault allegation.	**Management Systems** This was shared with the Luton MASH. Given what was known about Hasan's emotional vulnerability support could have been discussed and provided. In addition, there was a high incidence of suicide ideation in the family home. In addition, there was contact made by the Channel coordinator into school regarding possible radicalisation issues in respect of Hasan.

Period	Key Information	Comment
		It is worth noting that at the time of his sad death the allegation of sexual assault had been withdrawn.
02/11/99	**Hasan** Referral received from Hasan's school to MASH, about the sexual assault and social media posts. It was recorded that this was '*thought to be emotional blackmail to force the complainant to withdraw the allegation*'. It was considered that Hasan may be fearful of his father's reaction. Early Help was considered as an option but as his father was unlikely to engage, it was closed with support in place from school.	**Management Systems** This response was not appropriate as there should have been a single assessment in line with assessment procedures in place at the time. The comment about emotional blackmail was inappropriate given the vulnerability and Hasan's emotional stress about exams and the sexual allegation. There was also known self-harm and suicide ideation in the family.
06/11/99	**Hasan** A Strategy Meeting was held, but within the neighbouring local authority area where Hasan attends school, regarding Hasan and the alleged sexual assault. The School Nurse attended but Luton Children's Services were not invited to take part in the strategy meeting.	**Management Systems** This meeting should have taken place in the local authority area where the child resided. However, prior to this meeting there should have been a strategy discussion to determine whether it should have been a joint investigation. The response indicates that information sharing and multi-agency working was not prioritised. As well as the alleged victim, the meeting should have considered the needs of Hasan. Children's Social Care did not request or receive the notes of the strategy meeting. The outcome of the investigation was not known.
22/11/99	**Jila and Rahima** Domestic Violence incident between Jila and Rahima. Jila contacted the Honour Based Abuse Unit stating she was leaving the family home to stay at her cousin's house. Jila alleged that Rahima had assaulted her by hitting her in the face. Hasan was present at the time but was not involved.	**Management Systems** Further Peer violence within the family. There is no professional response as Jila left the family home. It is not known whether there were any referrals on GP records of this peer violence. A DASH was completed the following day and Jila did not want to take further action, this was yet again passive practice. However, it is not known whether any further referrals were made or support discussed with either sibling.
02/01/00	**Jila** It is reported that Jila is pregnant for the second time. The Health Visitor was contacted, and the situation discussed with the Independent Domestic Violence Advisor (IDVA). It was agreed if Jila had continued with the pregnancy, the health visitor would contact her. It is not known whether a pre-birth referral was made given the known history in respect of Jila.	**Management Systems** The response by health visitor is positive, there is no record of a referral to early help, if Jila was to progress with the pregnancy. There is insufficient information about the mental health support she will require if she terminates the pregnancy, given her emotional vulnerability.
30/01/00	**Jila** Jila (aged 21) was the subject of a MARAC notification naming Hasan, her parents and Rahima as perpetrators and Jila as the victim.	**Management Systems** There is no further information about any referral for Jila.
19/02/00	**Jila** Jila (aged 22) took a suspected overdose, the ambulance made a safeguarding referral and notified the Police. **Jila** Jila did not wish for any police involvement; details were sent to the Honour Based Abuse Unit. She declined support, she was considered to have capacity and therefore no further action was taken.	**Management Systems** This was the fifth overdose for Jila and eighth for the family and again this is dealt with in isolation with no triangulation with suicide attempts and with other safeguarding incidents. **Management Systems** This is another missed opportunity to provide case management (social work involvement long term). Long term involvement would have followed up referrals to Mental Health. As MASH intervention is episodic, there was no professional oversight about Jila's needs nor was a referral made to Mental Health services. At this point arguably, if mental health services had kept Jila under their

Period	Key Information	Comment
		care following the previous suicide attempts, a mental health referral would not be necessary.

3.6 Period 6: May to September 2000

Hasan: Incidents in school and completed suicide, *Jila:* Self-harm and suicide ideation; *Rahima*: Suicide ideation:

	Key Information	Comment
03/05/00	**Hasan** Whilst at school, Hasan punched a lamp post, with his right hand. **Hasan** This was after he saw his former girlfriend hugging another boy. He was seen in the medical room at school and sent home. Hasan attended the Emergency Department and told staff that he was receiving support with his anger at school. The Emergency Department shared the information with School Nursing Team.	**Management Systems** This is third self-inflicted hand injury for Hasan. The response to his presentation of anger and self-harm was dealt with only as an episodic medical issue, rather than a behavioural and emotional and mental health need matter. This was a missed opportunity to assess and provide support. His self-reporting about the support he received from school has been accepted without professional enquiry or curiosity.
11/05/00	**Hasan** Hasan aged 16, presented with exacerbation of asthma. He was assessed and admitted to the Paediatric Ward for treatment and discharged home on 14/05/00. The GP was to refer to adult asthma clinic. The outcome of this is unknown.	**Management Systems** This episode was considered as a medical issue without further medical investigation. Asthma can be exacerbated because of emotional stress. There is no evidence found that this was explored further. There was no professional curiosity about the reason for asthma.
17/05/00	**Hasan** Whilst on half term, Hasan was studying for his science exam using school access. Hasan googled ISIS and beheadings also searched 'let's make bombs. This was subsequently picked up by school IT staff by routine screening of searches. The school IT staff reported this to safeguarding team in school after half term as at the time. There was no mechanism in place to identify such activity during school closure. This has since changed.	**Management Systems** This is good practice on part of the school, the response was appropriate.
22/05/00	**Hasan** Information about Hasan's punch injury and attendance to the Emergency Department on the 03/05/00 was received by Luton School Nurses. It is not known whether there was any planned action as a result of receiving this information or whether there was any GP input or response.	**Management Systems** There are gaps in communication between the school nurse and GP. Information was shared between the Emergency Department and the school nurse. There was a lack of information sharing between school nurses due to Hasan attending school in a different locality to his residence.
25/05/00	**Hasan** Hasan was involved in a physical altercation with another student in school and taken home by school staff. **Hasan** Hasan was seen to kick a student when he was on the floor following a strike from another student.	**Management Systems** This is another example of peer violence within the school. The response from the school is appropriate, however, this was also an opportunity to consider a referral to children's social care.

	Key Information	Comment
	His parents were informed of the decision that due to the nature of the incident that Hasan would need to be escorted to school and to his exams. The pastoral head agreed with the plan for Hasan to complete the exams without getting into further conflict with others. This is the final contact with school.	
31/05/00	**Hasan** Completed Suicide of Hasan (R.I.P). Hasan (aged 16) had been found by his family in his bedroom. The Ambulance attended and he was unresponsive and in cardiac arrest. He was brought into the Emergency Department by the ambulance crew where resuscitation was unsuccessful, and he was pronounced dead at 9.09pm. The Police Child Abuse and Vulnerable Adult Abuse Team investigated the death of Child. His sibling disclosed that Hasan had texted her a conversation about suicide prior to the incident. They concluded that he taken his own life.	**Management Systems** Following the sad suicide LSCB made the decision to carry out a serious case review.
04/06/00	**Jila, Rahima** Jila (aged 22) and now married was brought into hospital by ambulance due to suicide ideation following her brother's recent suicide. A plan for admission as an acute in-patient bed was identified. A referral for a Mental Health Act assessment had been made and then cancelled accordingly. Jila's mental capacity was assessed, and she was discharged home as a comprehensive assessment undertaken.	**Management Systems** Collaborative decision-making with patient and husband was evident. Preparations were made quickly and effectively when it was felt an in-patient bed would be required but a further review of her mental state continued allowing time for the acute mental health crisis to pass and enabling a final outcome which was more collaborative, and recovery based. There was rapid communication with the GP following the assessments.
11/08/00	**Jila** 111 call from Jila stating she wanted to kill herself. 111 contacted the police who attended the scene. She was brought into hospital by ambulance due to a possible seizure. She disclosed to staff receiving threatening phone calls from an unknown person threatening her and family members with a petrol bomb. She reported she intended to hang herself or take an overdose. Jila was referred to psychiatric team in hospital. She self-discharged into the care of her mother.	**Management Systems** This did not result in a referral to (L&D hospital) Adults Safeguarding Team or a safeguarding alert to ASC Safeguarding team. It is not known what GP input or response was to this event.
28/09/00	**Jila, Rahima** Jila was taken to hospital, as she had been seen with cuts on her arms by Rahima. The family did not respond to several calls from MASH, it did not progress to Section 42 enquiry. Jila was spoken to and reported to be ok and settled.	**Management Systems** She declined additional support and was signposted to the GP for mental health support. It is not known what GP input or response was to this event. This was a further missed opportunity to provide long term support for Jila.

4. Appraisal of professional practice.

4.1 Practitioner Perspective and insights

Productive and open discussions were held with excellent practitioner engagement and involvement which was fundamental to the understanding of what happened to Hasan, Jila and Rahima and why.

- Most practitioners were surprised by the safeguarding concerns that emerged in discussions held at the event. This is especially important as they were unaware about the circumstances that all three siblings were faced within the family home. For example, practitioners in education were unaware of the negative dynamics in the family home, coercive control and violence within the family home.

- Practitioners were challenged by two issues: firstly, not having information about what was happening at home, and secondly, having overly optimistic cultural assumptions – particularly when Hasan's father told professionals that he would provide relevant support to Hasan relating to his anger and presentation of challenging behaviours in school.
- Hasan's behaviours were complex, but were not deemed to have met threshold for significant harm when a referral was made to the MASH. Therefore, professionals were faced with supporting him within universal services, primarily within school. Professionals were constrained by their own lack of confidence and cultural awareness to '*read*' what was happening for Hasan at home and link this to his behaviours at school. Since this review, there is one front door. It is reported that processes within the MASH team for Children's Services have changed. There is additional management capacity and there are additional triage officers to review referrals into the MASH. All triage workers and Social Workers are expected to follow a set template when gathering information which includes taking into account the history in respect of the family.
- The concern about not knowing what was happening at home, led to a wider discussion amongst professionals about how they develop their confidence in culturally competent practice. They were keen to improve in this area of their work. There was some reliance on dated research to inform their practice in cultural awareness. Research quoted in one of the IMRs is based on stereotypical expectations of norms and values of South Asian families. This is problematic in informing practice and developing culturally confident professional responses and intervention, this is because it relies on a linear and static perspective of lifestyle.
- Family culture is dynamic, and professionals are expected to respond to the needs of children and adults within that context of dynamic family cultures and community expectations. This highlights the importance of having confidence to safeguard children from different backgrounds, whilst at the same time taking account of their cultural background and identity. This discussion highlighted a key plank of findings in this review.
- Practitioners were keen to understand the wider contextual safeguarding issues identified in the lifestyles of all three siblings. Hasan had a group of friends and peers who engaged in violent behaviours. Although he was not identified as being part of '*the riskiest peer grou*p', there were incidents

highlighted by the school, where he was reported to be part of two different peer groups that engaged in anti-social and violent behaviours.

- Practitioners discussed the incident when Police attended an unkempt flat, where Jila was found with unknown males. Both Jila and Rahima presented with missing episodes that are often linked to sexual exploitation. The question is, who were the males and what was known about them? What circumstances led to Jila's use of drugs? Was she drugged by the males? Who called the ambulance? There was little professional curiosity exercised to scrutinise what was happening in the flat and the risk that Jila was under.
- In addition, both sisters came to the attention of medical professionals in respect of pregnancies. Given the cultural taboo of pregnancy, professionals were keen to understand and discuss what support could have been provided to them following termination of a pregnancy. Practitioners were keen to understand the impact of these events on the mental health of both sisters, and what services should have provided.
- The lead reviewer and practitioners discussed the importance of understanding the depth and impact of Adverse Childhood Experience (ACE) on all three siblings. Although there was insufficient information about their childhood experiences, the chronology cites incidents of hospital appointments and family difficulties that suggest ACEs. For example, Hasan went into hospital with asthma which could be caused by stress, medical professionals were keen to note that this was not explored at the time and the expectation would be that the question about stress is discussed with the parents. There were other medical and educational needs relating to Hasan when he was a child that were not queried as safeguarding concerns. In response to this, practitioners discussed the importance of considering the history of a child's medical needs and the need to exercise professional curiosity, to include social circumstances and make holistic medical diagnosis about some childhood illnesses.

  In addition, professionals needed to enquire about whether these illnesses indicated that there were safeguarding concerns, and to respond to these concerns.
- The role of the mother in the family home was significant by her absence, she is primarily absent from engagement with all professionals and missing from their records, especially with the school. When the older sibling Jila attended school with her father to discuss issues relating to Hasan, the school had thought that she was his mother. Jila's mother was reported not to speak English, and practitioners reflected on how she remained primarily invisible in their contact with the family. Practitioners were concerned about the gaps in their understanding about the 'unknown role' of the mother, and potentially the level of coercive control over her by the father. The view of the mother in the family home is likely to have been based on cultural assumptions. On one occasion, the chronology indicates she was involved in perpetrating violence towards Jila. There is no further information about whether she was coercively controlled to perpetrate the violence towards Jila, or whether she did so because the violence was 'honour based' and she was a willing perpetrator. There is no significant understanding about her position and role within the family. Practitioners were keen to reflect on why they had not questioned her role, and how they could work better with parents who do not speak English.

- The suicide ideation was misunderstood, and there was a need to reflect on how 'suicide' or attempts at suicide were a key feature within this family home. The pattern of suicide attempts was evident in all three siblings in the family. Jila, presented with self-harming and had made three suicide attempts. Rahima had made two suicide attempts and other threats of suicide thereafter. Hasan made a threat of suicide on social media and was successful in his attempt to commit suicide.
- Practitioners were keen to understand the reasons for this and the presentation of self-harming behaviours and suicide ideation for all three siblings when they faced managing their low mood, difficulties in regulating their emotions, or in response to violence and their difficult relationships with their parents and others.
- Practitioners discussed the possibility that this could be linked to the prevalence of Adverse Childhood Experiences, and that the children did not have the support to build resilience, or have protection to manage difficulties in their teenage and early adulthood.

4.2 In what ways does this case provide a useful window on the systems?

There are several complex and inter-related themes and findings in this SCR/SAR. The following seven findings have been identified by the review team as significant for the LSCB and LSAB to consider**.** As well as key findings set out below, there are many windows into the wider system that are useful to set out here:

a) Despite an emerging pattern of concerns and evidence of adverse childhood experiences, there was no triangulation or consideration of an early help assessment. Information sharing between agencies was poor throughout the period under review. The different structures between adult and children's social care may well have contributed to this. Early Help practitioners could reflect on their practice when services are refused, and consider developing creative and assertive approaches to respond to these needs.

b) There was an overreliance on the family members to '*present*' to services following safeguarding 'incidents'. In order for family members to do this, they would need to be motivated to change and to understand what was happening and why. This case has highlighted the importance of professionals '*determination to work with a child/adult/family'* to engage and find creative, culturally appropriate approaches to intervene and create change.

c) It is positive that parents can ask for support when they need it, and young adults access support when they feel they need it. However, this is often highly unlikely where there are safeguarding concerns for adults and children. In this case, none of the family members accessed on-going support to create sustainable change. The key role of professionals in understanding and responding to the needs of those who do not access services, but are vulnerable or at risk is essential.

d) The case was not open to children's social care or adult social care, although there are several key practice episodes where there was evidence of a likelihood of significant harm. In addition, there was no consideration of a strategy discussion or section 47 enquiries or follow through of Section 42 enquiry and the appropriate use of the well-being principle.

e) Although the consideration of honour based abuse by professionals is welcomed, there was insufficient assessment of the impact of this on the siblings. This is despite them living in a family dynamic where coercive control and physical abuse between siblings appeared to be accepted and unchallenged, and honour based violence continued to be perpetrated.

f) There was a lack of robust assessment of the poor mental health presentation of all three siblings and responses over time relied on self-referral or engagement with the father who negated the concerns and said, "*all was is well".* It appears that with this family, this assertion was not challenged, questioned or followed through by professionals.

g) There was some lack of recognition of the cultural issues of living a '*western lifestyle*' and a lack of referral to support services for South Asian Women.

h) There was a lack of understanding of the cultural nuances in Hasan's learning needs, behavioural problems and anger management issues, including contextual safeguarding issues such as involvement in gangs, stabbings and violence to others.

i) The response to domestic abuse was episodic and the typologies not well understood. Despite being heard at MARAC, plans were not shared with the school or GP. There was insufficient follow through with the siblings or parents on understanding domestic abuse, and to work with the family to address violence and conflict in the home.

j) There were some gaps in awareness by practitioners of the inter-agency procedures for working with multiple safeguarding concerns, for example, mental health problems, Honour Based Abuse, Harmful Sexual Behaviours, risks and vulnerabilities around self-harm and suicide ideation. Further options could have been explored by police when they attended the family home following incidents.

k) The lived experience of the siblings was not well understood, recorded or reflected on by agencies with whom they had contact. The voice of the siblings was often absent or overshadowed by their father. This reinforces gender stereotypes. The voice of Hasan was not sufficiently responded to when he told professionals that he was due to be stabbed, he was frightened, afraid of his father's responses to his school exam

results, having a girlfriend, and getting into fights. It is disappointing that his thoughts and feelings were not explored further.

l) Multi agency chronologies could to be shared between agencies when there are concerns identified by single agencies. For example, the problems experienced by the group of friends that Hasan was part of. Practitioners from educational settings highlighted the potential impact of a school in special measures on Hasan and his peer group. They were keen to understand the impact of what happened in the school on Hasan and his peer group. For example, for Hasan, could this have impacted on his education and his identified additional needs?

m) The school has made considerable progress in implementing learning from the circumstances that led to the sad death of Hasan. These are to be welcomed and should be shared with all other schools in both Local Authority Areas. For example, a suicide pathway.

n) Within the single agency IMRs, there was evidence that there was insufficient escalation and challenge by health professionals either in their own agency or to Children's Social Care. The Escalation Protocol supports professionally curious conversations and appropriate respectful challenge in these situations. More needs to be done to promote the role of escalation in partnership working. Challenge about threshold decisions and other key areas of practice is key to improve practice

o) Luton practitioners would benefit from focussed and restorative practice principles that foster and enhance partnership working. The author understands that Luton Children's Social Care and Adult Social Care undertook training on restorative practice 2-3 years ago. There may be scope for refresher training and for the training to include other professionals. The 0-19 Teams in Luton Children's Social Care used to undertake restorative supervision with 0-19 teams. However, this is not current practice. This is especially important when working with diverse communities and professionals are not always confident about diversity.

p) Within a culture of respectful professional practice, challenge is productive and welcomed. Police officers report that they have undertaken restorative training to respond to complex incidents.

q) Many aspects of the case over time were episodic and were attributed to 'lifestyle choices' that young adults are free to make. Decisions were based on Jila and Rahima having capacity and therefore professional engagement was limited. The question is how could they have been supported differently?

r) Fuller consideration could have been given to understanding the role of the parents in the family home. There was a lack of professional curiosity highlighted in many key practice episodes with little exploration of the wider family function, and the father's response to professional concerns. Professionals were assured by the father that things had or would change despite there being little evidence of engagement in

interventions over time. This finding is reflective of *Brandon et al. (2014)* who described that parenting approaches accepted by practitioners reflect fears about being considered judgemental when working with families who are vulnerable, poor, socially excluded or who have made certain life-style choices. This can cause '*undue professional optimism and an acceptance of less than adequate parenting practice that results in a failure to grasp the child's lived experience.*

5. Practice Findings

This chapter outlines the findings and suggested recommendations identified from the analysis of the key events and professional practice. The involvement of practitioners and their managers has been fundamental from the outset of the review, as has the support of the Local Serious Case Review Panel, the Board Manager and staff in the LSCB and LSAB. The learning points set out for consideration by the LSCB and LSAB reflect the collaboration and insight provided through the engagement and support professionals involved in this case.

The discussion of the key findings is in five central and connected themes that seek to inform learning and improvement across the system. Reference is made to the relevant literature including other local reviews, inspection findings where relevant, and to recent developments in improving the response to mental health problems, self-harm and suicide, Honour Based Violence and Domestic Abuse, as well as cultural competence. In delivering these findings, consideration has been given to providing partners with a summary analysis that does not repeat information already being shared in other recent local reviews or as part of the wider work streams.

The themes identified are:

Finding 1 – How assured is the LSCB and LSAB that professionals in Luton are confident and competent in providing a culturally sensitive safeguarding response to vulnerable adults or children?

Finding 2 - How do professionals use the LSCB threshold document or Care Act Guidance to assess risk in making decisions about safeguarding, well-being and appropriate use of the levels of intervention? How are unmet needs responded to in this case?

Finding 3 - How assured are the LSCB and LSAB that there is sufficient understanding, identification and impact of domestic violence and peer violence in South Asian Families by agencies and professionals in Luton?

Finding 4 - To safeguard and improve the lives of vulnerable children and adults, how well is the voice and lived experience of a child or adult recognised, and considered, in decision making and intervention by professionals? What can we learn about how professionals respond when presented with adults/parents/carers who actively non-engage?

Finding 5 - Are professionals equipped and confident in effectively responding to behaviours such as self-harm and attempted suicide in South Asian young people?

5.1 Finding 1

How assured is the LSCB and LSAB there professionals in Luton are confident and competent in providing a culturally sensitive safeguarding response to vulnerable adults or children?

How did this finding present for Hasan, Jila and Rahima? What do we know about its prevalence across the wider Children's and Adult Services?

The cultural background of the family is a key feature of this case. This was discussed in detail with practitioners, who also identified this as an area of practice that requires improvement. Practitioners agreed that the nuances of the family and their cultural background and how these manifested in the relationships between the siblings and parents, could have been explored further by individual practitioners. An example of this is that when communicating with the mother in the family, there was no interpreter, and one of the siblings was asked to convey a message. This is unlikely to be impartial communication. Therefore, as a starting point in working with diverse communities, practitioners should be using interpreting services to communicate with families.

It is also relevant to highlight that Hasan did not attend school in Luton but a nearby local authority and therefore Luton Safeguarding Children's Board will need to ensure that the learning from this review is shared with the respective local authority. Luton local authority policies and procedures clearly indicate that family members should not be used as interpreters in any complex case where there are safeguarding concerns in children or adults. Police report that all officers are expected to deploy the services of Bigword interpreting services to ensure that relatives are not used for interpreting. Luton and Dunstable University Hospital report that they have an interpretation and translation policy which clearly sets out that relatives, carers or friends must not interpret for patients in safeguarding investigations. In addition it warns against the use of interpreters from the same community for fear of judgement or stigma.

Professionals identified culturally specific safeguarding concerns; for example, honour based violence. When professionals assessed that the siblings were at risk of honour based violence, their response was appropriate and was mostly managed well by those involved. Most professionals working with Jila and Rahima gave consideration to 'cultural differences' between them and their parents. They assessed that the conflict in the family home was due to them both adopting behaviours of a "*western lifestyle"* rather the lifestyle preferences of their parents. Jila had informed professionals that she did not want her personal records shared with her GP because of 'cultural and confidentiality issues'.

This would make it difficult for her to attend the GP when she needed medical support for personally sensitive medical needs. Jila is likely to have been torn between loyalty to her parents and her preferred lifestyle choices which is an issue experienced by many BAME young people. The religious background of the family was considered as part of this review, however, there was insufficient information from agencies in respect of religion and religious practice to review the impact of religion on professional responses or the family lifestyle. There is no evidence of the three siblings mentioning their religion in detail to any professionals involved in this review. However, literature on Muslim young people does highlight how Muslim young people believe they are stereotyped by others.

Waiting in Line [6]quotes a Muslim young woman:

'I struggled to ask help before because I just felt like, as a Muslim, just because I'm a girl as well, it was really hard because, like, a lot of people...just have a stereotype that, oh, girls are more likely to have it, or, are more likely to just cry and stuff and I didn't like that and I didn't want people to know that.'
(Waiting in Line).

Further exploration is required to ascertain whether young people feel that they are stereotyped and not regarded as individuals. Is this more systemic than it was possible to evidence in this case. If this is the case, the LSCB and LSAB will want to assess how prevalent the lack of understanding about the gap between parental expectation and lifestyle choice of young people impacts on safeguarding them.

Writers from South Asian Women's organisations have highlighted the strong ties that can bind a community which can:

a. Occasionally lead to professionals compromising confidentiality.
b. Inhibit the person from accessing advice and support because they do not trust professionals from the same background as them with their personal and sensitive information and are worried that they will be judged because of it.

There are other questions that the LSCB and LSAB will want to consider. What were the professionals' understanding of what was happening within the family, for example lifestyle differences (western vs traditional lifestyles), religious expectations combined with relationship difficulties and violence? These require further work, as currently there is insufficient understanding to come to definitive conclusions.

Professionals reflected on the challenges of "understanding and managing cultural issues" especially within a safeguarding context. For example, how can you appropriately manage potential honour-based violence? They expressed concern that their work is required to understand and work with cultural differences and safeguarding. This 'confusion' is likely to be systemic and therefore of concern in work with others of a similar background and presentation as Hasan, Jila and Rahima. It is likely that even when staff have a good understanding of cultural issues, they may lack confidence in being able to articulate these into sensitive questioning, and as a result this prevents them from challenging situations and information provided by family.

What impact could this have on services to other children and adults in Luton?

Confidence and competence in working with a wide range of cultural and family backgrounds is essential in safeguarding adults and children in Luton. Agencies have informed the lead reviewer that they have made changes in their practice following the suicide of Hasan, and agencies have put measures in place to address cultural differences and presentation of emotional trauma.

However, further work needs to be carried out to make systemic changes.

[6]The Children's Society. *Waiting in Line – Stories of young people accessing mental health Support. February 2020.*

Practitioners identified cultural differences as an area for development. They report that this continues to remain a challenge. Managing complex family situations with concerns about honour based violence, domestic violence coercive control and cultural differences, is always going to be challenging.

Questions for the Board to consider

- How can the LSCB and LSAB assure themselves that professionals are competent and confident in working with families that have complex dynamics from South Asian Families?
- What resources are available in the community, to support troubled teenagers and young women from BAME background?
- Are the Boards confident that current service provision works in ways which promote access by vulnerable people? How do partners ensure that professional confidentiality is adhered to?
- The Boards need to consider:
  - If current guidance on managing complex cases, provide sufficient advice in relation to managing culture and family dynamics support?
  - What support is needed to enable professionals to have the confidence to challenge parents, or support adults and children under similar circumstances?
  - What support is available for young people/adults where there is interfamilial violence and they chose to remain within the family home?

5.2 Finding 2

How do professionals use the LSCB threshold document or Care Act Guidance to assess risk in making decisions about safeguarding, well-being and levels of appropriate interventions? How are unmet needs responded to in this case?

How did this finding present for Hasan, Jila and Rahima? What do we know about its prevalence across the wider Children's and Adult Services?

There were six contacts made to MASH in respect of Hasan, Jila and Rahima. Each one of these contacts were assessed as 'threshold not met'. Three of the six referrals were in respect of Hasan and were in respect of him inflicting violence on others. The other three were in respect of Jila and Rahima, and related to domestic violence. However, the impact of this on Hasan was not adequately assessed. For the school and education professionals, there was an additional complexity of considering two threshold documents to make a referral. Neighbouring Children's Safeguarding Boards may carry out an exercise of considering how to streamlining threshold documents and processes of making referrals between neighbouring local authorities.

Children's Social Care reflection on the case (IMR), highlights the importance of identifying and responding to the needs of a child in a household where domestic violence, including honour based violence is

persistent. The threshold was not appropriately applied, and on one occasion when the senior practitioner had assessed that a single assessment was appropriate (referral related to 24/11/1999), this was overturned by the team manager.

The practitioner event highlighted a disagreement between a worker who identified the contact as meeting the threshold for intervention and a manager who did not. It is not clear whether there was other relevant information available to the decision maker about the concerns relating to the two siblings within the family home.

The referrals to MASH were opportunities to review and intervene in the family with chaotic lifestyle and vulnerabilities. Luton Borough Council Ofsted report of Children's Social Care found that "*Thresholds are not applied consistently in the MASH".* [7] A concurrent Serious Case Review has also reflected this finding. This was a missed opportunity. What we now know, is that there was domestic violence from parents as well as between siblings, mental health needs, self-harm and multiple attempts at suicide and self-harm.

In respect of the two older siblings, the threshold for Section 42 was assessed as not met. Therefore, neither Adult nor Children's Social Care were aware of the inter-connectedness of the safeguarding needs of all three siblings, or the harm they were experiencing. A safeguarding alert could have progressed to a Multi-Disciplinary Team (MDT), partnership work, communications, strategy meetings to assess need and provide a holistic response to the needs identified.

Practitioners and managers agree that these actions were not undertaken following incidents highlighted in this review. There were referrals that ASC agree should have proceeded, whether these formed a S.42 enquiry or other intervention that could have benefitted this family.

The period referred to in this report pre-dates an organisational change by adult social care (ASC). There has been considerable ongoing work within ASC and with partners, to embed the principles of making safeguarding personal and promote the need for an MDT approach. The focus is now on the needs of individual adults and includes the 'think family' and strengths based practice across adult social care.

There were recurrent referrals to adult services, especially in respect of Jila, due to her suicidal ideation and self-harm. There is little evidence that there was a nuanced response to these. There was a need for an assertive approach to respond to her needs. Information held in adult services evidenced the two adult siblings as presenting with behaviours in response to chaotic lifestyles, the nature of family relationships and potentially some mental health needs. The responses to multiple referrals relating to the two siblings in the MASH (adults) could have been more responsive to their needs.

Practitioners responded to the individual incidents in isolation rather than being curious and consider if there were emerging patterns and increasing levels of violence towards himself and others. Innovations have since been

[7]Ofsted Luton Borough Council Inspection of children's social care services January 2020

put into practice and improvements made following the time period covered by this review. There is now an expectation of a holistic MDT response to adult safeguarding concerns. This includes MASH reviews in relation to concerns that have not progressed to S.42 enquiry but actions that have been taken at MASH. Initial stage referrals and recommendations are made and therefore review and assessment of ongoing risk is considered by professionals. MASH (Adults) led strategy/MDT meetings are held to determine who should be the lead professional/worker, which agency should lead the intervention and an action plan is agreed.

There has also been ongoing work to improve partnership working across professionals and agencies in relation to adult safeguarding. This includes a CCG employed safeguarding nurse now embedded with the ASC MASH team. This enables further and more immediate health input and cross checking to received concerns. There is a variety of multi-agency often issue specific issues and concerns groups such as VARAC, Luton Cuckooking meeting and the Vulnerable Women's' Group. There has been considerable work to raise awareness of both wider adult exploitation and sexual exploitation, including the production of 'tools' to support the work of frontline practitioners.

There was some evidence that at the time, the MASH was under pressure to meet required timescales for processing contacts and ensuring that all relevant information was available to make decisions. Therefore, the priority was likely to have been given to completing the enquiries on time. The LSCB and LSAB will want to be assured that decision making in the MASH has changed to prioritise time to consider contacts thoroughly, and that decision making is informed by history and information held by other professionals to triangulate the level of risk. The LSCB and LSAB will want assurance that decision making on referrals is applied in line with relevant guidance (Care Act or LSCB thresholds) and that all professionals are aware of the process for reviewing/escalating concerns around the decision making.

What impact could this have on services to other children and adults in Luton?

If the application of thresholds/guidance is not appropriate or robust, this leaves children and adults exposed to ongoing harm without the oversight of professionals and a relevant package of support to meet their needs.

Questions for the board to consider

- How assured is the LSCB and LSAB Boards that the relevant guidance is appropriately applied in the MASH?
- How assured is the LSCB and LSAB that the decision making in MASH is informed by history of referrals and is triangulated with information held by other professionals in the MASH
- How confident are professionals in using the escalation policy when they disagree with the decisions made?

5.3 Finding 3

How assured are the LSCB and LSAB that there is sufficient understanding, identification and impact of domestic violence and peer violence in South Asian Families by agencies and professionals in Luton? What can we learn about how professionals respond when presented with adults/parents/ carers who actively non-engage?

How did this finding present for Hasan, Jila and Rahima? What do we know about its prevalence across the wider Children's and Adult Services?

The violence and coercive control within the family household was significant with regular call outs of police to respond. On one known occasion, Hasan engaged in physical violence against Jila, his elder sibling. On another occasion police were called to the house because Rahima was violent against Jila. The victim of violence was Jila. For example, she was attacked by her boyfriend and she told police her father had assaulted her a few months ago. This is unlikely to be the only incident of violence that she did not report.

Domestic violence is not always reported, and research has shown that women of South Asian background are particularly reluctant to report. Linked to the issue of understanding domestic violence is the importance of understanding of the cultural needs of the victim. "*It is critical that practitioners, policy makers and health care professionals working with victims of domestic violence be culturally sensitive to the needs of South Asian women to provide effective services and interventions more effectively"*[8].

The mother in this case is invisible and professionals were unclear as to her role or involvement as a parent. Her views are unknown. On one occasion, the mother was a perpetrator of violence with Jila's father. Research suggests that she is also likely to have been a victim of violence, although there has been no report of violence towards her. Her involvement in perpetrating violence raises the question about whether this was her own decision, or she followed her husband's lead. In addition, although both parents had engaged in violence towards Jila, there were no consequences for any members of the family. The policy on domestic violence indicates that even where the victim is reluctant to press charges, professionals should intervene.

Violence towards Jila was referred to as honour based violence. "*Honour based violence is defined as abuse and violence that can occur when perpetrators perceive that a relative has shamed the family/or community by breaking their honour code"*[9]*.* Jila had engaged in activities that were perceived as 'western', that is having a boyfriend, staying out and going missing from home, and becoming pregnant. On one occasion, she and her boyfriend were 'attacked' outside her college, because she was seeing him. This was reported by Jila to the police as an attack by her cousin and an honour based attack; police identified it as such.

[8]7 The Howard Journal Vol 43 no 5 December 2004 – Voicing the Silent Fear South Asian Women's Experiences of Domestic Violence. Aisha Gill (Lecturer in Criminology University of Surrey Roehampton).
[9]CPS Definition of HBV.

However, she returned home on almost all occasions following hospital admission or a missing episode. Jila was provided supported for honour-based violence following an incident of violence against her or in response to a suicide attempt or self-harm incident. However, there was no on-going support identified or provided for her. This is a gap in service provision because she did not receive on-going support outside of the incidents set out earlier.

There are other questions that the LSCB and LSAB will want to consider. Firstly, how at a systemic level, can practice be improved in respect of honour-based violence and domestic abuse? Secondly, how to enhance professional understanding about domestic violence and honour based violence. That is, what actions and interventions professionals should take in order to respond to these and provide the victim with a more nuanced response and on-going intervention/support.

What impact could this have on services to other children and adults in Luton?

Confidence and competence in working with complex families on domestic abuse and honour based violence is key to safeguarding adults and children in Luton.

Agencies have made changes to their response to domestic violence and honour based violence following learning from other Serious Case Reviews. The recent Ofsted Report January 2020 indicates that "*authoritative action is taken to reduce risk"* (forced marriage), honour based violence is likely to be same at a system level. However, as has been found in this case, there is less evidence of "*direct work to understand their situation and reduce risk"*[10]. This work needs to be carried out to make systemic changes for intervention in this area

Questions for the Board to consider

- How can the LSCB and LSAB be assured that changes made by agencies working with domestic violence, have the same impact on work with honour based violence?
- How can the LSCB and LSAB be assured that victims of domestic violence receive ongoing support, as well as efficient and effective responses following an incident of violence?
- Is the LSCB and LSAB assured that in cases of honour based violence, there is sufficient understanding and confidence amongst practitioners to carry out assertive responses? That is, to protect victims when they have complex family dynamics and are reluctant to take legal action against family members. This is potentially a wider issue for all children and adults.

[10]Ofsted Luton Borough Council Inspection of children's social care services January 2020

5.4 Finding 4

How well is the voice and lived experience of a child or adult recognised, and considered in decision making and intervention by professionals?

How did this finding present for Hasan, Jila and Rahima? What do we know about its prevalence across the wider Adults and Children's Services?

Only universal services were engaged with Hasan, and therefore there are limited records of his voice, wishes and feelings and his fears and concerns in professional records. It is possible however, to hypothesise on his concerns based on discussions he had with the school (feedback in the practitioner event). This is especially true about of his fears on not passing his exams and what would happen to him if he was convicted of the alleged sexual assault. There is a record of his plea to the alleged victim that he would commit suicide under certain conditions. This did not lead to assertive intervention. In addition, his lived experience in the family home not known, that there was physical violence against his siblings, and he too was violent towards them on some occasions. He presented with anger and violence towards himself and his peers at school. This would have placed him in a vulnerable category, and the expectation would be that his threat of suicide was responded to with more curiosity.

The lived experience and voice of the two siblings who are also subject of this review is not known. It is not known how it felt to them to live in a family home where one of them was subject to persistent physical violence.

What impact could this have on services to other children in Luton?

The children in the U family were not known to specialist services designed to support vulnerable children and adults except when incidents of abuse occurred. Therefore, the only information available about their voices comes from contacts with school and universal health services. Consequently, there two issues for universal services:

How do practitioners manage the balance of attending to the presenting issues, whilst considering the factors of harm/abuse that may underpin them?

An understanding of ACES (Adverse Childhood Experiences), and the impact of trauma is important in this context. Can services work in ways which are trauma informed?

Questions for the Board to consider

- Are both Boards assured that the 'voice' and lives of children and vulnerable adults are consistently considered and factored in assessments and care plans?

- How can professionals work together to support a family where there are multiple vulnerable factors and where offer of support has been declined?

5.5 Finding 5

Are professionals equipped and confident in effectively responding to behaviours such as self-harm and attempted suicide in South Asian young people?

How did this finding present for Hasan, Jila and Rahima? What do we know about its prevalence across the wider Adults and Children's Services?

This case has highlighted the need to understand the pattern and chronology of self-harm, amongst troubled teenage boys who are not able to articulate their emotions, and this leads to them presenting with anger and violent behaviours. "*One study amongst young men with attempted suicide found that masculinity norms discourage disclosure of emotional vulnerability*"[11] (Cleary 2012). Hasan had 'punched the wall with his hands, punched a lamp post, and had presented with violence towards himself and others. His daily lived experience was in a family with complex dynamics, he experimented with drugs on at least one occasion that we know, and he searched the internet for terror activities on one occasion as well. In addition, he was also a child who is reported to have cried following an episode of anger.

Equally at risk during this time were his two female siblings, who presented at hospital on several occasions. Their presentation of self-harm, suicide attempts and other self-harmful behaviours, highlight the need for professionals to look beyond their self-harm and suicide ideation and to be professionally curious about their respective needs and the motivations driving their behaviour. Over the period the two siblings moved from being considered as children to adults and therefore from a children's to an adult safeguarding system

The pattern of self-harm and emotional trauma that was present within the family home was not identified sufficiently as a need for support, nor was there evidence of any meaningful multi agency intervention. Jila had been into hospital on numerous occasions due to self-harm and six times due to suicide attempts. Rahima had self-harmed following verbal assault from her father. She was hospitalised three times following attempted suicide. Research into suicide amongst South Asian communities suggests that self-esteem and a sense of identity can contribute to suicide ideation. Self-esteem, sense of identity and culture are reported as significant in suicide. "*It becomes more important that the individuals' perception of self are identified in the context of their culture".*[12]

What impact could this have on services to other children and adults in Luton?

Practitioners were aware of self-harm incidents, for example, when police attended the family home, Jila was found to self-harm. She had also informed professionals that *'she cuts her arms'*. Medical staff responding to incidents of attempted suicide in respect of Jila, recorded the incident and offered services to support her. Importantly, there is no record of staff or GP

[11] Adolescent Boys Health Eva Randell. UMEA 2016.

[12] *Attempted suicide in South Asian Women D. Bhugra and M Desai, Advances in Psychiatric Treatment (2002) Vo 8 pp 418-423*

responding to this as a wider issue within the family. In addition, the school supporting Hasan with his behavioural needs, were not aware until 2000, that his sisters had a significant history of suicide.

Questions for the Board to consider

- How can services work together to develop a proactive and responsive service for young people, including young adults who are vulnerable and have been assessed as not meeting the criteria for Section 47 and holistic work with adults including - Multi Disciplinary Teams (MDT), partnership working, communications between relevant agencies, strategy meetings to meet the needs of vulnerable adults. Where an agency has concerns about an adult, a referral should be made to the ASC MASH team for further work. It is important to note that just because a referral does not proceed to a s.42 enquiry it does not mean considerable safeguarding work/actions/referrals/ information sharing etc, has not been undertaken. The board will want to assure itself that this work is being carried out, recorded and improved upon to meet the needs of vulnerable adults.
- Is the Board confident that services for South Asian young people are culturally relevant, and that they are able to work in ways that recognise the contextual safeguarding issues for this cohort?
- Is the Board assured that services and professionals appropriately respond and support when individuals inform professionals that they have suicidal tendencies or will commit suicide?

What processes need to be in place for this to happen?

6. Recommendations

These recommendations have been devised from key lines of enquiry, findings and practitioner and senior leader feedback. To have meaningful and on-going impact of learning from this SCR/SAR some recommendations will require regular/or annual scrutiny by the Board and partners.

Time has moved on and partners have made changes since the commissioning of this review. As such, the Boards will want to be assured that the changes have had the required impact, especially on South Asian families.

- To develop a culturally competent professional workforce with confidence and competence to work with the dynamic nature of cultural practices and lifestyles, in order to safeguard adults and children from different cultural backgrounds. An action plan to be devised to implement changes, and this to be reviewed by LSCB and LSAB Chair with an annual oversight report.
- The LSCB and LSAB to gain assurance through audit, data and other forms of scrutiny that the recent changes implemented in the MASH (adults and children) have impact on outcomes and especially relating to South Asian and BAME referrals.
- Organisations identify how they will support professionals in developing an assertive and nuanced approach to working with South Asian and BAME families presenting with complex safeguarding concerns who are not 'engaged'
- Ensure that the LSCB threshold document is appropriately applied for children and the Care Act expectations including the Well-being principle is adhered to in practice. This is tested through auditing and peer challenge. LSCB and LSAB to measure impact especially on South Asian and BAME communities.
- A multi agency review (police, mental health, local authority) of safety planning and discharge from hospital of vulnerable adults including those who present with suicide ideation.
- To review and revise the current Suicide Pathway to account of findings from this review. for teenage boys and South Asian women
- CCG to undertake work with GPs to highlight concerns that some young people have about their personal information being shared in their community. CCG to undertake a review about the prevalence of this practice and a relevant response to disrupt this practice.
- The LSCB and LSAB to gain assurance that professionals follow current guidance not to use family members as interpreters in safeguarding work with adults and children.
- Management and leadership of adult and children's safeguarding agencies to revise and review professional understanding about information sharing across adult and children's services when an incident has occurred to ensure current policies and guidance to enable appropriate and relevant sharing of information about vulnerable adults and children..
- Work with BAME communities to highlight safeguarding concerns and the need for making referrals and supporting vulnerable adults and children.