KINGSTON LSCB
SERIOUS CASE REVIEW REGARDING CHILD B

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SCR PANEL: CHAIR IAN DODDS

Child B

Set out below are some of the responses made to Child B's death by other young people with whom he played a particular game online, and which show how important this community was to Child B and is to many other young people. The author is grateful to Child B's school for sharing these tributes.

[Child B] An average boy. 15 years of age, intelligent, funny, a great guy. As I am writing this thread I speak for many people, who all had the pleasure of knowing [Child B]. Who will all miss him so dearly.

I knew from the moment I met him what a great guy he was. He would always put others first, something you really noticed in game and just talking on Skype, you just couldn't [help] like the guy. He really was a pleasure to be around.

On Thursday 17th July 2014, around 5pm. We lost [Child B], there are two possibilities, he jumped, or he fell.. And I guess no-one will know. But that isn't what matters, what matters is the time he was here, the time he was with his family, the time he was at school with his friends, the time he was playing the game you now play. And I know I for one took it for granted. No one knew what was going to happen that day, no one knew that they were to talk to him for the last time. No one knew [Child B] would die.... And now I think back to the last time we talked, we were having a joke, a good time. It was like normal, like there was nothing wrong, but really... [Child B] could have known that what was going to happen, he could have known what he was going to do... But he kept it to himself.

I will miss him, His friends will miss him, His family will miss him, I am sure you, the Gamer community, will miss him. As he was an example to us all. He wasn't particularly well known, but he didn't mind, he didn't need to be. He just made an influence on the people that did know him, and made their lives far more enjoyable with his presence.

1. Introduction

1.1. Why a Serious Case Review in this case

1.1.1 Child B was a South Korean boy, living with his father and older brother in the UK. He committed suicide on 17th July 2014 at the age of 15.

1.1.2. Child B was considered at an Extraordinary Meeting of the Local Safeguarding Children Board Serious Case Review sub group on 29th July 2014. Members of the sub group were reminded in a letter from the Independent Chair of the LSCB of the relevant paragraphs in Working Together 2013;

For clarity the statutory guidance that underpins the decision set out in Working Together 2013 is below.

"Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where: (a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child"

"Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) must always trigger an SCR{Serious Case Review}. In addition, even if one of these criteria are not met an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Capacity Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

13.Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.

14.LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report."

1.1.3. The consensus in the sub group was that the criteria for a SCR had been met and that useful learning for the local authority and partners should emerge. On 30th July the Independent Chair wrote to all sub group members to confirm the SCR, and said;

In summary in this situation the criteria met is that '..... abuse or neglect of a child is known or suspected..... and the child has died...'

1.1.4. It is important to note that the previous abuse of Child B is not thought to have contributed directly to his death or to have caused his death. It will also be seen in the Appraisal of Practice that there was no specific act or omission or episode of substandard or negligent practice that can be linked directly to Child B's apparent conviction that he could not continue to be alive.

1.2. Succinct summary of the case

1.2.1. Child B committed suicide by throwing himself from the top floor of an indoor shopping centre that is of the typical atrium style design. He did not recover consciousness and died in hospital a couple of hours later.

1.2.2. Child B had lived in the UK since he was six. In late 2009, at the age of ten, he was subject of a Child Protection Plan after he disclosed that his father had hit him with a golf club. He was briefly accommodated under S. 20 of The Children Act 1989. At the time, father was working long hours to make ends meet and leaving his sons alone much of the time. Father was concerned about Child B's behaviour and the relationship between them was observed to be lacking in warmth.

1.2.3. The Child Protection Plan ended in September 2010 and a Child in Need plan was then in place until April 2011 when the case was closed.

1.2.4. Children's Social Care became involved again in June 2012. Child B had stolen 17 pairs of headphones from a shop, the family was about to be made homeless and he raised concerns with his Youth Intervention worker about his father. A core assessment was completed and the case was closed.

1.2.5. Early in 2014 Child B was referred to Young Carers, his father having had an accident at work some time earlier that had left him with memory problems. An intensive piece of work began to address the family's longstanding financial problems.

1.2.6. In July 2014 Child B used his father's credit card to pay for some £500 worth of online games. The day after this came to light, Child B spoke of wanting to take his own life at school. Child B was well supported throughout his day at school, including their making a referral to Children's Social Care. He took his own life later that day.

1.3. Methodology

1.3.1. Statutory guidance (Working Together 2013)requires serious case reviews to be conducted in such in 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;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

1.3.2. The SCR panel in this case chose to employ a version of systems' methodology. It was important in this case to move beyond the issues of what happened on 17th July 2014 and why it might have happened, to what learning there might be for multi agency systems and, potentially, for the shopping centre and other parents.

1.3.3. The decision was made to review the case from December 2009 through to July 2014. Children's Social Care had changed significantly in five years partly as a result of two poor Ofsted judgements and partly due to national developments in social work in the intervening period. The management structure and the management team had changed completely. Quality assurance is now in place and the auditing of work is regular and rigorous. The panel might have taken the view that practice previous to the second Ofsted judgment was no longer relevant but instead has used the opportunity to double check that improvements in social work practice have been made and are embedded.

1.3.4. It was clear through all the meetings with practitioners that Child B's death had affected professionals deeply. Without exception, workers wanted to reflect on what might have made a difference and frequently mentioned that changes in practice had already been made to try to guard against a similar tragedy in the future.

1.4. The author

1.4.1. The author of this SCR is Susan Ellery, an independent social work consultant since October 2014. Susan had previously co-authored a SCR published in 2014 in the local authority where she then worked.

1.4.2. The author was supported throughout the review period by the Professional Adviser to the LSCB.

1.5. The Panel

1.5.1. The panel was chaired by the Director of Standards and Improvement in the borough concerned. The panel acted as a review team by checking and challenging the emerging themes and Findings as the case review progressed.

1.5.2. The role of the panel members was to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development of the findings from the review. No members of the panel had any direct case management responsibility in relation to the services offered to Child B.

1.5.3. Professionals on the panel were;

- Director of Standards and Improvement (chair)Achieving for Children (AfC)
- LSCB Professional Adviser
- Associate Director of Kingston Public Health
- Interim Strategic Head of Family Support Services, AfC
- Police (Specialist Crime Review Group)(Metropolitan Police)
- Deputy Chief Executive Officer, AfC
- Detective Chief Inspector (Metropolitan Police)
- Paediatric Consultant Kingston Hospital,
- Director of Children's Social Care, AfC
- Lead Educational Inclusion, AfC
- Designated Nurse for Safeguarding and Looked After Children Kingston CCG,
- Principal Social Worker, AfC
- Senior Lawyer, Social Care and Education Team, Kingston Council
- Team Manager, CAMHS, South West London and St Georges, Mental Health Trust

1.6. Structure of the review process and timeframe

1.6.1. The review process began in September 2014 when a timeframe was agreed and chronologies were requested from all participating agencies.

1.6.2. A briefing on the systems' methodology was provided for all practitioners in late November followed by structured conversations in December 2014 and January 2015. The emerging themes were further explored and challenged in a practitioners' meeting in February. Attendance at both the briefing and the meeting was high, as was the level of engagement.

1.6.3. Practitioners who engaged in structured conversations with the author and panel members, and were invited to the practitioners' briefings and meeting, were;

- Team managers and or assistant team managers from the Single Point of Access (SPA), the Referral and Assessment Team (R&A), the Adolescent Response Team (ART) and the Targeted Youth Support Team (TYS);
- Senior social worker and a support officer from the SPA;
- Social workers who had held the case in 2010 and 2012;
- The current and former head teachers of Child B's primary school;
- The assistant head teacher, also the designated member of staff for safeguarding (DMS) at Child B's senior school;
- The school nurse who held the case in 2009/11;
- The manager and two team members of the young carers' network;
- The youth intervention support worker who worked with Child B in 2012.

1.6.4. In all a total of 18 structured conversations were held with practitioners.

1.6.5. The final draft report was shared with the panel in mid - April 2015.

1.7. Data available to the review

1.7.1. The data available consisted of;
- A multi-agency chronology;
- Case records, where available, since December 2009;
- Structured conversations with most of the practitioners who were involved in the case;
- A conversation between the author and Child B's father;
- Correspondence between the Independent Chair of the LSCB and the senior managers/managing agents at the shopping centre.

1.7.2. An anonymous letter was received by the LSCB shortly after Child B died. It claimed to be written by a group of concerned South Koreans living locally and raised concerns about alleged long term physical abuse of Child B by his father. The letter included an email address for further correspondence but the author was unable to get a response from the address. Further enquiry suggests that the letter may have had a malign intent in terms of seeking to damage the reputation of Child B's father and that this should be understood in the context of Korean culture. For these reasons, the letter has not been used as valid data in this review.

1.7.3. The author was supported by the Metropolitan Police Liaison Officer for the Korean community and by the Korean Link Worker in the Equalities and Community Engagement Team for the local authority. Both provided information about the structure, culture and history of the Korean community in the borough.

1.8. Methodological comment and limitations on the review

1.8.1. The majority of practitioners were available for a conversation with the author and a panel member. Three members of staff who had left the borough

returned, including the social worker who held the case when Child B was subject to a Child Protection Plan in 2010.

1.8.2. One worker, who had known the family well from mid - 2012 to mid - 2013 had left the borough and chose not to be interviewed. It might reasonably be assumed that the worker could have provided an insight into the functioning of the family in that period.

1.8.3. The author is grateful to Child B's father for undertaking an interview. As he explained, his motivation was to try to help other parents whose children are drawn to playing games online to the point where money is stolen to fund the games.

1.8.4. Child B's brother declined to talk with the author, when approached by a trusted intermediary, and the author has respected his decision.

1.8.5. In consultation with two assistant head teachers at Child B's school, it was decided not to ask Child B's friendship group to talk to the author. As is described later in this report, his friends designed and held a memorial service at school in October 2014. All are in their GCSE year and the view was taken that the risk of surfacing difficult emotions at this point in their school career was too great to justify the potential learning. As will be seen, one aspect of this case was the lack of any apparent or shared suicidal ideation by Child B before the day he died, and it did not seem that he had shared his intention with his friends.

2. Professional Practice

2.1. Child B's Story

Child B's father's account of his life

2.1.1. The information below was given by Child B's father in a structured conversation led by the author and supported by the LSCB Professional Adviser, a support worker from Young Carers, who knows Child B's father well and an interpreter. Child B's mother lives in South Korea and it has not been possible to talk with her, or to hear what she would say about Child B's story.

2.1.2. Due to memory problems since an accident at work several years ago, Child B's father was sometime uncertain of dates or the order in which events happened. It will be seen that the account of Child B's life based on agency records does not entirely dovetail with his father's account, but this does not detract from the emotional truth of what the father said.

2.1.3. Child B was born in South Korea on 04.06.1999, the younger son of his father and first wife. His brother (and only sibling) is 4 years older. Child B was born in hospital, in his mother's hometown, as is apparently customary in South Korea. At a month old he was taken home.

2.1.4. Child B's father said that his relationship with the mother was not good,

even when their first child was born. Child B's father had a job in construction, and would have to live on site, sometimes being away for several months, although he did return at weekends. He heard from others that on occasions, his wife would leave the two boys with others and go away herself. He suggested she move closer to him but she refused.

2.1.5. Child B's father described B as a placid baby, not minding what was happening to him or around him. He accepted who looked after him; if the environment was ok, it was ok for him. He would help himself and look after himself.

2.1.6. Marital problems continued. When the family lived on the east coast of Korea, they decided to buy a house in Seoul. The mother bought a house without telling the father and it only came to light when the father received a tax bill. The owner of the property was his wife. He challenged the mother, as he was the breadwinner, but she did not understand why it was a big deal. She made her own decisions.

2.1.7. In September 2002, Child B's father came to the UK and the children stayed in South Korea. Child B was three. In 2005 Child B's father was informed that the mother was not looking after the boys any more, so he started to prepare to bring them to the UK. Child B and his brother arrived in February 2006, when Child B was six. Their mother came, as well as the children, a condition of the entry visas. She planned to return to Korea after a week but stayed another week more, and then left without saying goodbye. They believed she had gone back to Korea, but in fact she stayed in the UK for another two or three years.

2.1.8. At the beginning, the children lied to him; their mother met them after school but told the boys not to tell their father. They also met officially twice. He understood that the mother and children would want to see each other. Child B probably never knew when he would be seeing his mother. He found it very hard to keep it a secret. Child B's father said he made no comment about their mother to the boys. He bought a cheap internet phone, so they could ring her. Once he found out the boys had lied about her, and he got angry and asked them why they thought he had divorced the mother. Child B replied that it was because their mother had lied so much. The father said that was right.

2.1.9. Child B's father said he decided to divorce his wife while they were still living in Korea, because she cleared all the money out of his bank account. He used to send money every month to his own mother. He called his wife and asked where is the money. She apparently said that his mother would have to manage without the money and take care of herself. The couple separated after this incident in Korea, but Child B's father considered divorce for 3-4 years before it happened, after he came to the UK.

2.1.10. Child B's father thought that Child B did not care when his mother returned to Korea. He and his brother did not show any emotion or say anything. But he also knew they missed their mother. Life was normal for the boys and

they behaved the same.

2.1.11. Child B was ten when some behavioural problems started. He would climb trees and had no sense of danger, as if he thought he could fly. His father said he had to tell Child B off severely about this, although now he repented that he had treated Child B so harshly then. The father would go out to work early in the morning and not see the boys all day or after school. When he saw them, he would ensure they were well disciplined.

2.1.12. Child B worried his father. Only about five or six months after he came to the UK, Child B disappeared for three or four hours. His father went looking around the area and found Child B wandering the streets, with the explanation that he wanted to find out about where they now lived. Child B had seen a nest in a tree and watched it for hours.

2.1.13. Child B's behaviour changed and when he went to secondary school it became very apparent. Before then, the father had been worried about his behaviour and it worsened. At the end of year 7, Child B started playing games on his mobile phone. This started free of cost, and then it crossed to him buying games. Child B had a mobile contract in his father's name. His father found out and took the mobile phone away from Child B. After a month he gave it back to Child B, who said he would never buy games again. But Child B did again buy games and the mobile phone would go back and forth. His father paid £280 over a period of time.

2.1.14. Money became a constant worry to Child B's father and he could not plan anything financially. About five or six months before Child B's death, his father had no money for basic items such as heating. Child B's father hit him and his brother stepped in to give him one more chance, and said he would make sure Child B didn't take money again.

2.1.15. Child B's father also said that his son had a good and caring nature, for example, he did not mind about his appearance and would not make a fuss about not having brand name clothes.

2.1.16. At the same time, Child B's father was helping his own brother over a period of six to seven years to sort out his visa for his family to settle in the UK. He had to take care of that – working to support a total of 7 people and doing the paperwork for his brother. So he was aware that he did not give all his energy to the boys.

2.1.17. Child B's father considered he had made a mistake when he bought Child B a computer for his birthday, a month before his death. Child B wanted to study a veterinary course that involved private tuition, and he was told he would need a computer to study at home. Child B's father had suggested he use the family's old computer, but Child B said he could not.

2.1.18. Once he had the computer, Child B only joined the family at mealtimes. He became very irritable and sensitive over small things. Before he would run errands, now he would not do so. He would talk back, not politely, and be

challenging. His father thought this was the maturing process. Child B once spent £140 overnight on online gaming. Then Child B's father found that £500 had gone from his account. Child B did not tell his father about this and probably knew he should not be doing this. His father thought perhaps that is why Child B died.

2.1.19. Child B's father wanted to warn parents about computer games and wanted to prevent other parents living through what he has had to live through. Child B used his father's credit card to fund his online game playing. In South Korea there was a system to ensure each card had an ID number related to the individual person and so this could not have happened.

2.1.20. Child B's father said, "Raising him, I did not know how to express my love and give him a sense of peace and protection".

2.1.21. Child B told some of his life story on a piece of paper found in his pocket. It was thought that this semi-autobiographical account of his life and family until he was 11 may have been connected to GCSE course work, but his school confirmed that this was not the case. It cannot be established when Child B wrote this account or why.

2.1.22. Child B knew or remembered that he had lived in South Korea with his mother, before coming to the UK to join his father. Child B related that he was recruited by a gang in South Korea and would steal from shops. This may not be strictly factual, especially as he was five or six at the time, but his comment that, "Life was not very controlled" is likely to be valid, and the gap between his mother's and his father's expectations may have been the root of what his father saw as behavioural problems.

2.2. Information from agency records

2.2.1. At the Initial Child Protection Conference, Child B's behaviour and demeanour are put into the context of having no out of school friendships, not being in any of the school clubs or able to have play dates. Added to being of a minority ethnic culture within the school, it is hardly surprising that Child B was on the social outskirts of school. He refers to being bullied, because of his race in his semi-autobiographical account, but this is not mentioned elsewhere.

2.2.2. Child B said (in his semi-autobiographical account of his life) that he was "very naughty and dumb" on arrival at primary school, because he hadn't been to school in South Korea and he spoke no English. Primary school starts as age 7 in South Korea, and Child B arrived in the UK at about that age. It has not been possible to find out how much schooling Child B had before arriving in the UK.

2.2.3. The designated member of staff at Child B's senior school referred to some low-level behavioural issues at primary school, and a need for support with anger management alongside below average achievement. This led to Child B briefly joining a Transition Group, when he started senior school.

2.2.4. Child B is remembered at primary school as a child who was "vulnerable, unkempt…on the periphery of the pupils' social circles and would act the giddy goat to gain attention from children and adults".

2.2.5. There was a consensus among the staff that he was a child "you'd want to take home with you". Child B seems to have been quite astute in that he was able to make himself appealing to the adults in his world. At the same time, he is described as something of a "loner…quirky and eccentric…he seemed aware that this was his lot in terms of how his life was".

2.2.6. The primary school was concerned that Child B travelled to school and back by himself at the age of 7, a walk of about 3 miles, which involved crossing several busy roads, including a major arterial road. The School Nurse noted in February 2010 that Child B had a dental appointment, but was expected to go by himself. There is a theme throughout his childhood of Child B being expected to do things seen as not age appropriate, although they may have been acceptable in previous generations.

2.2.7. Child B's mother left the family soon after an incident of domestic violence in April 2004 that was reported to the Police. Child B would have been not quite 4. This does not tally with the father's account which places Child B in South Korea at the time. Later on, mother returned to South Korea.

2.2.8. Towards the end of primary school, Child B was being privately tutored for the entrance exams to a competitive and prestigious local senior school, and was telling other children he would be going there. His actual SATs results indicate that he was highly unlikely to succeed in the exams, and this was the case. However, it should be remembered that both this episode and the later episode of private tuition should be seen in the context of it being very normal in the Korean community, where academic achievement is highly valued and sought after.

Referral to CSC 01.12.2009

2.2.9. Child B was 10 and in year 6 when he was referred by his school to Children's Social Care. He had told other children at school that his father had hit him with a golf club. When interviewed by social worker 1, Child B said that this had last happened in year 5, and it is not clear what prompted him to talk about it when he did. He said he had been hit round the face the day before, because he had not done his work for the entrance exam, so perhaps he wanted to find a way to reduce the pressure from his father.

2.2.10. Child B said that, in year 5, he had told staff at school that he had had an accident with some bricks, but he had lied and his father had hit him with a golf club and he felt his arm crack. His father used the golf club when really angry; otherwise he used his fists or hands. Child B's father later said that Child B had hurt his arm falling off his bike. At the Initial Child Protection Conference, the

explanation had reverted to being an accident when Child B accompanied his father to work.

2.2.11. Child B said that it was normal for children to be hit in South Korea, and that his uncle and aunt also hit him. He said he felt safe at school. His father told social worker 1 that in Korea a particular kind of wooden stick is used to punish children and that he had used a golf club as a substitute.

2.2.12. Child B said that his mother lived in the UK and he was allowed to see her sometimes [his brother later said they had last seen her 3 weeks previously]. He did not remember her name. He had a new mother in Korea, who would be joining the family soon. He liked his father's new wife; she held his father's arms to stop him hitting Child B. He wanted the hitting to end and to live a normal life, described as going home, having dinner and watching TV.

2.2.13. Child B and his brother were accommodated under S. 20 of The Children Act 1989. A medical examination on 04.12.09 showed no serious recent injuries although Child B did have 2 or 3 scars on his face, which he said were a result of playing or fighting at school. An X ray of his right arm showed no sign of previous fracture. Social worker 1 remembered at the time that Child B had pointed to his left arm, as being the arm that "cracked" and it is unclear why only his right arm was X rayed. However, it was noted that small fractures in young children may heal with no residual signs, so the X ray evidence was inconclusive.

2.2.14. When interviewed, Child B's father admitted to hitting him with a golf club twice; once for stealing money (which Child B was said to do regularly) and once for playing with fire. He had also made Child B stand with his hands held up in the air for about 20 minutes. Father said that in Korean culture, children are hit on the backs of the legs when they make mistakes.

2.2.15. Child B's father talked about being a single parent and working long hours (as a builder and heating engineer). He said he felt guilty towards his sons and worked hard to support the family. He admitted to drinking, usually whisky, and in small quantities.

2.2.16. Child B's father asked for help to manage Child B's behaviour, feeling there was something wrong with him, as his elder son caused no problems.

The Initial Child Protection Conference (ICPC)

2.2.17. The ICPC was held on 06.01.2010, out of timescale of 15 working days, presumably due to Christmas. Child B and his brother were made subject to Child Protection Plans (CPP) category P (physical abuse). The brother had returned home on 16.12.09 while Child B stayed in the foster placement. His father was said to be reluctant for Child B to return home without support in place to manage his behaviour.

2.2.18. The ICPC heard that Child B's father worked long hours, so that he could afford private tuition for his sons. He himself had not been able to attend

university. Due to his working hours, he was not at home after school to supervise homework. He wanted his sons to achieve academically, and was upset when they did not perform to the expected standards. Child B was reported to be bright orally, but less able when he had to write. He was also very active, and probably did not like the extra school work on top of his usual day.

2.2.19. It was commented on that Child B's father had a closer attachment to his older brother than to him, and this may explain his perception that the brother was better behaved.

2.2.20. Child B's mother was said to be living in the UK and to have sporadic contact, phoning only once or twice a year. Child B's brother had reported seeing her only about 3 weeks before the referral on 01.12.09 and that she took both boys bowling in Tolworth. There seems to have been little if any exploration of why contact was so minimal, or what that meant to Child B and his brother and instead an acceptance that this was how it was. The head teacher said that Child B said he saw his mother fortnightly. His father said that the mother had not kept to arrangements, so he had curtailed contact.

2.2.21. Child B's father said that his son's problems were due to having no mother at home. He was sure that when his new wife arrived in the UK the problems would "go away". He was challenged in the conference about this rather simplistic way of thinking

2.2.22. Child B and his brother were said to be close and Child B reported that his brother told him to be good. Another boy, aged about 15, was boarding with the family at weekends and school holidays (he was at a boarding school fairly near by) and Child B said that this boy hit him too.

2.2.23. The family was struggling financially, paying a high rent. At this time, Child B's father had a working visa until 2012, and was planning to apply for leave to remain. He was not claiming child benefit (or, presumably, child tax credit).

2.2.24. The police officer present reported that Child B's father had been interviewed under caution and been honest and frank. He was cautioned for common assault.

2.2.25. The ICPC was concerned by the different quality of relationship between father and his two sons. The conference saw Child B's behaviour as possibly a way to deal with the feelings generated by this. He also seems to have been a child who badly wanted and needed to spend some time doing enjoyable things with his dad. The conference plan included support to the family from a family support worker and a planned return home for Child B.

Child B is Looked After 03.12.09-19.01.10

2.2.26. Child B remained in his foster placement until 19.01.2010. Noticeable by its absence, is almost any evidence from his carer about how he responded to

foster care, what he talked about, etc. The author was assured that Kingston foster carers are now keeping written records about children in their care, and actively contribute to conferences and reviews.

2.2.27. The placement was intended to be brief. A Care Plan dated 03.12.09 stated that both boys would return home within a week with a written agreement in place, and the likely duration of the placement was given as one month. In fact, Child B stayed for about 6 weeks.

2.2.28. A statutory review was held on 23.12.09. The record is copied and pasted from the Care Plan, and tells us nothing about how Child B was in placement or his wishes and feelings, from his or his carer's perspective. The author was assured that the quality of direct work has improved significantly in Kingston over the last 5 years, and that this would no longer be the case.

2.2.29. Social worker 2 was allocated the case when Child B returned home. The school nurse records state that Child B was seen the day before his planned return, and that he was looking forward to it. He told social worker 2 that he missed his father.

2.2.30. The school nurse saw Child B the day before he returned home from foster care and recorded that he was, "looking forward to going home…chatty and helpful."

2.2.31. The school nurse continued to monitor Child B while he was subject to a CPP, and recorded his answers to questions about how he was. In March 2010 Child B was seen again and said he had no worries about home or school. He was asked whether he preferred being at home or in foster care and said they were both the same. When he returned from a holiday in South Korea in September 2010, Child B said he preferred life in Korea, but the context was his very recent transition to senior school.

The Child Protection Plan and Child in Need Plan

2.2.32. A Core Assessment was completed on 27.01.2010. Much of the information is copied and pasted. The assessing social worker makes a stand in terms of Child B's father's lack of engagement with his primary school, saying that if he did talk to the school, it would be clear that the entrance exams were asking too much of Child B. There is a reference to a change (implied as positive) in Child B's behaviour while in foster care due to people "investing" in him, but little further explanation. He is said to have responded to firm boundaries accompanied by a clear explanation why a behaviour was inappropriate.

2.2.33. The assessing social worker touches on the potential clash of cultures, exacerbated by father not having learnt English. The worker speculates that Child B was influenced by his peer group and his resulting behaviour was more alien to his father than it would be if the family were better integrated into the mainstream culture.

2.2.34. Child B is described as being very much at the bottom of the pecking order; he describes being hit by his father, brother, step-mother, uncle, aunt and the weekend boarder. In addition, he was having to move out of his bunk bed onto a mattress in a box room to accommodate the boarder, and his father readily accepted that the boarder did not like Child B, and neither did his aunt. Within his family network, Child B seems to have felt disliked and seen as a problem, a contrast to the positive views expressed about him at both his schools.

2.2.35. The analysis emphasises Child B's need for stimulating activities, praise and emotional warmth. His father had engaged with the assessment, but left the assessing worker with a sense that he was looking to Children's Services to solve problems on his behalf.

2.2.36. A Review Child Protection Conference (RCPC) was held on 29.03.10. Social Worker 2's report states that Child B's father had missed parents' evenings for both boys, and that engagement with school showed no improvement. Child B was enrolled in after school clubs, but it had taken a long time. He was also due to go on the year 6 residential trip.

2.2.37. Child B had reverted to attention seeking behaviour at school on his return home. His father was thought to be focusing more on difficult behaviour than what was causing the behaviour. Child B had said he felt "unloved" by his father who, in turn, was sceptical of the effectiveness of boundary setting as advised by the professionals and thought that Child B needed a more hard-line approach.

2.2.38. On a more positive note, Child B's father had taken his sons fishing and he had made himself available for most home visits and core groups. There had been no reported incidents of physical punishment. However, it was noted that Child B's father had destroyed some of their possessions, when in a rage after a stressful meeting. He had also been drinking. The episode had been understandably upsetting for both children. It does seem incongruous that high standards of respect and good behaviour might be demanded from the children, but that the father felt justified in behaving in a way that showed poor behaviour. This anomaly seems to have passed unremarked.

2.2.39. Social worker 2 argued that Child B was subject to emotional abuse from his father. At the conference Child B's registration category was changed to E (emotional abuse).

2.2.40. A further core assessment was undertaken in September 2010, by which time Child B was in year 7 and at senior school. It was noted that in May, Child B had bruises on his left arm, and ascribed them to a paintballing trip that turned out to be fictional. Child B and his brother admitted that the brother had hit Child B in return for damage to his mobile phone. This was seen as a departure from their usual relationship.

2.2.41. The family had been to Devon for a holiday at Easter, and Child B and his brother had spent 3 weeks in Korea in the summer, with their mother. Their stepmother had moved out, and the reasons for this remain unknown, although there has been no suspicion found that it was due to domestic violence.

2.2.42. Child B was said to be more confident and happy, and comfortable in his father's company. His father was said to be at pains to persuade Child B that if he was honest, even if he had done something wrong, he would not be punished.

2.2.43. Social worker 2 recommended that the second RCPC on 20.09.10 removed Child B from a Child Protection Plan and onto a Child in Need plan, and this was agreed. The Core Group was to meet 6 weekly. The subsequent plan seems to be almost entirely copied and pasted from the previous Child Protection Plan.

2.2.44. The school nurse recording of a network meeting in January 2011 recorded that social worker 2 had observed (through a window) Child B's father hit him over the head with a wooden spoon when arriving on an unannounced visit. Social worker 2 remembered notifying his manager, who decided not to take action; he commented that the borough was then "not used to dealing with these issues" and that he would now take the case back to a Child Protection Conference. It does raise the question of whether this was normal treatment of Child B, rather than extraordinary.

2.2.45. Unfortunately, there are no records of Child B's journey as a Child in Need which lasted until the Closure Record on 01.04.11. The Closure Record is again almost entirely a copy and paste of what needs to be achieved with a 5 line summary of overall progress. Father was said to have reappraised his parenting and Child B to have matured, so that he recognised the stress his father was under. The financial situation was improved due to more regular work and Child B's father had, after several attempts and a considerable financial outlay, passed the test to stay in the UK.

Further Initial Assessment June 2012

2.2.46. Child B was referred by his Youth Intervention Support Project (YISP) worker with whom he was working on a voluntary basis. He had stolen 17 pairs of headphones in May 2012. By this time an accident at work in November 2011 had given Child B's father on-going problems in terms of dizziness and double vision.

2.2.47. Child B said he stole the headphones to make money to give his brother. At this time, it seems to have been Child B's brother, whose behaviour was being experienced as problematic. He was not attending college and, according to Child B, their father had decided not to support his brother financially.

2.2.48. The YISP worker worked with Child B on a voluntary basis over a period of several weeks. They did some work about bullying (Child B said that he

wasn't being bullied but had been in the past) and work about offending. Child B said it was his first offence, other than stealing sweets when younger.

2.2.49. The YISP worker said that Child B "engaged brilliantly, attended and cooperated at every session". The impression given is that Child B was enjoying positive attention. However, the YISP worker also described him as "sad, lonely, never saw him smile, polite and quiet" and said that he reported doing a lot of chores at home.

2.2.50. The YISP worker recorded that Child B's father had moved Child B into his bedroom, because he was playing games at night.

2.2.51. In June 2012 Child B texted his YISP worker and said that his father "needs help desperately" due to financial and health problems and the imminent threat of eviction. His text ended, "Please help me and my dad".

2.2.52. On 25.05.12, Child B's father made a homelessness application due to impending eviction due to rent arrears. On 13.06.12 the family was placed in B&B in Hounslow, but they were moved just 5 days later to a hostel in Kingston where they would stay for a year.

2.2.53. On 28.06.12 further information was received that Child B's father had hit him round the head, and slashed his brother's clothes with a knife in a rage due to the dishes not being washed, and his brother being late home. The similarity between this incident and the previous incident in early 2010 is evident. The incident led to a S. 47 investigation by social worker 3. At this time, Child B was not seen as the son causing problems, and his brother was. Father told social worker 3 that he felt constantly let down by his elder son.

2.2.54. Social worker 3 undertook a core assessment of Child B and his brother, which was not completed until 22.11.12, more than 2 months over the 35-day deadline (as context there were about 250 outstanding initial assessments at this time). The YISP worker was doing the actual work with Child B.

2.2.55. Social worker 3 found that Child B's brother had been removed from his course by college, after he ceased to attend due to his father not paying his fares. Social worker 3 intervened and got the brother back on the course with an increased bursary. She reports that the father also stopped talking to Child B's brother for a month, which probably left the brother feeling very isolated. Child B seems to have been trying to bridge the gap between his father and his brother.

2.2.56. Social Worker 3 thought that Child B was not used to being hit by his father, and was not scared of him. She felt he'd worked out how to bring support back into the family, and that he wanted intervention when he texted his YISP worker. Social Worker 3 experienced Child B as "Self - contained, quite switched on, a bit secretive…He was holding a lot of (father's) aspirations as his brother had gone off the rails. He had to be responsible for organising his day; he was more self-sufficient than most children his age, but not to the extreme of, for example, children of drug abusing parents." And, "There was a blame culture

within the family. He was used to there being a reason why things are wrong, someone taking the blame."

2.2.57. The core assessment has a weakness in that, although it states that information has been copied and pasted from the previous core assessment 2 years earlier, it does not make clear (e.g. by a change in font) where current information restarts.

2.2.58. The case was closed again on 23.11.12. There was a brief episode a month later, when it transpired that Child B and his father had left the hostel and gone to South Korea over Christmas, leaving the brother behind. Father had not notified the hostel manager who would have forbidden him to do this, the brother being still 17. Arrangements were made for Child B's brother to stay with his uncle until his father's return. Father's stated reason for going to Korea was for an operation, and his homelessness application was reopened in mid-January 2013.

2.2.59. In June 2013 the family moved from the hostel to a flat controlled by the Borough.

Kingston Young Carers

2.2.60. In late 2013, a clinical psychologist made a referral to Kingston Carers' Network and on 07.01.14 the Young Carers Project Coordinator visited Child B and his father. Child B's father was keen for him to be involved with young carers activities and came over as concerned for his son. He also said that Child B had daily tuition, but that he would agree to this stopping on the night of the young carers' group. Later, it emerged that the daily tuition was to prepare Child B for scholarship exams for a private school sixth form.

2.2.61. Child B was introduced to a young carers' group in a youth centre on 15.01.14. He was given a lift there and back, and was dropped off with another boy near home; he was observed to be chatting happily.

2.2.62. After his second meeting, he was given a lift back to the bus station with two other boys. The worker noticed that one of the boys was pushing Child B and remonstrated with him, and Child B said, "Don't worry, I get this all the time at school". He did not seem upset and it may have been typical teenage male jostling.

2.2.63. Financial and health difficulties still troubled Child B's father, and he had told a specialist in September 2013 that his elder son went absent for days at a time which caused him concern. On 17.01.14 a Family Support Project Coordinator (FSPC) visited Child B's father, and assessed the main needs as financial and health. The FSPC began an intensive piece of work to sort out father's problems, which was still on-going at the time of Child B's death.

2.2.64. Child B attended the young carers' group 3 times. It is unclear why he stopped going. The FSPC said a number of boys stopped when funding for a male

worker, who used to run basketball, ran out and the worker was made redundant. Once, however, the FSPC went to the family home after the group to deliver a letter she had intended to give to Child B, and he arrived at the same time, as if he had been to the group. It would seem likely that he took advantage of his night off study to go where suited him.

17th July 2014

2.2.65. To set the context, at Child B's school, the 17th July was the penultimate day of the school year and the last full day before the summer break.

2.2.66. In Children's Social Care, all the Service Managers and above were out of the office at a day-long event, but available by phone. The Single Point of Access (SPA) had a team meeting that continued until 12.15, somewhat longer than usual. The Team Manager of the SPA had an afternoon health appointment and left the office at 14.00. The Assistant Team Manager, who was responsible in his absence, said she was not aware of this until she returned from a brief lunch break and found he had gone. The Team Manager is certain he informed everyone, including the Assistant Team Manager.

2.2.67. On 16.07.14 Child B had taken part in a GCSE drama production after school, leaving at about 10.00pm. He told the Designated Member of Staff on 17.01.14 that when he got home, his father was angry because he had discovered from a bank statement that Child B had stolen a total of £500 from his account to buy online games. His father hit him round the head a couple of times.

2.2.68. On 17.07.14 Child B arrived at school very early, at 07.30, to help put away props and clear staging. To have a good reason to go to school early would also have suited him, enabling him to leave the house without seeing his father. Child B helped throughout period 1 in the school day.

2.2.69. The Designated Member of Staff for Safeguarding, who was also an Assistant Head, was due to meet with Child B at 10.30 to discuss incomplete French coursework (in his role as Assistant Head). He should have been meeting with three students, but only Child B was in school that day. The Designated Member of Staff (DMS) had known Child B for several years. Even before Child B joined the school, the DMS was a member of the Core Group while Child B's brother was subject to a Child Protection Plan, and the DMS stayed in the Core Group throughout 2010, because he knew that Child B would be starting at the school in September. The DMS could see that something was wrong and asked Child B what it was. Child B replied that he wanted to kill himself and that it would make his dad happy, then told the DMS about events the night before.

2.2.70. The DMS phoned the Single Point of Access (SPA) at 10.45. The SPA team meeting was happening and, as was the practice, Business Support took messages. The meeting continued until 12.15 and a Safeguarding Support Officer (SSO) phoned the DMS at 12.30, when he was on duty. The DMS phoned back at 12.45. The SSO asked the DMS to complete an online referral form, and return it

as soon as possible. Meanwhile, the SSO informed the SPA Assistant Team Manager (ATM) of the concerns.

2.2.71. The ATM discussed the contact with the Team Manager of the Referral and Assessment Team who advised that, on the information provided, it did not meet the threshold for a S. 47 investigation. At this point Child B's full history was not known, but he was flagged on ICS as being previously subject to a Child Protection Plan. The ATM then discussed the case with the manager of the (then) Targeted Youth Support Team, who agreed that her team was appropriate to take the referral.

2.2.72. The DMS returned the referral form at 14.30 and informed the SPA that he would stay at school until 16.00 to see the situation through.

2.2.73. Child B was tracked through his school day to an impressive extent. After break, at 11.00 he had Maths, where he was told he would be moving up a group in year 11 due to his improved performance and he seemed pleased. Subsequently he had Geography, where he was quiet and spent some time with his head on the desk. He also sat in a different place to usual. After lunch, he had Science at 13.15 and was again quieter than usual. During period 6, Child B sat in his Head of Year's room. He seemed "down", but said he had talked to the DMS and did not want to talk again. He was offered a drink and lay down on some chairs. At the end of the school day, he was collected by the DMS and taken to his French teacher to discuss the coursework.

2.2.74. In Children's Social Care, once the referral had been received by the SPA, the Senior Social Worker looked at the case again, in the absence of the TM and the ATM (who was on lunch break). The SSW completed the outcome namely referral on to Targeted Youth Support. An email was sent to the DMS at 15.17.

2.2.75. The DMS agreed by email to tell Child B of the decisions made, but he phoned at 15.30, because Child B had told him he was scared to go home. The SPA ATM took this new information to the R&A TM, but the R&A TM did not know that Child B had talked about killing himself, only that he "didn't seem himself". The R&A TM thought the case should transfer to the Adolescent Response Team (ART).

2.2.76. The SPA ATM then went to talk to the ATM of ART and reached an agreement that the Adolescent Response Team and Targeted Youth Support Team would make a joint home visit the next day, Friday. The DMS at school was asked to phone Child B's father and talk to Child B.

2.2.77. The DMS phoned Child B's father and explained the situation, although he felt some hesitation as he was worried about whether the father would understand, and be understood in English. Child B was present while the DMS spoke to the SPA and to his father. The DMS explained to Child B that his father did not seem angry, and asked how he felt about going home now. Child B replied that he would go home, and the DMS asked Child B to come and see him first thing the next morning.

2.2.78. Child B left school at about 16.00 and walked to Kingston town centre where, at about 17.00, he climbed the stairs to the uppermost floor of the shopping centre and jumped. Although taken to St George's Hospital, he died at 18.16 the same day.

2.3. Appraisal of practice

2.3.1. The context of this appraisal of practice is that it dates back to late 2009 and covers a period in which Children's Social Care in Kingston has undergone considerable change. In June 2012 and again in June 2013 Kingston was rated Inadequate for its safeguarding services by Ofsted. A series of fundamental changes to services began in 2012 and accelerated in 2013. As a result, services are delivered differently and managed by a new team of frontline and service managers.

2.3.2. The period also, of course, covers national changes to practice in Children's Social Care, that have driven improvements in tandem with the inspection regime.

2.3.4. The author will note where assurances have been given that practice has changed in Kingston, and recommend that senior managers use their auditing programme to assure themselves that change has been embedded, unless they are satisfied that they have done so already.

2.3.5. The Child Protection episode in 2009/2010 shows little evidence of sustained effort to find out what Child B's daily life was like, or to use Child B's voice in work with his father. There was limited exploration of the impact of his mother's departure, and his limited contact with her. We hear from the foster carer that Child B's behaviour improved in her care, but her potential to contribute is not used to the full, particularly in the Initial Child Protection Conference.

2.3.6. We also have a very limited picture of what being looked after meant to Child B. Due to the lack of foster carer recording, we know nothing of how Child B presented on arrival, what his worries were, what he enjoyed, what he said about life at home, etc.

2.3.7. This is compounded by the LAC review that does nothing to fill out the picture of Child B. The sole example of Child B's voice is an attributed quote that he told his carers and social worker that he gets bored easily. There is no record of how often Child B had contact with his father, and how he responded to it. The report concentrates on needs identified by professionals and actions to be taken to meet those needs. What is needed is the narrative that, had Child B remained looked after, would track the child's development and give him a continuing voice.

2.3.8. The author is told that a range of direct work tools are now routinely used by Kingston social workers, so that the lived experience, hopes and fears of children can be better understood and used to guide practice. And that foster carers routinely keep records on the children they care for and are enabled to contribute fully to multi agency meetings. The LAC reviewing service was outsourced at that time and concerns about the quality of the service led to it being brought back in house. As a result, LAC reviews are now judged to be more rounded and complete.

2.3.9. It is concerning that, although it was known that Child B had been hit with a golf club, no one apparently asked which end of the golf club and which size of club. And no one seems to have found out what the wooden stick said to be used in South Korea looks like. This is not to suggest that there is an acceptable end of the spectrum of physical punishment, but it does suggest a lack of professional curiosity about what Child B had actually experienced and what the expected physical impact might be. An assessment of risk that does not establish properly how the injury was caused will inevitably lack important data, and be limited as a result.

2.3.10. Similarly, it is concerning that when social worker 2 reported to his manager in January 2011 that he had witnessed Child B being hit round the head by his father, the management response was not to open a S. 47 investigation. This was despite that fact that Child B had only recently ceased to be subject to a Child Protection Plan resulting from physical abuse. When interviewed, social worker 2 had very limited recall of this event, but commented that if this was to happen now, he would expect to be told to take it back to a Child Protection Conference.

2.3.11. The 15 year old who was boarding with the family at weekends and during school holidays would have been privately fostered by Child B's father if he stayed for more than 28 consecutive days. It is probable that he returned to South Korea for the summer holiday, but the question does not seem to have been asked. If he was privately fostered, the suitability of the placement should have been assessed and it is possible that it would have failed on safeguarding arrangements. Private Fostering is too often missed, especially when the circumstances are at all unusual.

2.3.12. In addition, the 15 year old should have been assessed in his own right even if not privately fostered, because he was staying in a household where another child was subject to a Child Protection Plan.

2.3.11. When Child B transferred to a Child in Need plan in September 2010, recording almost ceased. The school nurse kept records of the CiN meetings for her use, but there was no agreed and circulated record. This was presumably indicative of the comparative priority given to CiN work, compared with Child Protection work. The author is told that records are now kept during a CiN episode.

2.3.12. A "copy and paste" theme emerges in this phase of work which means that actions are added to the plan (whether CP or CiN), but not flagged or removed when achieved. As a result, plans become longer and more difficult to make any sense of. After June 2012, all recording formats in ICS were revised and the author is assured that out of date addresses and details of people no longer involved are not pulled through. Before the changes to ICS, it was difficult to know who was involved at any point, because the system replicated names and addresses from earlier documents.

2.3.13. The "copy and paste" theme is carried over into the core assessments, so that the core assessment completed in 2012 has information carried over from two years previously. This would not matter so much, if it was clear what was new and what was old information, but it is not. Feedback elsewhere strongly suggests that parents tend to be understandably upset or angry at seeing information that is out of date, and they may interpret it as an accusation that they have not taken an action that has, in fact, been signed off some time ago. Time constraints and pressures of work often lead to such short cuts, but social workers should also be aware of their potential impact on children and parents, as well as their capacity to muddle inspectors and auditors.

2.3.14. There is good practice too in this phase. The school nurse records are meticulous and show regular monitoring of Child B's health and well being, in addition to notes about how he seemed and what he said.

2.3.15. The first core assessment, in January 2010, brings out Child B's need for activities shared with his father, praise and emotional warmth. The subsequent core assessment, in November 2012, shows that the social worker took swift action to get Child B's brother back into college.

2.3.16. The YISP worker did an intensive piece of work at the same time with Child B as a first time offender, and there is no further history of shoplifting.

2.3.17. The work undertaken by Kingston Young Carers was also very supportive to the family as a whole, and continues to be so to the present time. With the benefit of hindsight, one might say that Child B should have received more individual attention, but the response was proportionate and reasonable at the time. His caring responsibilities were relatively light, he was showing no outward sign of being adversely affected by them, and the pressing need was to sort out the family's precarious finances, in order for them to keep their accommodation after a year in a hostel for the homeless. The project coordinator has shown a high level of tenacity and commitment to the family wellbeing.

2.3.18. Moving on to the final day of Child B's life, the support he received at school shows a high level of commitment to the emotional wellbeing of a vulnerable student. He was tracked through his school day and the Designated Member of Staff did his best to ensure that he worked collaboratively with Children's Social Care, and that Child B felt all right to go home.

2.3.19. In terms of practice, there would seem to be three factors that may have contributed to the tragic outcome on 17th July 2014.

2.3.20. The practitioner group was agreed that both the contact and the subsequent referral were seen primarily as being about physical abuse; the one or two slaps on the head from his father reported by Child B. This framed the response throughout the day, and is discussed in detail in Finding One which has a focus on decision making in the SPA (Single Point of Access).

2.3.21. In addition, the referral details, once available, did not result in a decision at the SPA, and swift onward transfer to the receiving team. There is a difference in the perception of what this was about between the (then) assistant team manager and her colleagues. What happened was a number of informal discussions and varying opinions, as to whether the case was at child protection, child in need or common assessment framework level. This links to the framing of the referral as relatively low level physical abuse. It also suggests a lack of knowledge, or confidence, or use of the transfer protocols that had been in place since May 2014 within the SPA, linked to the unavoidable absence of the Team Manager. This is further discussed in Finding One

2.3.22. As a result of the focus on the physical abuse of Child B, his statement of intent to kill himself was not explored. In addition, had there been a focus on Child B's suicidal intent, the answers from the practitioner group to the question, "What might have happened if Child B had been seen as a child at immediate high risk of suicide?" suggest a level of uncertainty at that time about the appropriate response, that is explored in Finding Two.

2.3.23. Several practitioners commented at the end of their structured conversation with the author that it had been personally useful as a means of debriefing. One practitioner felt strongly about what she perceived as a lack of support to the CSC workers affected at the time of Child B's death. The school received good support from the Educational Psychology Service, and health professionals were also able to access emotional support. In Children's Social Care there is no access to Critical Incident Stress Management (CISM) or an alternative. Although CISM is not a panacea it is used widely in the health service and in some local authorities, and it may have left some professionals feeling better supported in Kingston.

3. Child B's Suicide

3.1. What factors might have led Child B to feel suicidal?

3.1.1. We cannot know why Child B felt, on 17th July 2014, that he could not bear to continue to live, but we can try to understand contextual and immediate factors in his loss of resilience.

3.1.2. Child B was South Korean, from a community that is well known to be the largest South Korean community outside South Korea and the US. The Korean

Link Worker for Kingston explained the push and pull factors that contribute to South Korean immigration. Several South Korean businesses have opened up, including Samsung, some 20 years ago. The UK is seen as a good place to live. South Korea is a small country; smaller than the UK, but with roughly the same population. Consequently, it is a crowded country, and that has encouraged South Koreans to seek opportunities overseas.

3.1.3. At Child B's primary school, about 10% of the children were South Korean and a similar proportion at his senior school. However, the majority of South Koreans, who come to the UK do so as a member of a company and quite often for a limited period of time. Learning English is given a high priority, as the international language of business. Parents are typically professionals with a comfortable income, and high aspirations for their children.

3.1.4. Child B's father seems somewhat on the edge of the South Korean community. He was self-employed, financially insecure, a builder/heating engineer, a single parent, and he lacks confidence in his ability to speak and understand English. The comments from professionals about Child B being on the periphery at school might also apply to his father's place in the South Korean community. When Child B was subject to a Child Protection Plan, his father was persuaded to play less golf at weekends, and spend more time with his sons which, while undoubtedly meeting Child B's needs, possibly took from his father his primary opportunity to integrate into South Korean society, and to make the contacts, which would bring in more work.

3.1.5. We don't know what sense Child B made of his early life other than the autobiographical account found in his pocket, and this does not add up with the chronology or his father's account of his life. His mother seems to have left the family after a domestic violence incident in 2004, in Kingston, yet Child B indicates that he was living in South Korea until he was 7 i.e. 2006/07. He doesn't seem to have had a clear narrative about what had happened in his life and why. In addition, there was confusion among some professionals between Child B's birth mother and his step-mother, who joined the family briefly in 2010 and they would not have been able to share a clear narrative with Child B. It is likely that Child B was more affected by the departure of his mother, than anyone knew and that he had no one he could share this with.

3.1.6. Child B's father's parenting style was well-intentioned. He wanted the best for his sons, for them to have a better life than he had had, to be high academic achievers, well-behaved and responsible. He seems to have found lone parenting a struggle, probably exacerbated by the factors already mentioned. He certainly expected too much at too young an age, for example sending his 10 year old alone to the dentist. And the evidence is that he continued to hit out at Child B long after telling social worker 2 that he accepted he should not use physical punishment in the UK. It seems likely that Child B learned to "navigate" his father, that he usually knew how to avoid a scene, and that is why his outward behaviour improved. He would have known that the parenting he received was different to that received by most (but not all) of his peer group.

3.1.7. The family was under financial stress to a greater or lesser extent throughout the period in question, so much so that they were evicted in 2012, and spent a year in homeless accommodation. Child B showed that, as he grew older, he became acutely aware of the stress and the contribution played by his father's inability to read and speak English as shown by his text to the YISP worker; "I am worried about my dad, because I have seen lots of bills and letters about court saying to get out of the house and I know my dad can't cope with all of that…" The text suggests that Child B was beginning to feel responsible for his father, especially as his brother was choosing to absent himself. He was just reaching 13 at the time. If Child B was also beginning to feel that he was the favoured son, it came at a high price.

3.1.8. When Child B's father confronted him on 16.07.14 with a bank statement showing that a total of £500 had been taken from his account, Child B must have known how grave this was, because the family had already experienced financial meltdown. He had a history of stealing from his father when younger, and that fitted into the context of an emotionally needy child taking what he can get from a largely absent parent. This was of a different order.

3.1.9. Child B's father told us he had given Child B a laptop for his 15th birthday on 04.06.14, under some pressure as he understood his son needed it for school work. As a consequence, Child B no longer had to use the main computer which could be monitored, and he began to spend increasing amounts of time playing online games where the entry level may be free of charge, but which become paying as one progresses. Child B's father felt that for his son, this was out of control and he was effectively addicted. To fund his playing of games, Child B used his father's credit card. Child B's father seemed to feel somewhat powerless about this, and Child B's brother had apparently taken on the task of stopping Child B's illicit spending.

3.1.10. Child B knew that he had let down his brother, as well as his father, in the context of a society that expects high standards of obedience and duty from children to parents. In addition, he was causing real financial harm to the family and risking reputational damage to his father. It seems likely that it was knowing that he had to face the anger and/or disappointment of both his father and his brother, that made Child B feel he could not face returning home.

3.1.11. In addition Child B knew that he would again be sitting scholarship exams which he had little, if any, hope of passing after spending 4 nights a week in private tuition, perhaps to the detriment of school work (such as the French coursework he had not completed). He had talked at the age of 10 about the rage his father showed, when he failed the first time, and he probably knew that his father had given up on his aspirations for his brother, instead pinning all his hopes on Child B.

3.1.12. It seems probable that a number of factors collided for Child B on 17.07.14. His apparent belief that his death would make his father happy indicates that he felt an enormous burden of disappointment to his father; he had let his father down by stealing a large sum of money, and he expected to let

his father down by failing the scholarship exams. It was also almost the end of term. School had probably continued to be the safe place, it was when he was 10 and he was facing 5 or 6 weeks out of school, and with his now unemployed father.

3.1.13. The author was told that the South Korean community expects high levels of obedience and respect from child to parents throughout child hood and into adult life. The Eurocentric view that respect should be earned and that parents should lead by example, seems to be less prevalent. In addition, reputation within the community is very important. It may be that Child B felt his lack of obedience in terms of promising not to use his father's credit card again more acutely, than a child of similar age and a different culture. And it is possible that he was aware of reputational damage to his family as well.

3.1.14. An online search will quickly reveal that Child B is by no means the only child whose suicide has been linked to online games and/or the debt incurred through playing online games. As an issue, it crosses racial and cultural boundaries, but would seem to affect boys more than girls.

3.1.15. It seems that this was all simply too much for Child B, and led him to take his own life. The fact remains, however, that adolescence can produce crises of parenting and crises for young people, as severe and acute as Child B's. When he said that he would go home at the end of the school day, no one could have predicted that he would instead not even attempt suicide, but kill himself in a way that he would have known was failsafe.

3.2 Understanding suicide in the Korean context

3.2.1. South Korea has a high rate of suicide. According to the World Health Organisation it had the third highest rate in the world in 2011. However, there is evidence that the risk of suicide is highest in the over 65 population, rather than in young people.

3.2.2. It has not been possible to talk to a professional in mental health services about suicide and the South Korean population in the UK. The author was however given a link to an article, "*An ecological understanding of youth suicide in South Korea*", from School Psychology International 2010, Vol.31(5), via the School of Oriental and African Studies, University of London[1].

3.2.3. The article is concerned with the incidence and causes of youth suicide in South Korea, but it may have relevance to youth suicide in the South Korean community in the UK.

3.2.4. In South Korea, suicide was the second leading cause of death (4.6 out of 100,000) among youth aged 10–19 in 2008. The authors argue that, as youth suicide has become a major public health concern, an important component of

[1] "*An ecological understanding of youth suicide in South Korea*" Lee SY, Department of Psychology, Ewha Womens' University, Seoul, Korea; Hong JS, School of Social Work, University of Illinois, Urbana, USA; Espelage DL, Department of Educational Psychology, University of Illinois, Urbana, USA.

suicide prevention and intervention efforts has included a need to understand risk factors. Individual, family, peer, and school level risk factors for youth suicide in Korea have been examined by a number of researchers. The authors argue that these studies have not considered factors, such as cultural beliefs and values, which are inherently relevant to youth suicide.

3.2.5. The article talks about academic stress and notes that suicidal high school students in Korea reported the most significant stressor in their life to include difficulties with career choice, low academic achievement, the amount of academic work and lack of rest. It is also reported that poor academic performance contributes to depression and suicidal ideation among adolescents..

3.2.5. The article also discusses internet addiction; the internet has become a major part of youth culture since South Korea emerged as the "most wired nation in the world". Consequently, internet addiction among youth has become a serious social problem in South Korea. In recent years, a number of researchers in South Korea have investigated the relation between the internet addiction and psychological health problems, which may induce suicidal ideation in young people. Several studies reported that South Korean high school students, who were addicted to the internet were at greater risk of psychological problems, which lead to suicidal behaviours, than those who were not addicted to the internet.

3.2.6. The authors note that South Korean society has been characterized as collectivistic ,where the basic unit of a society consists of groups and where inter-dependency or in-group harmony is emphasized. It is assumed that the emphasis on interconnectedness or responsibility to the family might serve as a protective factor for suicidal behaviours. However, studies have shown that South Korean society is moving toward individualism, and many South Korean adolescents tend to have more individualistic tendencies than previous generations. Therefore, young people with strong individualistic tendencies and those who value self- reliance and independence may feel trapped between two opposite cultures and struggle with their cultural identity, which could lead to suicidal behaviours. Child B was navigating two cultures, but he seemed, to people who knew him, to do this without apparent stress or difficulty.

3.2.7. To summarise, the relevance of the article, the evidence for causational factors in youth suicide is generally inconclusive and can provide only suggestions to explain the hopelessness apparently felt by Child B.

3.3. The response of the shopping centre

3.3.1. The shopping centre in question is owned by an investment company which employs a firm of managing agents. Following Child B's death, a meeting was arranged between senior representatives of the centre's ownership and management, the professional adviser to the LSCB and officers from public health and environmental health.

3.3.2. The shopping centre had held an internal management review and the learning was shared with the LSCB. The shopping centre representatives shared

that Samaritans had provided support for their staff although other employers (who had made their own arrangements) provided security and cleaning. More security staff had been employed.

3.3.5. A letter was received from the managing agents by the Independent Chair of the LSCB in February 2015. A number of measures had been taken to increase public safety at the centre;

- The shift pattern of the security guards was changed, so that there is 1 guard on level 2 at all times who is looking for people who seem distressed or are acting abnormally in a shopping environment. This had led directly to the identification and support of one person, seen to be acting in an abnormal manner. The point was also made that all staff are trained to look for abnormal behaviour as part of counter terrorism training.
- Public access to the 3rd floor had been blocked, following the closure of a gym that had its main access on that floor. Removal of the stairway used by Child B was not possible, as it is a fire escape.
- The Samaritans were invited into the centre and chose to have a stall on 26.07.15.
- Both the Samaritans and the managing agents had offered support and counselling to all staff affected by the incident on the day.
- A survey had been commissioned to see if sound / music recordings could make a difference in the centre environment.

3.3.6. Confirmation was given that the shopping centre meets all current health, safety and building requirements. In addition, the managing agents had considered measures taken by other major centres in the UK and abroad.

4. Findings and Questions for the LSCB

4.1. Finding One

The functioning of a point of access to Children's Social Care is dependent on the sharing of relevant information with the right people in a timely way, underpinned by procedures or protocols that are known to and used by everybody involved.

4.1.1. The ease of access to a coherent chronology or history for a case is a crucial factor in enabling managers at access points to make robust and evidenced decisions about the immediate conduct of a case. Information may be shared verbally and in writing, and it is important that a verbal culture does not predominate, and that the verbal transmission of information is done with due regard for its importance.

4.1.2. Any protocols or procedures that support the functioning of an access point need to be complete, well known and actively used. They should be dated and they should have an ascribed author and a date for review.

How did the issue manifest in this case?

4.1.3. Because the SPA members were in a team meeting until 12.15, messages were taken by business support. It was clarified that messages were just that; a note in a book and a verbal message to the caller that a SPA support officer would ring back. Business support would not ask for the online referral form to be completed and returned. Despite the fact that the business support officers were told they could interrupt a team meeting, it seems they tend not to. The impact was to delay the point at which information from the DMS started to come through until 12.45. Given that the DMS first rang in at 10.45, this equates to a delay of 2 hours before any information of value was known.

4.1.4. There are two presenting issues about the extent of the information shared in and outside the SPA on 17.07.14. The first is the history of the case, and the second is the fact that Child B had talked of killing himself.

4.1.5. It was known to the SPA that Child B had previously been subject to a Child Protection Plan, as soon as his record was opened because he was flagged. In addition, when the DMS had sent in his written referral at 14.30 he clearly stated the fact. There seems to have been a delay in pulling off the whole history of the case, although the SPA support assistant said she found it easy to access case histories on ICS.

4.1.6. The R&A team manager was not made aware of the history or the threat of suicide when the SPA ATM came to discuss it. She was told that Child B had run up £500 of debt on his father's credit card, and had been hit round the head. On this basis, she assessed there to be no immediate risk and suggested a CAF level response, thinking perhaps Child B was being bullied at school.

4.1.7. The SPA ATM then spoke to the TYS TM, giving the same information, but adding that Child B had said he was scared of his father. The TYS TM offered to look him up on ICS, and remembered that the SPA ATM could not remember the boy's name. This is a small but important point; a child will not begin to have an identity and become a person about whom we are concerned, if he does not have his name. It is a point of respect. In addition, the use of the name may prompt others to remember the case from previous involvement and add their knowledge.

4.1.8. The TYS TM then discussed the case with the ART TM and agreed on a joint home visit the next day, following information from the SPA that Child B was saying he would go home. On the information shared, this was a reasonable response. Child B had been spoken with by a professional he had known for several years, he was 15 years old and competent to make a decision, and he had said he felt "OK" about going home.

4.1.9. The practitioners' meeting agreed that the referral was seen as primarily one of physical abuse, and when the history was established it would, ironically, have supported this assumption. The information about Child B saying that he intended to kill himself got lost.

What makes it underlying, rather than particular to this case?

4.1.10. Several factors suggest that this was an underlying issue at the time.

4.1.11. During the SPA team meeting, new contacts were taken as messages by another team and passed on (except in an obvious emergency) when the meeting finished. This would seem to be too weak a system to support a good response, and to inspire confidence in other agencies.

4.1.12. SPA Coordinators, who are not qualified social workers, receive contacts from other agencies and the public. Managers might want to consider whether the benefits of deploying qualified social workers would outweigh the added cost. It is also concerning that the SPA deals with calls to named social workers, acting as a switchboard. Perhaps triage at the point of a call coming in would help, so that any call relating to a child, who may be at risk, is sent straight on to a social worker.

4.1.13. The practice of having informal conversations with colleagues to try out ideas is important in social work, but perhaps had been taken too far in the SPA at that time. It is also usual and appropriate for team managers to stand in for each other, but delegated responsibility must be overt and understood. It does seem that a culture had arisen in the SPA whereby, if the manager was absent, there would be a conversation between the SPA ATM and the R&A TM about whether a case should be transferred there or elsewhere. This can easily slide into an assumption that such decisions are taken collaboratively, whereas it is the SPA that is responsible for deciding on the immediate direction a new case will take. The protocols and escalation procedures need to underpin this.

4.1.14 It is not the author's intention to criticise a cooperative and supportive culture among first line managers, but rather to suggest that managers need to be aware that if the decision making process is not followed, and there is a lack of full and real-time information about a case, the two may elide, as they did on 17.07.14 leading to increased risk.

4.1.15. It took several months for the author to be sent the Transfer Protocol for the SPA and the SPA procedures. The protocols shared with the author do not lend themselves sufficiently to being used as management instructions. There is no badging as belonging to Kingston/Achieving for Children, no mention of how they fit into other practice guidance or management instructions, no attribution of authorship or sign-off by senior management, and no date for review.

4.1.16. The Transfer Protocol states;

3.1 The SPA will be responsible for identifying which children/ Young People require assessment.

- *Where a child / YP is likely to be at risk of significant harm the matter will progress immediately to the duty Referral and Assessment Team for action;*

- *Where the SPA manager concludes that an initial/single assessment is required they will meet with the Referral and Assessment Manager to discuss the concerns. Transfer will occur within 48 hours of the receipt of the contact.*

4.1.17. The protocol does not set out what happens if the child is not assessed as likely to be at risk of significant harm, or at such immediate risk that he or she cannot wait 48 hours. The protocol is incomplete, and as such cannot fully support the SPA and receiving teams, where cases do not fit obviously into the above category.

4.1.18. The SPA Procedures were shared after the Transfer Protocols. The SPA Procedures are clearly badged, but are in draft, have no date and no authorship or evidence of being signed off by a senior manager. They would benefit from proof reading and editing, as they are difficult to understand in parts.

4.1.19. The author was assured that the decision of the SPA manager as to whether a case should transfer to the Referral and Assessment Team is final in that the R&A team must accept the transfer and work the case. There might then be disagreement and/or escalation, but cases should not be left hanging. However, the wording of the procedures is ambiguous;

13. Escalation or Threshold Dispute Resolution

The SPA manager makes the decision/recommendations in line with the local AfC thresholds or ultimately in accordance with PAN London Child Protection Procedure. The SPA Manager will notify immediately the Team Manager responsible for S.47 investigations so that the case can be progressed as per London Child Protection Procedures.

However if the receiving duty manager disagrees with the decision/recommendations, the two managers should discuss this further and come to a mutual decision keeping the child in a centre. Every effort should be made to reach satisfactory resolution under relevant guidance for the circumstances on the day the dispute arises.

4.1.20. It is also unclear whether the protocol or procedures have been shared with the multi agency network and/or with the public via the Kingston CSC website. The author was unable to find them on either the Kingston or the Achieving for Children websites.

What is known about how widespread the issue is?

4.1.21. This has been more difficult to establish. By its very nature the issue pertains only to Children's Social Care, although there is a risk of an impact on multi agency confidence. The aspects concerning the structure of the SPA and the usefulness of protocols obviously carry across much of the work coming in.

4.2.22. The "softer" issues of organisational culture, which might be summed up as everyone knowing when a decision is a decision and not a conversation, are harder to establish. There was some confidence in the practitioner group that people are "sharper" about knowing and using the protocols and procedures now, although there seemed to be a lack of awareness of their limitations.

4.2.23. The author has been assured that recent auditing of SPA decision making shows that it is robust and evidence based.

What are the implications for the child protection system?

4.2.24. The implications are that there may be an unnecessarily high risk of decisions being taken on too little or poor quality information, and of uncertainty about the processes involved in making decisions.

Questions for the Board to consider

1. Is the Board satisfied that the SPA has been set up so that contacts relating to risk to children are passed on quickly to social workers, who are qualified to assess the level of risk?
2. Do the agencies represented at the LSCB understand how the SPA works and do they get good and timely feedback on decisions made about referrals taken?
3. Is the Board satisfied that the Transfer Protocol and SPA Procedures which govern the relationship between the SPA and receiving teams is sufficiently robust and well understood?
4. Is the Board satisfied that the awareness of the protocols and procedures governing their work is sufficiently high among practitioners?
5. Would the Board encourage CSC to electronically publish policies, procedures and protocols in a way that makes them simple to access?

4.2. Finding Two

Although some individual practitioners expressed some confidence in their skills and knowledge about young people who express the intent to kill themselves, this confidence is not spread across the multi-agency work group. This suggests that more or better training and/or awareness is needed and access to support to assess at a primary mental health worker level.

4.2.1. It is acknowledged that Child B lacked some of the risk factors that might have informed an assessment of the likelihood of him committing suicide. For example, he had no history of self harm or suicidal ideation, he had never (to the best of knowledge) alluded to or discussed killing himself with friends face to face, or online (quite the reverse from the evidence of the response of the online Minecraft community), and there is no evidence that he researched suicide methods.

4.2.2. But, although Child B's suicide was not predictable, this does not take away the responsibility of the multi-agency safeguarding community to be capable of responding usefully to other young people, who feel a similar sense of hopelessness and express a wish or intention to end their lives.

How did the issue manifest in this case?

4.2.3. The issue presented itself in the practitioner group when one professional asked whether Child B had been asked, on 17.07.14, if he had a plan when he said he wanted to kill himself. On the face of it, it seemed a bleak question to ask and could provoke a view that the professional was helping the child to think through how to do it. It is also a question that demands the right intonation and note of enquiry.

4.2.4. The practitioner later explained that she was referring to Mental Health First Aid (MHFA) training which many front-line workers are trained in, and is delivered by (amongst others) two Kingston Council staff, although not employed in CSC. The training provides guidance on "First Aid for suicide" for frontline workers. The first step is to "Ask, Assess, Act" and includes guidance as to questions that can be asked including "Current plan; find out if the young person is thinking about suicide, and if they have a current plan, have they made preparations to do so, including the means".

4.2.5. There was a division of opinion in the practitioner group as to the most appropriate immediate response to Child B on 17.07.14 regarding his threat to kill himself. He could have been taken to A&E by a teacher or social worker, where he would probably have waited some time to be assessed, probably by an adult psychiatrist, who would have the options of admitting him to a paediatric ward for further assessment, or sending him home, assuming that he had consented to go to hospital and wait to be seen. Given the lack of known risk factors, it would seem possible that Child B would have been sent home, especially if he was saying he felt safe to go. The alternative response might have been for a social worker to go out to the school, and offer to accompany Child B home and assess how safe home was, after talking with Child B's father and brother, if he was there (preferably with an interpreter). This would require a social worker to feel confident in their ability to make a basic assessment of the immediate likelihood of suicide, and at this point the training referred to above would be useful.

What makes it underlying, rather than particular to this case?

4.2.6. The response from CSC practitioners in the group indicated that they did not see themselves as experts, or able to make a diagnosis in mental health issues. This is right, but social workers will find themselves working with children, who have mental health issues and, even if a referral to Child and Adolescent Health Services (CAMHS) is accepted, the social worker will need to continue working with the child during the waiting period. The social worker will then support the work of CAMHS with the child, and perhaps take over from CAMHS when work ends.

4.2.7. Social workers cannot be guarded from being with children and young people, who talk about killing themselves any more than teachers, school nurses, youth workers and other non mental health specialists can. However, it is also of note that the DMS in this case was unaware of the training referred to above, suggesting that the need for training is wider than Children's Social Care.

What is known about how widespread the issue is?

4.2.8. Locally, although the CAMHS budget has not been reduced, it is reasonable to assume that demand is rising, so the same resources are having to cover more children.Nationally, CAMHS are experiencing a steady rise in demand and cuts in funding. More than a year ago, Young Minds were warning that over two thirds of local authorities had cut their CAMHS budgets since 2010, and it is likely that this figure has since increased. And CAMHS was not a service that was generally thought to be well-funded before cuts.

4.2.9. The inevitable result of pressure on CAMHS is that other professionals have to support children through episodes of a lack of emotional wellbeing that might formerly have resulted in a service. There will be times when there is a perception that CAMHS is insufficiently available, whether or not it is justified. And wherever possible, CAMHS will work with a child via their carers in order that other children may subsequently benefit from a more informed parenting style.

What are the implications for the child protection system?

4.2.10. Child B had not been referred to CAMHS and no criticism is implied here. As far as we know, Child B was not suffering from a mental health disorder, had not self harmed and had not researched suicide methods nor talked about suicide before his death. His death was not predictable and so was not preventable.

4.2.11. However, most young people who achieve or attempt suicide do so having shown behaviour and/or voiced feelings that indicate they are at risk of suicide. To quote the website of The Samaritans; *Suicidal behaviour is a complex phenomenon that usually occurs along a continuum, progressing from suicidal thoughts, to planning, to attempting suicide, and finally dying by suicide.*
The implication is that everyone in the multi-agency network needs to have a basic understanding of adolescent suicide, and of how to get help when the professional is feeling out of their depth.

4.2.12 Suicide is a significant cause of death for boys aged 5 to 19 in England and Wales (and for the most part within the higher end of the age range). The Office for National Statistics data for 2012 showed that suicide and injury or poisoning of undetermined intent were jointly the second highest cause of death in this age group, at 12%, the first being land transport accidents at 18%. This reinforces the point made above that knowledge and skills in this area are required from a range of professionals.

4.2.13. It should be noted that in Kingston, a member of the CAMHS service now provides dedicated support to the SPA. In addition, a two day youth mental health first aid training is available for anyone who works with, lives with, teaches or cares for young people (11 to 18 years old) with emotional or mental health problems. There is no charge for the course.

Questions for the Board to consider

1. In terms of child suicidal ideation, is the training on offer meeting the needs of professionals and is it well used and rated?
2. Does the Board have sufficient information to provide support and challenge to drive improvements in mental health outcomes for children?
3. Is the Board satisfied that the local commissioning of CAMHS meets the identified needs of Kingston children?

4.3 Finding Three

If a minority community makes few demands on statutory services, and is not well represented among service users or providers, its culture is liable to remain hidden or poorly understood. The impact is felt when statutory services need to get involved and do so, on the basis of insufficient understanding of the culture, attitudes and beliefs of the service user. There is then a heightened risk of poor outcomes.

4.3.1. It is not possible to make an obvious link between Child B's ethnicity and his suicide. Neither the time he spent as a looked after child, or a child subject to a Child Protection Plan give us a real window onto how he experienced his culture, or bridged the divide between the two. The fact that he was quite vociferous about his wish not to be hit or beaten, strongly suggests that he was aware of difference from a young age, but what is less clear is whether the professionals working with him had the understanding necessary, or the means to find out information that they needed.

How did the issue manifest in this case?

4.3.2. The strongest manifestation in terms of the writing of this SCR is the fact that fundamental questions remain unanswered, because it has not been possible to identify professionals who might help. Would Child B's emotional state in June/July 2014 have been more obvious if he had not been Korean? Should his stated intent to kill himself on 17th July have been seen differently, because he was Korean (even though he later said he was willing to go home)? Are there any differences between cultural norms about suicide and, if there are, had a risk assessment been done would it have been too Eurocentric to detect any differences?

4.3.3. During the structured conversations, several participants were asked about their understanding of the South Korean community and the representation of the South Korean community on their caseloads. In general, the response was that limited information was known about the community and that they worked with few South Korean children.

4.3.4. The lack of knowledge and curiosity about the South Korean community meant that limited efforts were made to find out how Child B, his brother and his father experienced their culture, what it meant to them and how they wanted to live. For example, it has been commented on above that telling Child B's father that he must spend less time playing golf on Sundays and more time on activities with his sons was right in terms of the father and son relationships. What the worker did not do was explore why the father played golf. The author has been told that the local golf range is an important meeting place for Korean men, and it is likely that Child B's father picked up business and/or kept his place in his community by attending. At the time, questions were not asked as to why Child B's father played golf, so there was no attempt at a compromise which met the needs of the son and the father.

What makes it underlying, rather than particular to this case?

4.3.5. Members of the panel were keen that this should not be seen only as an issue affecting the South Korean community, but other ethnic minority communities too.

4.3.6. Since July 2014 and in response to the limited information known about the Korean community, Kingston Children's Social Care has put together an information pack for social workers. In terms of Children's Social Care, it notes that; "*Korean attitudes towards authority and intervention by children's services in Kingston can be best understood by considering certain cultural factors. Korean parents are not generally familiar with the services that are offered by children's services within the UK. Whilst various types of children's services are available in Korea, the tendency is for Korean parents to care for their children on their own, without any outside intervention…. The general belief of Korean parents is that any problems they face with their children, unless it is severe, should be solved within their family circle. For this reason they feel uncomfortable and embarrassed when there is any form of comment or intervention by others."*

4.3.7. This tendency not to look for outside intervention is probably exacerbated by language barriers. The nature of the Korean language makes it even more different to English (and other European languages) than, say, Chinese or Japanese. This can lead to embarrassment for Koreans, who may struggle to understand official letters or how to access services via the internet. It also means that professionals need to be comfortable in working with interpreters, and that skilled interpreters need to be easy to book and fund.

What is known about how widespread the issue is?

4.3.8. In late 2014 a Korean Information Centre was set up in New Malden offering practical and legal advice, as well as English conversation classes. The Centre is open only on Mondays and it is busy. The author was told that a previous initiative where a Korean speaker was attached to the Citizens Advice Bureau was less successful, and it would seem that the difference is that the Korean Information Centre (although in borrowed premises) is distinct and anyone going in, will know that Korean speakers will greet him or her.

4.3.9. There was a shared view between the panel and the practitioners' group that the Korean community, although well established in the area, is poorly known and understood. None of the practitioners interviewed referred to Korean colleagues, and it would seem that young South Koreans are not generally choosing the public sector for employment. This is not a criticism, but the opportunities for shared exploration and understanding of cultural contexts between colleagues are then missed.

4.3.10. Across the UK, professionals involved in the child protection system find themselves working with people from an increasing spectrum of nationalities and cultures, each with its own beliefs and methods in child rearing. In areas with a high and/or transient population of first and second generation immigrants, workers become proficient in understanding other cultures and in asking the questions they need to. In areas, like Kingston, where the ethnic minority population is lower, the need to know about, and understand other cultures is just as, or even more, important in order to avoid mistakes and oversights.

What are the implications for the child protection system?

4.3.11. The child protection system works best when parents and carers understand and accept why professionals are worried, and when the lived experience of the child is central to planning. If there are barriers of language or understanding between service user and service provider, it is generally more difficult to achieve the dialogue that supports the actions that keep children safe.

Questions for the Board to consider

1. Is the Board satisfied that professionals in all member agencies have access to information about Korean and other local ethnic minority cultures?
2. Is the use of interpreters embedded? Do workers understand how best to work with interpreters?

4.4. Further Practice Questions for the LSCB

4.4.1. There are aspects of practice that have not been developed into Findings, because they reflect practice that has moved on. Nevertheless, the author recommends that the LSCB satisfies itself that the auditing programme in place

in Children's Social Care is used to check quality and compliance in the following areas;

1. The voice of the child is heard, recorded and used to inform planning with parents and carers across child protection, children in need and looked after children;
2. Parents and carers are also heard, and planning is done with them and not to them wherever possible;
3. The use of copying and pasting from a previous assessment/plan to a new one does not obscure new information or allow out-dated information to be presented as if it was new.
4. The regulations governing private fostering are understood by all practitioners, qualified and unqualified, and that assessments of the suitability of private fostering arrangements are robust and pay due attention to the safeguarding of vulnerable children.

4.4.2. In addition, the LSCB should compare the access to Critical Incident Stress Management, or equivalent support, across member agencies and assess the effectiveness of this provision. It may then follow that Achieving for Children and other local agencies or sectors commission training and/or the provision of a specific package of support for staff affected by any incident which causes emotional distress.

5. Epilogue

5.1. Child B's School

5.1.1. This is an account of actions taken by Child B's school, as related by an Assistant Head, included here with the intention that other schools might benefit, should they experience such a tragic event.

5.1.2. The school was contacted by the Samaritans, as soon as the news of Child B's suicide was made public, which meant that their advice guided actions over the summer holidays and into the autumn term. The Assistant Head (AH) took the coordinating role throughout, working with parents, as well as boys. AH shared the Samaritans' guidance with the senior team, before the start of the new term and went to all year 11 tutor groups.

5.1.3. On the 18.07.14, the boys who were known to be Child B's friends were taken out of assembly (where the news was shared with the whole school) and their parents were contacted. The Educational Psychologist and the Health Link Worker were in school all day.

5.1.4. For the first 10 days of the school holidays, a rota was organised so that a teacher would be available every day, and the parents informed that they could phone or email for support. AH kept in close contact with 6 boys and their parents.

5.1.5. The Samaritans' advice was to let the boys, who were Child B's particular friendship group take the lead. The boys designed a memorial and a service,

working with AH over about 2 months. The Head joined one meeting. The boys decided on a tree as a memorial and spent time researching the right tree. A memory box was buried beside the tree after the memorial service in October. The Educational Psychologist gave AH on-going support.

5.1.6. AH no longer arranges meetings, but the boys know they can talk to her. A recent decision had to be made about the Year Book, and a page will be dedicated to Child B.