Buckinghamshire LSCB

Serious Case Review

Executive Summary

in respect of

child Z

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Report Author

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1. Background to the review

1.1 This review relates to the death of a sixteen year old girl (known in this report as Z) and her unborn baby. Z was eight months pregnant when she was found having apparently jumped from a high place; she and her baby later died from their injuries. A subsequent inquest recorded an open verdict.

1.2 Z had been known to social care since her birth having moved from the care of her parents to being looked after by other family members at a young age. She also experienced a variety of placements in residential care, including two periods in secure units due to concern that she was placing herself at risk. During her life Z experienced significant losses since as well as being separated from siblings, her mother died whilst Z was in an out of county residential placement

1.3 At the time of her death Z was subject of a care order made to Buckinghamshire County Council.

2. The serious case review process

2.1 The serious case review was chaired by Donald McPhail, Independent Chair of Buckinghamshire Safeguarding Children Board. The overview author was Jane Wonnacott, Independent Consultant, In-Trac Training and Consultancy Ltd.

2.2 The serious case review panel members were

- Donald McPhail: Panel Chair and Independent Chair of Buckinghamshire Safeguarding Children Board
- Tricia Bratby: Lead Professional for child protection, Buckinghamshire Hospital Trust
- Heather Clarke: Divisional Manager, Prevention, Assessment and Protection, Buckinghamshire Children's Services
- Mary Davern: Operations Manager, Quality Assurance Buckinghamshire Children's Services
- Yvonne Gibson: Group Solicitor Buckinghamshire County Council
- Yvette Hitch: DCI Thames Valley Police
- Coral McGookin: Business Manager Buckinghamshire Safeguarding Children Board
- Peter Whitaker: Educational Psychologist

2.3 The following agencies were asked to contribute to the serious case review process and produced individual management reviews in line with the terms of reference.

- Young Addaction
- Barnardos R-U-Safe? service
- Buckinghamshire County Council Legal Services
- Buckinghamshire Children's Services Achievement and Learning
- Buckinghamshire Children's Services Social Care
- Buckinghamshire Hospitals NHS Trust
- Oxfordshire &Buckinghamshire Mental Health NHS Foundation Trust

- Buckinghamshire Primary Care Trust
- Buckinghamshire Youth Offending Service
- Cafcass
- Clare Lodge Secure Unit
- Stonham Housing
- Thames Valley Police

2.4 Terms of reference included each agency completing a chronology of their involvement from 31st March 2005, when the young person was accommodated under Section 20 and care proceedings were first initiated. Any background history known by agencies relevant to the terms of reference was included in the individual management review reports.

2.5 Specific issues to be considered were:

- Whether all agency processes and procedures were fully followed, particularly in relation to the pre-birth assessment of Z's child.
- Whether communication, referrals and action across all agencies relating to Z's mental health and wellbeing considered the risk of harm to herself..
- Whether there was sufficient support and services offered to Z following the death of her mother and through any assessment of ongoing bereavement issues.
- Analysis of the decision making processes in each agency and of how that was shared with all professionals involved. Consideration must be given to the level of appropriate information sharing that occurred across all agencies.
- To establish whether the information made available and accessible by, 'Out of Hours' services was relevant in this case to the assessment of risk.
- Background issues relating to Z's family history or culture that might be relevant.

3. Agency involvement that worked well

3.1 The serious case review found that the following aspects of practice worked well:

- there was evidence of continuity of staff throughout the period of the review. The same guardian worked with Z throughout her life and during the majority of the period covered by the review there were two consistent social workers and one independent reviewing officer;
- social workers went out of their way develop a close working relationship with Z and there is evidence that she viewed this positively.

4. Lessons learnt in relation to this case

4.1 One important lesson from this review is the need for thorough assessments which make sense of family history and use this to inform planning.

4.2 The review has highlighted a need to ensure that multi agency planning for planning for looked after children is robust. There was no coherent planning in relation to meeting

education needs of Z as well as a lack of liaison between health and social care. This resulted in Z registering with a GP who was unaware of her looked after status. The approach to work with Z was incident driven and key people such as the guardian were often unaware of placement moves until after they had happened. There was an absence of individualized care plans for Z within the secure units, and this meant there was a lost opportunity to use the time in those settings productively.

4.3 The need for risk assessments where young people are placing themselves in danger through their behaviour is evident from this review. This particularly relates to situations where the young person goes missing. The meaning of Z's behaviour was not explored and appropriately responded to. Z was consistently putting herself in risky situations but at no time is there evidence of a risk assessment which could be used to inform a risk management plan. This is an area for practice development.

4.4 It is apparent from this review that there are no clear protocols for responding to situations where looked after children experience bereavement. In this case the response to Z at the time of her mother's death did not take full account of its likely psychological impact.

4.5 Generally there was a lack of a coherent approach to assessing and meeting Z's mental health needs. There were lost opportunities to fully assess these whilst she was within secure units and greater use could have been made of CAMHS outreach services.

4.6 It was an important lesson from this review for all agencies to ensure that where a young woman is pregnant she is seen alone.

4.7 The assessment in relation to the unborn child appears optimistic and did not include any information about the father of the baby. Social workers and midwives failed to ask any information about his background highlighting the need for all staff to be made aware of the importance of gathering and analysing information about both parents.

4.8 Z fits precisely the profile of the hard to help young people in the overview of serious case reviews 2003-5.[1] Namely:

- History of rejection and loss
- History of long term intensive involvement from multiple agencies
- Parents or carers with their own history of abuse or rejection
- Exclusions from school
- Self harm, including drugs and alcohol
- Pattern of self neglect
- Numerous placement breakdowns
- Running away
- Going missing linked with risky sexual activity.

[1] Brandon et al (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn?* London: The Stationary Office

4.9 The cumulative risks associated with the above were not properly understood in this case and practice tended to focus on managing incidents rather than assessing and analysing the whole picture in order to inform plans for Z. There is little evidence of consistent effective first line management and supervision within social care, and the independent reviewing service did not ensure that plans were scrutinised and challenged. Whilst social workers always went the extra mile in their work with Z, it is apparent that they were not always able to stand back, understand the meaning of her behaviour and move beyond an incident led approach. This lack of an analytical approach to practice was reflected in the poor recording. Staff involved in working with young people in the care system need to be supported by managers who have good supervision skills. Supervisors should:

- provide the emotional support needed to address the psychological impact of working over a long period of time with challenging young people and apparently intractable situations;
- enable staff to reflect and analyse the meaning of sometimes complex and conflicting information;
- challenge practice and ensure proper assessments and plans are completed and recorded.

5. OVERVIEW REPORT RECOMMENDATIONS

These recommendations are in addition to the recommendations from the individual management reviews and aim to enhance agency recommendations as well as provide a focus for action within the LSCB.

There was no coherent planning or risk assessment following the death of the young person's mother. The potential impact of this on her emotional wellbeing over the medium/long term appears not to have been understood.

Buckinghamshire Safeguarding Board should develop a multi-agency protocol in relation to the expected response of all relevant professionals when a looked after child's parent dies.

There was no evidence of risk assessments related to the young person's absconding behavior.

Buckinghamshire Safeguarding Children Board should review existing local guidance in the light of DCSF guidance issued in June 2009 regarding children who run away and

go missing from home or care. All relevant staff should be reminded its contents.

The young person's mental health needs were not adequately assessed or met. This was in part due to difficulties in engaging with the young person.

Buckinghamshire LSCB should develop a strategy for implementation by the children's trust in respect of engaging with hard to help young people. This should be based on a coordinated and flexible approach to meeting their mental health and other support needs.

Planning and service provision whilst the young person was in secure accommodation was not based on a full assessment of history and the individual needs of the young person.

Children's social care should circulate guidance reminding staff that when a young person is admitted to secure accommodation the unit should receive immediately a full history and work with the social worker to develop an individualized plan. Where the secure unit does not fulfill its part in delivering the plan the operational manager should inform the Divisional Director for safeguarding and the Divisional Director for Commissioning.

There was little evidence of a joined up approach between social care and the education for children in public care team.

Buckinghamshire Children and Young People's Services should ensure that social care and education work together to implement the recommendations from the education individual management review that are aimed at facilitating more effective joint working.

The pre-birth assessment did not identify potential risks to the unborn child.

Buckinghamshire Safeguarding Children board should develop practice guidance alongside their pre-birth procedures in order to assist in the assessment of risk when an initial assessment is being undertaken. The implementation of this guidance should be backed up by staff development opportunities.

Staff supervision arrangements in social care and the midwifery services did not provide a forum for reflection and analysis where practice could be critically appraised within a supportive environment.

The delivery and quality of supervision within midwifery and social care should be audited in order to ensure that staff are receiving high quality reflective supervision that meets the specification set out in the Laming (2009) report, i.e. that it is "open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting targets" (para 3.15).

There was evidence throughout this case that risks were not clearly identified or managed appropriately.

Buckinghamshire LSCB should ensure that agencies have a coordinated approach to risk assessment and management for children and their families.

Since the court process is outside the remit of serious case reviews it has not been possible to fully explore the process for instructing and using experts.

Buckinghamshire Safeguarding Children Board should recommend to Government that the serious case review process includes provision for exploring decision making within the court process including the work of expert witnesses.

INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

Buckinghamshire Children's Social Care

1. Assessment and Care Planning - There should be regular file and case audits be carried out by managers for the purpose of checking that comprehensive and well evidenced assessments have been completed, are updated as necessary, and inform planning, decision making and intervention

2. Safeguarding Procedures - The LSCB should decide how best to disseminate the findings from the case review and ensure that this happens.

3. Contact - Practitioners and managers should receive training in relation to contact issues, especially in connection with family and friends placements.

4. Secure Accommodation - The local authority should review its policy and guidance on the use of secure accommodation.

5. Health of Looked After Children - Practitioners and managers should comply with the currently available guidance and with the revised guidance (currently being consulted upon) when available. Senior managers must ensure that the revised guidance becomes embedded in practice.

6. Assessment of Family and Friends Carers - The local authority should review policy and guidance for family and friends placements, including making clear who has

authority to agree Regulation 38 placements, under what circumstances, and the mechanism for ensuring that approval is given within 6 weeks by the Fostering Panel if the placement is to continue

7. Pre Birth Assessment - Recently revised pre birth assessment procedures have been formally launched and are now available to staff. It is crucial to make sure that they are made familiar with them, provided with written guidance and training in relation to their use, particularly the staff that will undertake pre birth assessments and be responsible for implementation of safeguarding plans.

8. Supervision - It should be established via immediate audit that staff, especially managers, are aware of and implementing the Council's policy. This should establish the level of compliance and any operational difficulties and shortcomings. It should also establish any learning and development requirements on the part of supervisors/managers generally and/or individually and these should be provided.

9. Recording - It should be established via immediate audit that recording requirements are being met, unless this has been done already, and there is confidence in the standard of work being completed. There should be ongoing audit to check that recording requirements are being met.

10. Independent Reviewing Officers - Where an IRO identifies poor practice, including previous care planning decisions not being acted upon, they must bring this to the attention of the social worker and of his/her manager and, focusing on problem resolution, work with them to expedite solutions. If this is not successful then the IRO, using the available protocol must bring the concerns to senior management for action.

11. Management Oversight - In high risk cases, especially those with potential for or characterised by chaos and crises, a named senior manager (at the level of Operations Manager or above) should assume responsibility for case oversight and decision making and this must include ongoing progress monitoring.

Buckinghamshire County Council Achievement & Learning

1. Education of Children in Public Care Team should improve tracking and monitoring of Looked After Children within Education of Children in Public Care.

2. Education of Children in Public Care and Reintegration Teams should ensure reliable, consistent approach to support of Looked After Children returning to area

3. Achievement & Learning Division to make appropriate training re: Looked After Children's Special Educational Needs available to Social Care Staff, to ensure understanding of the importance of considering Special Educational Needs when placing children.

4. Achievement & Learning Division should improve recognition and understanding of children and young people with mental health needs and how to engage with specialist

services on their behalf.

5. Education of Children in Public Care Team should improve case recording procedures.

6. Safeguarding in Education Team should improve recording system within Safeguarding in Education Team.

Thames Valley Police

1. The phrase / term “Missing Person to be sighted” should be eradicated. It is commonly used in deployment logs, and conveys completed the wrong message to front line staff. A more appropriate phrase would be “return interview / risk assessment”. It should be noted that the policy and procedures in place around Missing People are clear and robust. The concept of “sighting” is a colloquial expression used throughout the organisation, and is does not reflect the true policy. It is often used by control room operators when deploying resources.

2. Each and every officer who is involved in a missing child enquiry should consider child protection issues, and whether the issues of the specific case should be referred to the CAIU for further action, or multi agency referral. The role of the area Detective Inspector is important in quality assuring whether a referral to CAIU has been done or is needed, but there is no reason for any officer to wait for the Detective Inspector’s intervention for this type of referral to be made.

3. There needs to be training to front line staff outside of CAIU about how information needs to be shared with other agencies. The method of creating a “Crime Related Incident”- “Child Protection Log”, on the Police crime recording system called “CEDAR” is a robust and auditable method of ensuring that the information reaches the CAIU and is appropriated actioned. The problem is not the procedure, but a lack of wider knowledge about the process.

4. There needs to be a review into how information received into the AIT is disseminated to and from the CAIU within the Buckinghamshire BCU. There is a concern that information is not shared. In this case there is no audit of what was done with the information

Young Addaction

1. To review and update guidance for including partners/family members/friends in one to one support sessions

RUSafe

1. All Core Groups, LAC Reviews, CIN meetings or any other multi-agency meetings called on any open case will be attended by a member of the team. There will be an explicit requirement that consideration not to attend can only be given following

discussion with the CSM, who will make the final decision.

2. Staff team of R-U-Safe? to make every reasonable effort to be flexible and support each other to prioritize requests from young people open to the service when they request a meeting.

3. The CSM of R-U-Safe? to ensure that a case limit of 15 cases for full-time staff and 10 cases for part-time staff, are adhered to.

4. The use of the Initial Assessment Tool is monitored to ensure its proper completion, the use made of the information gathered and that the effectiveness of the format is reviewed after the first year of use.

5. The CSM ensures that the quality and frequency of case recording is a core element of supervision and Annual Appraisal.

6. Barnardo's to review the selected outcomes for Sexual Exploitation Services and add an element which addresses mental health and the risk of self harm of young people referred.

Buckinghamshire Hospitals NHS Trust

1. Record keeping is an essential part of communication and information sharing. More detailed documentation should be held in the hospital records, with particular references being made to:

- All identified risks or possible risks to a pregnant mother and her unborn baby.
- All discussions with other professionals or agencies and the outcome of those discussions.

2. All Child in Need Plans and Child Protection Plans are held in Maternity Hospital Records and are transferred to all baby records as appropriate.

3. Practitioners must have a clear commitment towards Clinical Supervision and this should be endorsed and supported by managers. (BHT Clinical Supervision Guidelines Oct.2008).

4. Consideration should be taken by Practitioners to discuss mental health issues and potential risks to a mother and her unborn baby with other Health Care Professionals and to develop processes as appropriate.

Buckinghamshire Primary Care Trust

1. Buckinghamshire PCT to develop a flexible service to support the Designated Nurse for Children in Public Care to meet the healthcare requirements of this vulnerable group of young people as described in Care Matters, 2008.

2. General practice to consider ensuring that practice records show when young people under the age of 18 years are not living with their birth family, or are subject to a child protection plan, care order or supervision order.

3. New patient registration questionnaires obtain information to indicate if young people, under the age of 18 years, are living independently of their family.

4. Appoint a GP with a special interest to develop a relationship with these vulnerable young people to build expertise within the practice and to coordinate communication on all aspects of their care.

5. Community Health Buckinghamshire to review its policy on transfer of records.

6. The Designated Nurse for Children in Care should receive prompt formal notification of when a child comes into public care and should be informed when placements change particularly when moving in and out of the LA area

Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust

1. When children are known to be subject to a child protection plan, staff working with them or their parents/carers must obtain copies of minutes of case conferences. .

2. Safeguarding procedures must be adhered to when there is concern about significant harm to a child.

3. Assessments of risks need to be documented in the records.

4. Documentation must be clear and signatures to have names printed underneath in line with OBMH record keeping policy.

Buckinghamshire County Council Legal Services

1. Legal Services - risk assessment - Review classification of cases to ensure proper classification of 'high risk' case.

2. Instruction of Legal Services - Social Care and Legal Services should clarify the processes for seeking legal advice

3. Training - Court training for social workers and other key professionals should emphasise the importance of the court process and adherence to procedures

4. Delay - Highlight and address the issue of delay in care proceedings through the local Family Justice Council and regular reviews of cases by Social Care and Legal Services

5. Instruction of experts - Seek the development of a local multi-disciplinary team of experts for instruction in care proceedings

Buckinghamshire Youth Offending Service

1. The Youth Offending service, conduct a review of the YOS archiving system to ensure the Final Warning files are easily accessible.

2. There is a more specific process in place to quality assure the completion of Final warning Assets, specifically concentrating on the Serious Harm and vulnerability sections of the assessment tool.

3. That all Final warning cases that are identified as medium/high risk of re offending, high risk of serious harm or high risk of vulnerability are discussed within supervision, as standard practice.

4. That the Yos induction process for all staff fully incorporates the safeguarding lessons learned identified within the IMR.

Cafcass

The first three recommendations relate to Cafcass as a national organisation. The final three relate to development within the local Head of Service area.

1. Cafcass practitioners should understand their responsibilities to critically appraise the use of experts instructed in family proceedings.

2. All public law cases that have been ongoing for over forty weeks should be reviewed and quality assured.

3. The issues of poor case recording to be robustly addressed and monitored to ensure compliance with the 2008 case recording policy. This is to include all practitioners irrespective of employment status.

(local Head of Service area)
4. The management and supervision arrangements for self employed contractors and other flexible workstaff be subject to the same principles as that of employed staff.

(local Head of Service area)
5. Cafcass practitioners appointed as Children's Guardian in public law proceedings should be explicitly aware of the need to identify and assess risk in all their cases and understand these requirements in relation to the Children and Adoption Act 2004.

Clare Lodge Secure Unit

1. Transfer and safe-keeping of records - Clare Lodge, and Children's Services, should reach clear agreement on what records should be transferred at the end of placements, and how this should be done; and about what records should be kept, and for how long, regarding this process.

2. Providing information on admission - Children's Services must invariably ensure that they provide residential workers (in any setting) with comprehensive information about

the child – and this must always include a detailed assessment of risk and need.

3. Updating assessments - Work with young people in a safeguarding context should include detailed and regularly updating of the assessment of risks and need.

4. Ongoing evaluation and development of plans - Issues that arise for a young person should invariably be evaluated against the overall assessment of risk and needs, and plans to address the issues should be agreed within and as part of the overall care plan.

5. Child-specific and SMART objectives - Care Plans should be unique to the child concerned, tied in with risk and needs analyses, and defined in terms of SMART objectives..

6. Taking on board a child's views - The views of young people should be routinely sought, evaluated, recorded and built into care plans.

7. Recording incidents - The format for reporting incidents at Clare Lodge should be reviewed.

Stonham Housing

1. Improve initial assessment, ensure that support plans and risk management plans are completed prior to client moving in. Imbed new paperwork

2. Ensure that referral forms are completed appropriately and fully

3. Continue to engage in move-on forums in Bucks, to ensure that barriers are captured and worked to across a multi organisational strategy

4. To ensure that where interagency working is occurring that clear notes are made about who is doing what, and who is supporting/ owning processes.

5. Copies of interagency plans to be requested so that accurate support and need assessments can be drawn up.

6. Copies of risk assessments relating to individual clients to be placed in client files and not just risk assessment file

7. To embed new support planning and risk management tool with staff and to regularly check its effectiveness.

8. To challenge referral agencies more effectively to ensure that all information required is available at the initial assessment

9. Where referrals are received electronically to ask for referring agencies to send back page signed or an email confirming that the details are accurate

10. Where joint support plans have taken place that copies are evident so progress can

be tracked

11. That information is recorded so that all understand content and context.

12. That initial support plans are developed prior or just after a client moves into a service.

13. Where other agencies are involved to ensure that staff document outcomes of meetings where known.

14. That support plans are developed to take account of changing needs including a full update of initial assessment To ensure that helpful agencies and phone numbers are identified and given out as part of induction process and that this is recorded in client file.