Buckinghamshire BSCB Safeguarding Children Board

SERIOUS CASE REVIEW

Re Case B2009

Executive Summary

Re Young Person "B""

October 2009

Introduction

1.1 This Serious Case Review relates to the death of a 15 year old girl, who will be referred to as Young Person "B" in this report, who tragically died in the summer of 2008. She was found hanging in the garden of the house in which she was living at the time, and it was assumed that she took her own life. The subsequent Strategy Meeting came to the view that there was no crime suspected. However, at the time of writing there has been no Coroner's Inquest.

1.2 As part of the Buckinghamshire Safeguarding Children Board's (BSCB) commitment to learn and develop inter agency child protection practice, this Serious Case Review was undertaken in order to establish what support Young Person "B" and her family received from relevant local agencies, and to analyse the professional involvement that was undertaken. The purpose of the Review was to identify and recommend any relevant changes to professional practice, and about the ways in which the different agencies in Buckinghamshire work together to safeguard children and young people.

Case Review Process

2.1 Each agency that had some direct involvement with Young Person "B" and her family was required to undertake an Individual Management Review, to look openly and critically at individual and organisational practice as it related to their involvement with this family. In undertaking this, each agency was required to produce a chronology of its contact with the family. Those managers conducting the Individual Management Reviews were not directly concerned with the services provided for the children or family, or the immediate line manager of the practitioners involved.

2.2 Selected representatives of the BSCB and of key agencies within Buckinghamshire were brought together to form a Serious Case Review Panel to collate the information provided from the Individual Management Reviews and then to analyse the professional practice and inter agency working as it related to this family.

2.3 The agencies requested to provide Individual Management Reviews were: -
Thames Valley Police
Oxford and Buckinghamshire Mental Health NHS Trust
Buckinghamshire Social Care
Legal Services – Buckinghamshire county Council
Achievement and Learning – Buckinghamshire County Council
Buckinghamshire Primary Care Trust
"Way In" Young People's Counselling Agency
Youth Offending Service
Children & Family Court Advisory Support Service (CAFCASS)
Aberdeenshire Council Social Work Service
Buckinghamshire Primary Care Trust

2.4 The members of the Serious Case Review Panel were:-
Donald McPhail - Independent Chair of the Bucks LSCB, Chair of the Panel

Heather Clarke	- Divisional Manager, Prevention Assessment and Protection
Coral McGookin	- Business Manager – Bucks LSCB
Yvette Hitch	- Buckinghamshire Police, DCI
Mary Davern,	- Bucks Children Social Care, Operations Manager
Debbie Hartrick	- Named Nurse CP
Yvonne Gibson	- Legal Advisor to the BSCB – in attendance

The independent author of the Overview Report was Ron Lock, Independent Consultant in Safeguarding Children

2.5 Contribution to the Review and this Executive summary was also sought from members of Young Person "B"'s family who were able to provide an important perspective about the services that she and her family received.

Case Details

3.1 Young Person "B" was brought up by her mother and her step father, although concerns did develop in respect of the care that Young Person "B" and her two younger step sisters were receiving, which resulted in the children's names being placed on the Buckinghamshire Child Protection Register in 2005. Arrangements were straight away made for the children to move temporarily to live with extended family in another part of the UK. Whilst the children were there, their mother died, although plans continued for Young Person "B" to be rehabilitated to her step father.

3.2 Young Person "B" and her step sisters returned to Buckinghamshire after almost two years, and resumed living with their father (Young Person "B"'s step father). Also by this time, Young Person "B"'s natural father had been contacted by extended family, and in response he immediately sought involvement in Young Person "B"'s life, and he and her step father eventually obtained joint parental responsibility.

3.3 As a young teenager**,** Young Person "B" began to show some challenging behaviours, including school attendance problems, and alcohol misuse, and this eventually led to her having a disrupted lifestyle, when at times of family arguments or crisis, Young Person "B" regularly moved to stay with different family members such as her uncle, natural father and her step father, and sometimes a school friend. Relationships within the family continued to be strained. Young Person "B" clearly very much missed her mother and found it difficult to come to terms with her death. She regularly took advantage of counselling that was available within her school.

3.4 At the time of Young Person "B"'s death, she had moved to stay with friends against the advice of her natural father and step father, and a private fostering assessment identified that this was an unsuitable living arrangement for Young Person "B", and that the placement could not be approved by Children's Services. It was before alternative arrangements for Young Person "B"'s care and living arrangements could be made, that she was tragically found dead.

Key Findings

4.1 There was a failure to ensure that appropriate procedures were followed at times of early child protection concerns, with Strategy Meetings not initially being held and then later not reporting or ensuring that investigative actions were undertaken. Nevertheless Young Person "B" and her sisters were eventually protected by being placed on the Child Protection Register and then being moved a considerable distance to another part of the UK. However the placement was not established within the correct legal framework (Fostering - Regulation 38) and the plans for the children, once resident there, were unclear, meaning that the case tended to drift. Although the independent review chairpersons raised concerns about the management of the case, this did not generate change or improvement at the time. Whilst the children were considered by professionals to be physically safe and well cared for, there was concern that Young Person "B"'s emotional needs were not fully addressed, although her name was removed from the Child Protection Register. However, the original child protection plans had not been fully implemented in respect of the need to help her deal emotionally with her experiences.

4.2 Overall there was a lack of understanding and assessment of Young Person "B"'s emotional needs sufficient to provide her with the appropriate form of intervention at that time. The impact of early experiences were not assessed and then no weight was attributed to the impact of her mother's death, and insufficient attention given to the range of emotive experiences through which she needed to navigate. This included the rehabilitation to her step father's care and her natural father returning to her life, whom she had not previously met or knew of his existence. It was regrettable that when therapeutic or counselling services were identified at this time as being needed by Young person "B", referrals were not followed through, reflecting a lack of focus in the management of the case.

4.3 Whilst assessments were eventually completed, initially at the instigation of the step father, which led to the rehabilitation of Young Person "B" back to his care, not all of the original issues of concern had been properly addressed. However, once returned, there were no further concerns in respect of her day to day care by her step father, and there was a degree of supportive work undertaken to try to assist the children's reintroduction to family life back in Buckinghamshire.

4.4 After a year following the rehabilitation back to Buckinghamshire, the case was closed by Children's Services, (there was no legal remit for continued involvement), although by then some increasing intermittent concerns had emerged about Young Person "B"'s challenging behaviours at school and within her family where relationships were becoming fraught. Because of Young Person "B"'s large extended family and their general willingness to try to help address Young Person "B"'s difficulties, then it was surprising that the professionals involved at the time did not consider using a Family Group Conference to try to achieve appropriate solutions. Young Person "B"'s natural father was also significantly involved by this time in trying to find solutions to her difficulties. CAFCASS involvement at this time in respect of the application for

joint parental responsibility, did not lead to a detailed assessment of Y9oung Person “B”’s circumstances.

4.5 The schools that Young Person “B” attended worked hard to provide a supportive environment for her, and relevant procedures were followed and generally, duties were properly discharged. However, it was recognised that a member of school staff had a personal conflict of interests when working on Young Person “B”’s behalf, but this was not effectively dealt with by the school. Nevertheless Young Person “B”’s views were sought by the school, although ultimately the school became unable to provide the level of stability that Young Person “B” needed. Whilst the natural father expressed concerns to the school, no new referrals were instigated in response in order to find ways to address her difficulties. The adults in Young Person “B”’s family were also unable to provide the necessary foundation for her self esteem to grow and for her well-being to be managed, despite some clear commitment to this end, and Children’s Services did not respond to requests for support for actions at this time.

4.6 As Young Person “B” began to experience personal difficulties, despite the willing intentions of her family, to a large extent Young Person “B” began to manage her own life, and found her self getting into increasingly difficult and unfulfilled situations. Once the decision to close the case had been made by Children’s Services in autumn 2007, further concerns which arose tended not to reach the threshold for intervention and Young Person “B”’s situation was often very variable, and occasionally she seemed to have settled down. Individual family members unfortunately were not strong enough or could not maintain sufficient authority over Young Person “B”, to bring about necessary stability. Whilst members of Young Person “B”’s family expressed increasing concern about Young Person “B”’s welfare, and offers were made to provide a more stable home for her, these were not progressed, and Children’s Services were not proactive in responding to these concerns and in providing support in reaching a solution. In these circumstances, Young Person “B” had a chaotic lifestyle with few boundaries, exhibiting some risky behaviour, and eventually she went to live with another friend’s family. Because of the concerns about Young Person “B”’s living arrangements, this then warranted renewed Children’s Services intervention, and their private fostering assessment finding was that the placement was inappropriate for her needs. Before a resolution could be achieved, and although Young Person “B” was apparently about to move back to her family, she sadly died before doing so.

4.7 Immediately prior to her death, Young Person “B” was referred to the Child and Adolescent Mental Health service (CAMHS) by the Education Welfare Officer and the GP. CAMHS discussed the referral within a team meeting the next day, and based upon that discussion, decided not to offer a service to Young Person “B”. The rationale for this decision was primarily that the cause for concern was not suggestive of a mental health problem, and that as the referral was identified as “routine” then there was also no need for an urgent response. Whilst the GP’s referral letter was quite detailed and used the term “distraught” to describe Young Person “B”, it did not mention all the details of her past difficulties. There was also an inaccurate assumption that Children’s Services were still involved. A referral to a different tier level of adolescent mental health services may have had greater chances of a service being offered.

4.8 One of the risk factors to teenage suicide is drug and alcohol abuse, and Young Person "B" had been drinking at the time of her death which may well have acted as a factor. Unfortunately there was no real understanding of the extent of her alcohol use, although the GP's referral letter to CAMHS had made reference to "heavy drinking".

4.9 Also there was no evidence that Young Person "B" had previously tried to self harm, and there had been no suggestion to any professional that Young Person "B" had suicidal intentions. In her continued counselling sessions held at the school, which Young Person "B" seemed to get some support from, the counsellor did not consider that there was any reason to believe that Young Person "B" had mental health problems which needed addressing by a specialist agency.

4.10 In reviewing all the information, whilst clearly Young Person "B" had a troubled life and she found it very difficult to achieve any level of security and stability, there were no strong predictive factors which would suggest that Young Person "B" would try to end her life, and so in this way the eventual tragic outcome was not predictable. "Teen suicide may come with no warning signs or may be missed and intent misjudged. Experts in this field can find it difficult to judge a young person's mental state, so it is no surprise that parents and friends do not recognise warning signs and take the right steps to prevent teen suicide"[1].

Summary of Recommendations

All of the different agencies who supplied Individual management reviews to this Serious Case Review have separately made recommendations regarding what their own agency needs to do the improve and develop their services in the light of their involvement with Young Person "B" and her family. These will be undertaken and monitored by the development of relevant action plans. The following recommendations are those which primarily relate to the development of inter agency practice in Buckinghamshire.

5.1 The BSCB needs to satisfy itself that Strategy Meetings/Discussions are being appropriately held and are compliant with procedures, and that decision-making processes and actions agreed are recorded in the minutes, and their implementation monitored.

5.2 All the components of a child's Child Protection Plan must be fully and separately addressed to the satisfaction of the Child Protection Conference before they can decide that the child should no longer be subject to such plans.

5.3 The BSCB needs to identify if services exist locally for the provision of Family Group Conferences, and if so, that they are being utilised in appropriate circumstances to address family difficulties.

[1] Teenage Suicide – Risk factors and what to watch out for in teenage suicide – About.com – Article presented on the internet – June 8th 2006

5.4 There should be an audit of cases which require Regulation 38 placements of children, to ascertain that they are complying with legal requirements and that children's needs are being appropriately met.

5.5 The BSCB must satisfy itself that independent chairs of Child Protection Conferences and of Looked After Children reviews, are able to use their authority and independent status effectively to challenge professional practice when necessary.

5.6 The BSCB must satisfy itself that there is clarity for relevant referring agencies in respect of the correct referral pathways and thresholds to the different tiers of adolescent mental health service provision, and that there is evidence that appropriate and timely referrals are being made.

5.7 The model for suicide prevention set out in Appendix 7 of the DCSF biennial analysis of serious case reviews 2003-2005, should be promoted as part of the development of local policies in relation to suicide prevention in young people, and should also inform the local CAMHS strategy and relevant LSCB training.

5.8 BSCB constituent agencies must identify how their relevant teams and professionals who work with children and young people living away from home, and with adolescents who present with chaotic lifestyles and living arrangements, will most effectively learn the key lessons from this case.

5.9 The BSCB should consider the most appropriate way of providing guidance to professionals on the management of young people who shun parental authority and who live chaotic and risky lifestyles.

Buckinghamshire County Council - Achievement & Learning (Educational Services)

5.10 Role conflicts for school. Staff to be identified and reduced

5.11 Access for schools to training and consultation on mental health matters, including deliberate self –harm

5.12 Counselling services for young people introduce risk assessment for DSH and clear referral protocols when risk is identified

Buckinghamshire County Council – Children's Services (Safeguarding)

5.13 There must be proper management, supervision and oversight of assessments in order to ensure quality of content and analysis within the reports. Systems should be in place to record decisions taken on the basis of SW's assessments and should be fully explored by Team Manager's in a supervision context. Decisions should be fully recorded including the rationale behind the decision.

5.14 The emotional needs of children must be a priority consideration. BCC should ensure that they are satisfied that SW's in their employ are able to access advice

and guidance in complex cases of separation and loss. Operations Managers must be confident that all managers supervising SW's within the team have the ability, training and experience to recognise such needs. Where necessary further training on the subject should be made available to both managers and SW's within the teams.

5.15 The issues relating to inappropriate parental sexual boundaries and the impact of potential sexual abuse children may experience in witnessing their behaviour and its long term consequences should be fully understood and recognised. Operations Managers must be confident that all managers supervising SW's within the team have the ability, training and experience to recognise such needs. Where necessary further training on the subject should be made available to both managers and SW's within the teams.

5.16 There should be clarity about management and supervisory responsibility for all staff. Provision of regular supervision should be monitored, reasons given and action taken where this fails to take place.

5.17 In order to prevent drift and failure to carry out decisions, supervision sessions must revisit previous decisions, recording any delays and providing clear explanations when a previous decision is delayed or overturned. Supervision notes should record any thought processes leading to decisions to act/not to act.

5.18 A specific record of all statutory visits should be placed on file. The record should include detail of who has been seen, whether separately or together with other siblings/adults and where the meeting has taken place.

5.19 Any work undertaken by agencies commissioned by BCC should be recorded on file, in terms of purpose and aim of the work. In addition a requirement for the provision of a record of all contacts with the child, (date, time, etc) and any necessary feedback should form part of the contract.

5.20 Assessments that fail to include the wishes and feelings of the child should not be signed by the manager until complete.

5.21 A Legal Planning Meeting must be held prior to any arrangements being made for a child to leave the jurisdiction of English law.

5.22 SW's should seek to establish regular patterns of contact with wider family group members when children have had a succession of care givers. Family group conferences should be held to ensure consistency and exploration of all care options. Full assessments of care givers within the family should be made and consideration given to foster placement as a possible positive alternative.

5.23 There exists within the organisation a requirement for representations, complaints and similar correspondence to be responded to within a set timeframe of 10 days. More complex issues may take up to 28 days, however there is still

an expectation that an acknowledgement by way of a holding letter should be processed within the initial 10 day period. All staff should be made aware of this requirement. An administrative process to monitor compliance should be introduced.

CAFCASS

5.24 The Cafcass representative on this Local Safeguarding Children Board should raise the need to amend the process, to ensure that all core member agencies are asked to report on involvement whenever a SCR may be needed. Responsibility – operational Head of Service, within 6 months.

5.25 Cafcass should review its system for responding to requests for an individual management review from a SCR panel, to minimise delay. Responsibility – Cafcass Head of Safeguarding – within 6 months.

5.26 Cafcass should share this case example (in an anonymised version) with the President's Private Law Working Group, with a view to ensuring that the changes that have been made in the proposed new way of working are maintained beyond the current trial periods. Responsibility – Cafcass Director of Policy - within 6 months

5.27 Cafcass should review the system for providing Wishes and Feelings reports to the courts, to ensure that guidance is explicit about the process to be followed when the need for a wider investigation is identified. Responsibility – Cafcass Director of Policy - within 6 months

5.28 (as recommended by service manager Jo Cross) A sample audit of cases closed within the past 6 months is undertaken in the Slough office to ensure compliance with key policies, especially case recording and safeguarding. Outcomes to be reported to the Service Improvement Meetings (SIMS) Responsibility – Head of Service (Quality Assurance) and Service Manager Quality Improvements, within 6 months.

Primary Care Trust

5.29 When a child, who is subject to a child protection plan, moves out of the area every effort should be made to contact a health professional in the other area to ensure timely sharing of information.

5.30 If the child is slow to register at a school or with a local GP then communication should take place between safeguarding teams in each area.

5.31 A review to be carried out to ensure that the child health departments follow the same procedures for transfer of records, both in and out of the county.

5.32 There should be a mechanism for alerting appropriate staff to children who (1) are not registered with a local GP on transfer in. and (2) when notes are not requested of children who are known to have moved out of the area.

5.33 A guideline should be developed to help school nurses prioritise responses to A&E referrals

5.34 Decision with school nurse management should take place around an acceptable record keeping process in relation to A&E attendance by school age children.

5.35 Ensure health staff that are unable to attend a case conference to which they have been invited understand their responsibility to follow up on any health actions requested at conference.

5.36 The designated nurse for safeguarding in Berkshire and Grampian are made aware of the findings from this review.

5.37 Buckinghamshire PCT to give consideration to how to meet the needs of school age children outside term time particularly over the six-week summer holiday period.

Thames Valley Police

5.38 Officers to refresh themselves regarding National Crime Recording Standards and to ensure that crime reports are appropriately recorded to CEDAR.

Way Inn

5.39 That the Buckinghamshire, Information, Counselling and Advice Group (YES, Way In and Connexions) review record keeping and make recommendations for new standards including:

- Requiring all counsellors' notes being kept at the agency and ensuring all paperwork is handed over when a counsellor leaves.
- That a regular random audit review takes place to ensure that counsellor's are adhering to the new standard format.
- Specification of note format including:
  - Points of discussion.
  - Other agencies engagement.
  - Assessment of risk of harm and points considered.
  - Any information given by the counsellor and the outcomes of options discussed.

5.40 The review be completed by 1st August 2009 and fully implemented by 1st October 2009.

YOS (Youth Offending Service)

5.41 All YOS staff to attend safeguarding training/single agency refresher training which will happen on a quarterly basis from 1.4.09.

5.42 All YOS staff to attend training on the triggers, identification and accurate assessment of vulnerability.

5.43 Staff to evidence their training by presenting their learning (in this particular case the Asset) for inclusion in their training portfolio. This will be signed off by a manager.

5.44 Supervisors of YOS Police Officers to quality assure a dip sample of Final Warning ASSETs during each supervision session as stated in Supervision policy and involve the YOS Mental Health worker in this process to quality assure the emotional and mental health and vulnerability sections. (Details of this involvement are yet to be finalised as this will be a partnership decision with CAMHS).

5.45 All Final Warning cases that are either high risk of re-offending, high risk of serious harm to others or high risk of vulnerability are brought to supervision for discussion.

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