# SERIOUS CASE REVIEW

Executive Summary of

Overview Report

***Re Young Person G***

**Independent Chair of the Serious Case Review Panel – Keith Ibbetson**

**Independent Overview Report Author – Ron Lock**

March 2014

## 1. Introduction

**1.1** This Serious Case Review relates to the death of a young person, who will be referred to as "G", who died at the age of 17 years in November 2012 after apparently hanging himself with a bed sheet. At the time, G was a young person who was in the care of Buckinghamshire County Council and who was living in semi-independent accommodation where he had been for approximately 2 ½ months. Prior to this, G had been in a number of placements in Buckinghamshire and across the country, and had been in care for 6 ½ years.

**1.2** Because it was considered that Young Person G took his own life whilst in the care of Buckinghamshire County Council, then it was considered appropriate to commission a Serious Case Review in order to identify if there were lessons to be learned about the way that professional interventions and services were delivered to G by a range of different agencies whilst he was in care. Subsequent to the decision to undertake a SCR, the inquest into G's death was held which came to a narrative conclusion that G "suspended himself with a sheet from the bannister but his intention in so doing (if any) could not be established beyond reasonable doubt."

**1.3** The purposes of this SCR reflected the relevant government guidance at that time to: -

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

- Improve intra and inter-agency working to better safeguard and promote the welfare of children.[1]

**1.4** Each agency that had some direct involvement with G and his family was required to undertake an Individual Management Review (IMR) to look openly and critically at its practice in relation to their involvement with them. In undertaking this, each agency was also required to produce a chronology of its contact with the family. These included a number of agencies outside Buckinghamshire. The managers/officers conducting the IMRs were independent of the management of the case.

**1.5** Senior representatives from relevant agencies in Buckinghamshire were brought together to form a SCR Panel in order to review and analyse the material from the IMRs. The role of Independent Chair of the SCR Panel was undertaken by Keith Ibbetson, and the Overview Report author was Ron Lock, both being safeguarding consultants who were independent of all agencies in Buckinghamshire and had extensive experience in safeguarding children and young people.

[1] Paragraph 8.9 – Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – Dept. for Children, Schools and Families – March 2010 *(NB:* This guidance was reissued in March 2013 and where relevant. its contents will be reflected in the production of the Overview Report)

## 2. The Serious Case Review Process

**2.1** As this SCR was commenced prior to the revision of Working Together in March 2013, it was decided by Buckinghamshire LSCB that formal Individual Management Reviews (IMRs)would be requested from the statutory agencies that had direct involvement with G as well as the secure training centre and the secure children's home which G attended whilst in care. Written reports were additionally requested from the range of independent care providers who commissioned to care for G on behalf of Buckinghamshire, as well as some hospitals who had limited involvement outside Buckinghamshire.

**2.2** In addition to the above IMRs, written reports were provided by four independent care providers and a training college that G attended in 2012. Information of involvement was also sought and provided by two hospitals outside of Buckinghamshire who provided A&E services to G. A short report of the work of Addaction, who provided support to G as a young person affected by drug and alcohol problems, was also provided. Furthermore, because of minimal involvement with G, basic information was provided of their contact by Connexions in Buckinghamshire and by Cafcass.

**2.3** In order to provide additional input into the SCR process, two meetings were held with practitioners and first line managers who had the most contact with G during the last year of his life. The purpose of these meetings was to more clearly understand the events and decisions made at this time and to consult with involved practitioners about the initial findings and analysis of the work of the SCR.

**2.4** Family Contribution to the SCR

G's mother was contacted and her views sought about her experiences of professional interventions in respect of her son and her views have been incorporated into the body of the report.

## 3. Summary of Factual Information/Key Events

**3.1** Following concerns about abuse and neglect within his family, G came into local authority care in April 2006 at the age of 10 years 8 months. For the 6 ½ years that he was in care until his death in November 2012, he experienced twenty one different placements, the majority of which were outside of Buckinghamshire. After his first few weeks in care, all the placements were residential care units of varying types.

**3.2** From the end of 2009, the average stay in one placement for G was just 3 months and much of the reasons for the placement breakdowns related to G's challenging behaviours, which included going missing, committing criminal offences and self-harming, sometimes at very significant levels. Often, because of the need to make urgent placement changes, only six of his placements had any element of detailed forward planning.

**3.3** G was sexually abused by a care worker in one of the residential units in 2009 – the worker was prosecuted for the sexual offence.

**3.4** Whilst G was regularly offered counselling and therapy, including for the impact of his sexual abuse, he generally was reluctant to engage in this work although he did maintain productive working relationships with some key professionals. He experienced a high number of changes of social worker, particularly during the early years of his time in local authority care.

**3.5** All relevant reviews, health and educational assessments as well as multi-agency meetings were held in accordance with the requirements and procedures for a Looked After Child [2] (LAC) as well as for a young person who was in receipt of services from the Youth Offending Service.

**3.6** G generally experienced his greatest periods of stability and personal development when living in very structured environments, for example when residing in a Secure Training Centre serving a Detention and Treatment Order in 2011 and in an activity based placement in the previous year.

**3.7** G was never diagnosed with a mental illness when assessed after self-harming incidents, and such assessments generally did not view G as having suicidal thoughts at that time.

**3.8** G generally maintained contact with his family throughout his time in care, although contact sometimes generated tension and difficulties for him.

**3.9** At the time of his death, G was residing in a semi-independent placement, after a three month period of living back with his family. It was apparent that whilst residing in this placement, he was experiencing difficulties in adjusting to life outside of the residential care system.

<u>The last year of G's life</u>

**3.10** After being in a secure children's home up until late 2011, G had made sufficient progress to be able to move into the "open" unit of that residential home – this was his 18th placement. Unfortunately due to an incident in February 2012 which suggested that G may pose a risk to another resident, the placement was immediately terminated and G was then placed in a new independent residential provision in Northampton. However, three months later G refused to return there and wanted to go back to his family home and stay with his mother. Prior to this there had been some successful weekends home, and so G was allowed to go back home as it was thought that at the age of 17 years, there needed to be some preparation for him to become more independent before moving out of the care system.

**3.11** However following a violent altercation with his step father, and G then taking an overdose, this placement back home ceased after a period of 3 months. At the time of the overdose no mental health assessment was arranged by the A&E hospital as part of the Self-Harm Pathway.

**3.12** In August 2012, G was found a semi-independent placement outside of Buckinghamshire but within reasonable distance of his home area. He was on a curfew at this time because of recent offences and he had also started to attend a training college.

[2] "Looked after" is the term introduced by the Children Act 1989 to cover all children in public care, including those in foster care or residential homes and those still with their own parents but subject to Care Orders.

**3.13** Two days prior to his death, G self-harmed by cutting himself, and again no mental health assessment was arranged by the hospital. An altercation on the following day with another student in the training college made him very upset but which then led to his temporary suspension, although the college later decided to make this permanent, something which G feared would happen.

**3.14** When seen the next day by one of the professionals working with him at the time, it was reported that G was generally content, though concerned about the possibility of losing his training place. It was later that evening after being on his own in his placement, that G was found dead by one of the care workers.

## 4. Analysis and Key Findings

**4.1** This was not a case where LAC procedures were not followed or where there were professional errors which impacted on G's overall care, but rather the case tended to reflect that even when professional practice was undertaken with diligence and in line with expected policies and procedures, this was insufficient to meet the needs of a young man in care with very complex needs and challenging behaviours.

**4.2** Nevertheless, the overall pattern and provision of services to G had features which, if replicated, might adversely impact on the care of other young people in care. Therefore the LSCB and its member agencies need to respond to the lessons learned from this SCR in order to remedy those wider weaknesses in the systems and arrangements for children and young people in the care of the local authority.

A Looked After Chid with Complex Needs

**4.3** Whilst G was subject to many assessments of different types, they were often incident focussed, and overall it was difficult to identify that they achieved long term or useful outcomes in informing effective later interventions with him.

**4.4** When G's circumstances and problems become more complex and protracted, more professionals tended to get involved and there were more procedural requirements about how interventions were coordinated and planned. The evidence of G's case is that this in itself did not lead to more effective interventions and that there needed to be scope to apply procedures more flexibly, taking particular account of the overlap of responsibilities, the number of professionals involved and the number of meetings that were required.

**4.5** There was no process for updating assessments for Looked After Children, or in completing a holistic assessment of a young person in care, which meant that there was less chance of implementing appropriate interventions and being left with a plethora of assessments which had a short "shelf life" but were nevertheless later used out of context.

**4.6** There needed to be a recognition that adherence to LAC procedures would not in itself provide the full amount of protection for G as a young person in care or be able to fully assess his needs. There was a potential danger in a sense of inappropriate reassurance developed by professionals simply because procedures were being successfully applied.

**4.7** Professionals need to have the capacity to stand back and undertake a fundamental reappraisal of a case which had become protracted and where the outcome for the young person were not what agencies would have wanted. As they were constituted and managed, the 6 monthly LAC Reviews did not provide the sort of forum to achieve this.

**4.8** As G had been in care for a long period of time, then a move to semi-independent living was a most significant step posing major new challenges. Therefore a thorough assessment at the time of transition should have been undertaken as part of good practice, to identify the different components of support that would now be needed.

**4.9** Planning for young people aged 16+ relied heavily on processes and pro-formas for "Pathway Planning". In G's case these met more of an administrative need rather than being able to provide real meaning to the services needed and as a means of engaging G in the plans and interventions being created for him.

Self-Harm Pathway

**4.10** The local Buckinghamshire multi agency Self-Harm Pathway was not being applied in practice. In particular G's circumstances have identified that the management by hospitals of adolescents who self-harm needs reviewing.

**4.11** Hospitals usually rely on parents and cares who know the child well, to inform them of the needs of a child presenting in an A&E Dept., but with G as a Looked After Child, this was not a possible approach. Professional carers such as residential staff seemed more reliable but they did not know all the relevant history. Adherence to the Self-Harm Pathway would have compensated for this lack of knowledge by triggering a fuller assessment. Hence the need for the Self-Harm Pathway to have been adhered to on the two occasions in 2012. The lack of assessments on these occasions therefore compromised the ability of professionals working with G to appropriately address his needs at such times.

**4.12** The experience of the case suggested that if professionals do not fully understand the role and limitations of the Force Medical Examiner's role when a young person who is in police custody, the involvement of the Police in incidents of self-harm can add potential confusion to the Self-Harm Pathway.

Out of County Placements

**4.13** Regular placement changes, especially those out of county had considerable negative impact on the ability of G to achieve appropriate social relationships, positive attachments, good self-esteem, academic success, access to health care with professionals who knew his history and, mental health support. Professionals needed to have greater recognition of this impact as well as the significant limitations it placed on social work interventions, and how it compromised information sharing.

**4.14** Whilst G presented a range of very challenging behaviours, and there were finite resources to address these, steps should have been taken to reduce the number of out of county placements as well as the overall the number of placement moves. Additional risks are

associated with placement out of the authority area and it was therefore necessary for steps to be built into practice to mitigate them

**4.15** To become more effective, Children's Social Care staff needed greater clarity and understanding about how to work in the most effective way with young people in care who are placed out of county and with professional networks in different localities.

**4.16** There was the potential that greater proactive sharing of information about G's circumstances to agencies in the different new areas that G moved into could have been helpful, in order to generate better opportunities for those agencies, such as the Police and adolescent mental health services, to provide more informed and coordinated services with G when required to do so.

**4.17** G's case showed that there was a need for the Independent Reviewing Officers (IROs) to stand back from the current or recent circumstances and review the trajectory of the case over a longer period of time in order to identify patterns of difficulties or of interventions that had been unsuccessfully applied before.

Health of a Looked After Child

**4.18** In this complex case, the effectiveness of the LAC health assessments was compromised, and therefore a review of their role needs to be undertaken to ensure that it makes the expected and necessary contribution to a young person's health, especially when they are placed away from the home authority and when adolescents have mental health and behavioural problems.

**4.19** There needed to be greater integrated working in respect of health LAC assessments and LAC reviews, which would have generated greater opportunities for a more coordinated and effective set of services that were offered and provided to G.

**4.20** It would have been beneficial if chronologies and updated information (including significant events e.g. sexual abuse by professionals/ offending behaviours/ involvement of other professionals) were available prior to annual LAC health assessments and to GPs at the time of registration with a practice to ensure that these professionals had a full and clear picture of G. This would have enabled the health professional to be proactive in addressing the health issues arising from this information.

Recording of Decisions and Actions

**4.21** Commissioning and decision making processes needed to be clearer and recorded as part of G's file which would have helped to reflect his "journey" though the care system. Poor record keeping by Children's Social Care did not help to inform decisions made by new social workers and their managers who were later appointed to the case.

**4.22** Care must be taken to avoid the sort of incident-focussed culture that sometimes existed in this case and therefore meant that patterns of concerns which were emerging were not recognised. It also restricted opportunities to involve senior managers in providing objective

and authoritative input, particularly when G's instability and significant difficulties were becoming entrenched.

**4.23** Senior managers in CSC needed to have taken a more long term hands-on role in order to have given some objective strategic direction to the complex issues which G's circumstances presented, rather than only being engaged at a time of crisis or when substantial financial decisions were needed.

Young People at Risk of Harm

**4.24** As a young person who was at risk of self-harm, G was involved with a number of agencies, which meant that there was a greater need for regular and more coordinated use of risk of self-harm assessments. Additionally an agreed way for agencies to respond on a collective basis was needed in order to provide confidence to care providers and other involved practitioners regarding their management of self-harm events.

**4.25** A clear agreement between the LAC process and the YOS in terms of its risk and vulnerability function was needed in regarding how they were working together and which forum was responsible for what function.

**4.26** Improvements were needed in the way in which G's access to alcohol and drugs whilst in care was understood and managed, and that substance misuse assessments needed to inform service delivery and Care Plans.

## 5. Summary

**5.1** It was clear at the time of G's death, that there was a build-up of anxiety by G over the two days prior to his death and it was appropriate that his social worker responded by making sure the care staff were aware of the current tension, and by the Addaction worker undertaking a home visit. The existing multi-agency self-harm pathway required that a formal self-harm risk assessment should have been conducted at the hospital or a referral made to CAMHS on this occasion. This would have created the option of a fuller assessment of his current state of mind and circumstances by professionals who knew his history. Clearly it is impossible to say whether this would have changed the final tragic outcome, but an important intervention was nevertheless not undertaken.

**5.2** This SCR has considered whether the death of G could have been predicted, and if so whether it could have been prevented. In a number of respects G possessed many of the risk factors associated with adolescent suicidal behaviour – i.e. hopelessness, anger and hostility, substance misuse and behavioural problems that often led him to behave in a reckless way. These features of his behaviours were evidently rooted in the chaotic nature of his early life. G had a long history of self-harming so it could be said that there was a good chance that at some time he could ultimately seriously harm himself. These features were well known to social workers, youth offending workers, care workers and adolescent mental health workers who worked with G. Yet it was despite this knowledge and the commitment from many practitioners, alongside repeated offers of help and support, that G could not be prevented from taking his own life. Whether different interventions or different placements could have made a difference is not possible to tell. Overall, the relevant LAC processes were followed,

with LAC reviews, Health reviews and a range of inter-agency forums and assessments undertaken, and yet these processes in themselves were ultimately insufficient to prevent G's death. These processes are a means of delivering effective services, but alone they cannot protect children. As G generally chose not to respond to many offers of help, this significantly reduced what could be achieved with him. He could not be forced into accepting therapeutic interventions.

**5.3** The high number of placements nevertheless presented considerable difficulty for G, and this fact alone must have had a significant impact on his sense of worth and self-esteem. Of course it cannot be underestimated that G presented with a range of most challenging behaviours and there were limitations regarding the resources available to manage and care for him. The pattern of short term failed placements urgently needed to be addressed, and different initiatives taken to reduce the likelihood that a young person in similar circumstances in the future would experience such a fragmented and disrupted time in the care system.

**5.4** The range of difficulties presented by G inevitably meant that different specialisms became involved such as the local authority, CAMHS, substance misuse and youth offending workers. Each agency had its own formalised processes and arrangements, to some extent limiting the greater use of professional judgement. This is consistent with the findings of the Munro Review of Child Protection which identified that "unintended consequences" of professional interventions can occur when a prescriptive approach is applied other than one which is freed up to use greater professional judgement[3]. It would have required innovative thinking to merge some of the work into a lesser number of assessments and to involve fewer professionals. Nevertheless, once it had been recognised that established processes were either counter-productive or not achieving intended outcomes; greater attempts should have been made to address these.

## 6. Areas for Learning and Development

Key areas for learning and development of services for Looked After Children have been developed based on the findings of this SCR as identified in section 4 of this Executive Summary. The following recommendations are based on these findings.

## 7. Recommendations

**7.1** The LA should ensure that LAC Reviews always collate and review recent assessments of the young person, seeking comprehensive assessments as necessary.

**7.2** The LA should ensure that annual reports on the IRO Service provide evidence of the way in which it implements the full range of its statutory functions.

[3] The Munro Review of Child Protection – Part One – A Systems Approach – Eileen Munro 2011

**7.3** The LA should ensure that at a time of a young person's transition from long term local authority care into semi-independent care, there is a multi-agency care planning meeting held to supplement the statutory Pathway Planning meeting.

**7.4** The current review of the Self-Harm Pathway should take account of the learning from this review.

**7.5** The LA should ensure that Individual Care Plans for LAC and their LAC Reviews always identify how additional risk, complexity and vulnerability associated with a child/young person being placed out of county is being identified and mitigated.

**7.6** Multi-agency workshops should be convened for professionals working on behalf of Buckinghamshire LAC who are placed out of county.

**7.7** A review should be conducted of the information available to LAC review health assessments.

**7.8** The LA should set criteria for LAC cases to include that a senior manage will retain a formal overview and interest for children/young people with numerous placements.

**7.9** The BSCB's High Risk, Harder to Reach Protocol should be re-launched and embedded across all agencies.

**7.10** LA, YOS, TVP and health agencies should agree collective multi-agency arrangements for the assessment and management of young people where there is high risk and/or vulnerability.

**7.11** Where there are substance misuse concerns about a young person, linked to the potential failure of a LAC placement, involved agencies must assess the associated risks and ensure the engagement of substance misuse services.

**7.12** Agencies should demonstrate how they enable professionals to move away from a rigid adherence to procedures where appropriate.

**7.13** The Department of Education is asked to consider a meta-analysis of Serious Case Reviews where there is an interplay of risky behaviour/self-harming behaviours and/or suicide, to provide guidance on how children's social care and adolescent mental health services jointly manage such challenging young people.

**Ron Lock**

**March 2014**