Serious Case Review

Overview Report

Re Young Person G

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March 2014

Contents

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 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 the Buckinghamshire Local Safeguarding Children Board (LSCB) considered it 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.

1.6 Summary of case and key findings

[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)

Factual Information

- Following long term 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.
- 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. Only six of his placements had any element of detailed forward planning sometimes because of the urgency of the need for a new placement.
- G was sexually abused by a care worker in one of the residential units in 2009 – the worker was prosecuted for the sexual offences.
- 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.
- 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.
- 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.
- 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 ideation.
- G generally maintained contact with his family throughout his time in care, although contact sometimes generated tension and difficulties for him.
- 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 the semi-independent placement, he was experiencing difficulties in adjusting to life outside of the care system.

Key Findings

<u>Managing G's complex needs</u>

- 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 appropriately for a young person in

[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.

care, this was insufficient to meet the needs of a young man in care with very complex needs and presenting challenging behaviours.

- Whilst G was subject to many assessments of different types, they tended to be incident focussed, and overall it was difficult to identify that they achieved long term or useful outcomes in informing effective interventions with him.
- Greater integration was needed between the LAC Review process and the annual LAC Health assessments to enable them to more effectively drive and coordinate G's time in care. The LAC Health review process was often insufficiently informed of important detail regarding G's prevailing circumstances.
- There was no holistic assessment at the time of G's transition from care into semi-independent living when this would have been very informative at such a significant stage in G's life.
- Children's Social Care did not have sufficiently detailed and accessible case records to reflect G's journey through the care system and to support all operational activity and decision making.

<u>Self-harm, risk and vulnerability</u>

- The self- harm pathway was not followed within Buckinghamshire, particularly when G attended A&E Depts. following incidents of self-harming.
- There was a need for a more coordinated and agreed response by the different professionals and agencies in the use of self-harm risk assessments and how to manage such behaviour.
- A clearer agreement between the Looked After Child process and the Youth Offending Service in terms of its risk and vulnerability function was needed.

<u>High number of county placements</u>

- The high number of out of county placements created considerable instability for G and significant difficulties for professionals in maintaining effective links with him. These difficulties should be recognised by providing greater clarity in terms of professional guidance for undertaking work in such circumstances.
- In respect of a number of the placement moves, insufficient opportunity was used to plan for the most appropriate.
- Whilst senior managers from the Local Authority were involved in the case at times of crisis, they needed to provide greater consistent hands-on involvement in order to provide the necessary objective direction to the work with G, and to help prevent continual placement change.
- Insufficient opportunities were used to stand back and review the trajectory of the case in order to identify emerging patterns of placement changes that needed to be halted.

2. <u>The Serious Case Review Process</u>

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 provided care for G on behalf of Buckinghamshire, as well as some hospitals who had limited involvement outside Buckinghamshire.

2.2 These IMRs, the integrated chronology and the written responses from the care providers provided the bulk of the information to the SCR Panel to enable a critical analysis of the professional interventions with G to take place. IMRs were requested from the following agencies:

- Northampton Youth Offending Service
- Clinical Commissioning Group (GP)
- Oxford Health NHS Foundation Trust
- Buckinghamshire Healthcare Trust
- Oakhill Secure Training Centre
- Buckinghamshire Youth Offending Service
- Thames Valley Police
- Northamptonshire Police
- Warwickshire and West Mercia Police
- Buckinghamshire County Council – Children's Social Care
- The Virtual School Buckinghamshire ECPC
- Leverton Hall secure children's home

2.3 Additionally, 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. These were the Kettering General Hospital NHS Foundation Trust and the Basildon and Thurrock University Hospitals NHS Foundation Trust. 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, information was provided by the Joint Commissioning service, Buckinghamshire County Council, by Ofsted in terms of their role with one of the care providers in 2010, by the Child and Family Consultation Service in Basildon, Essex. and by Connexions in Buckinghamshire and by Cafcass.

2.4 The authors of the IMRs were invited to present their reports to the SCR Panel and these reports were scrutinised by the SCR Panel, requesting when necessary that changes or further analysis be undertaken by the IMR authors.

2.5 The SCR Panel was made up of the following:

- Business Manager, Buckinghamshire Safeguarding Children Board
- Head of Children's Quality Standards and Performance – Buckinghamshire County Council – Children's Social Care
- Senior Psychologist, Educational Psychology Service
- Detective Chief Inspector, Protecting Vulnerable People – Buckinghamshire, Thames Valley Police
- Group Solicitor, Childcare and Litigation
- Lead Professional for Child Protection, Buckinghamshire Hospitals NHS Trust
- Buckinghamshire Designated Doctor for Looked After Children
- Safeguarding Lead, Buckinghamshire Vale CCG and Chiltern CCG
- Head of Youth Offending Service, Buckinghamshire
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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 the first of these meetings was to:

- understand the process for G's transition into semi-independent living during 2012,
- What of the past information and G's experiences helped to inform those decisions (including the return to the family home)?
- To what extent were other agencies such as CAMHS, YOS and Addaction, able to contribute effectively to a multi-agency approach to identifying G's needs?
- What was the understanding of the extent to which the final semi-independent living placement was able to meet G's needs at the time and of the level of practical and emotional support he required?

The second meeting was used to share and consult on the initial findings from the SCR and to help develop relevant areas for learning and development. The outcomes from this meeting have been incorporated within the analysis of practice and in the lessons identified in Section 12 of this report.

2.6 Those agencies who were represented by practitioners and first line managers were: -

- Children's Social Care – Buckinghamshire,
- CAMHS, Oxford Health
- Semi-Independent residential Unit
- Buckinghamshire Youth Offending Service
- Addaction,
- Children's Social Care, Commissioning
- Training Centre (which G attended during autumn 2012)

2.7 <u>Family Contribution to the SCR</u>

G's mother was informed of the SCR at an early stage in the process so as she was aware of the work of the SCR and what it would entail. At a later stage, she and her husband were visited by the Overview Report author when the general findings from the SCR were explained and discussed. G's mother was given the opportunity to contribute to the SCR and gave some views and comment about her experiences regarding professional interventions conducted with her and G as part of his time in local authority care. These contributions have been included within the body of the report and their source identified accordingly.

3. Factual Information

<u>Family Details</u>

G was the youngest child of his family. His father killed himself when G was still a toddler and he was then cared for by his mother and step-father.

3.1 Young Person G initially became a Looked After Child at the age of 10 years 8 months in March 2006 after it had been claimed that he and his siblings had been subject to long term abuse and neglect within their home. Initially G's mother agreed to him coming into care although she did later try to seek his return home and disputed that abuse had occurred, but G became the subject of a full Care Order in July 2008.

3.2 The following is a summary for each year from 2006 of the main factual events under the separate headings of:

- Placements,
- Self-Harming Behaviours,
- Offending Behaviours/Going Missing, and finally in respect of
- Professional Interventions with G

2006

Placements

(See Figure 1 on Page 10 which represents the placements experienced by G, when they took place and their duration)

3.3 During this nine month period **from April until the end of 2006**, G experienced eight different placements. During his first four weeks in care, he had five of these placements, the first four being with foster carers that lasted for between one and twelve days, and then after a few days in a local residential settling, moved to his sixth placement with an independent provider which was situated near to G's family home. This was a little more settled, with this placement lasting for a period of two months. It was then in **mid-2006** that G moved to an independent residential unit in Cheshire, approximately one hundred miles from home, which lasted just over a month, and because of the extent of the difficulties in managing and containing G at that time, a Secure Training Centre was considered but it was not thought appropriate because of his age. His last placement during 2006 (No.8 in Figure 1 on Page 9), was in Telford, Shropshire with another independent provider and was a therapeutic residential placement. G remained here for the rest of 2006.

3.4 The reason for so many placement changes in 2006 was generally put down to G's behaviour difficulties which were claimed to be unmanageable on occasions by those staff/foster parents who tried to care for him. Examples of the behaviour difficulties were assaults upon staff and other children, extensive damage to property (e.g. smashing windows), threatening staff with a knife and sometimes needing to be restrained. On one occasion he tried to wrap a wire around a staff member's neck. Carers stated that they were unable to keep him safe.

Self-harming Behaviours:

3.5 The first reference to self-harming was in **July 2006** at about the time of leaving his placement in Cheshire (No.7) though this was only self-reported to Police a few days later whilst in custody for assault, and was not otherwise noted by the residential unit. He had apparently placed a rope round his neck.

3.6 In **November 2006**, G was found hanging from a door in his care home, though was not seriously harmed – he was later taken by a staff member to the GP. At that time whilst in the unit in Telford, he had been on "suicide watch". An urgent referral to Shropshire Child and Adolescent Mental Health Service (CAMHS) was made.

Offending Behaviours/Going Missing:

3.7 G was arrested for assault in **July 2006** – this was in relation to his attacks on staff at that time at the end of his placement in Cheshire. G later received an absolute discharge in relation to three charges for assault.

3.8 There was just one occasion when G was reported missing which was at the end of the year. He was reported missing at 9.45 pm and was located and returned to the care home early the following morning.

Key Professional Interventions:

3.9 Throughout his time in care there were regular Looked After Children (LAC) reviews, and health reviews as well as Personal Educational Plan (PEP) meetings and others associated with his education - these appropriately took place during 2006. **In August 2006** a multi-agency Placement Planning meeting was held when it was recorded that G's educational statement was on hold, due to his many placement moves. It was noted that his education was suffering greatly because of the number of placement moves. However, **by October 2006**, an education report from the Telford residential unit (No. 8) stated that G was making some positive relationships, enjoyed physical activities and was making progress in Maths.

3.10 Other reports from the placement at this time identified G as having "complex emotional needs and very poor self-esteem". Prior to this, a statutory assessment under the Education Act 1996 was initiated with it being stated that for the foreseeable future that G would require "a regime of highly skilled specialist 1:1 or even 2:1 support".

3.11 An urgent CAMHS assessment was undertaken (it is believed by the local CAMHS service in Shropshire) after the self-harming attempt in **November 2006** and the resulting letter to the local GP identified that G was not suffering from any mental illness but found to be very impulsive and prone to aggressive outbursts. Low dose medication was prescribed to help with aggressive outbursts and psychotherapy was recommended.

3.12 A permanency planning meeting was held in **December 2006** which recommended remaining at the current placement with a possibility of a return home noted, though a residential placement was considered the most appropriate for his needs currently. During 2006, G had four different Buckinghamshire Children's Social Care (CSC) social workers.

2007

Placements

3.13 Compared to his first nine months in care, 2007 was a more settled period of time for G in terms of placements. **At the beginning of 2007**, G was almost 11 ½ years old. He remained in the therapeutic residential placement (No.8) **until July 2007**, a period of a year in all. A review of the placement recorded it as a positive experience for G who was generally much more settled at that time. However, there was a plan set that G would move placement in **July 2007** as originally this placement had been seen as short term. Although initially some consideration was given to a move to a more local establishment, it was decided that another independent residential placement, though part of the same group who had provided the preceding placement, would more appropriately meet his needs. This new placement, (No 9.), was in Staffordshire.

F1G.1 Placement	2006	2007	2008	2009	2010	2011	2012
1st 5 placements (Foster carers x 4)							
6. Residential Unit - **Buckinghamshire**							
7. Residential Unit - **Cheshire**							
8. Residential Unit – **Telford**							
9. Residential Unit – **Staffs**							
10. Residential Unit – **Telford**							
11. Residential Unit – **Staffs**							
12. Activity Centre - **Anglesey**							
13. Res. Unit – **Northamptonshire**							
14. Residential Unit - **Buckinghamshire**							
15. Secure Training Centre – **M/Keynes**							
16. Residential Unit - , **Buckinghamshire**							
17. Secure Children's Home - **Essex**							
18. Open Unit – **Essex**							
19. Residential Unit, **Northamptonshire**							
20. Returned Home							
21Semi Independent **Oxfordshire**							

Self-Harming Behaviours

3.14 Whilst, soon after G's move into this new placement, the staff reported some troubling behaviours which they described as "shallow threats of suicide", they were however confident that they had dealt with these. There was an incident in **November 2007** when concerns were raised by residential staff about G head butting the floor and that he needed restraint.

Offending Behaviours/Going Missing

3.15 G was reported as missing on two occasions in **May 2007** but on both occasions was returned to the care home without additional concerns. On the third and final occasion that he went missing during 2007, this was for only a short period of time during the day but he caused criminal damage at the time and he received police reprimands for four related offences.

3.16 Overall, G's behaviour improved during 2007 although he continued to be a challenging young person to care for. One significant incident of anti-social behaviour within the care home occurred at the **end of October 2007** following G having contact with his family.

Professional Interventions

3.17 In **January 2007**, the psychiatrist in G's residential unit suggested that following G's suicidal behaviour the previous year, that a low dose of medication normally used for adults, should be used. However the Children's Guardian (the Care Proceedings[3] were being progressed at this time) was unwilling to agree to this unless sanctioned by other health professionals or the Court. The Buckinghamshire Children's Social Care (CSC) IMR notes that "In the event it would appear that as his behaviour improved, the idea was abandoned". In fact it was reported at the time of his discharge from CAMHS services (Shropshire) on the **1st March 2007** that he had never started on any medication and that he had been seeing a psychologist. There was also a reference to a CAMHS assessment by Buckinghamshire in 2007 which diagnosed G with Attention Deficit and Hyperactivity Disorder (ADHD)[4] and emotional and behaviour disturbance, but that he refused to engage with CAMHS. There were no other records of this assessment.

3.18 By **February 2007**, G was issued with a Statement for special educational needs (SEN)[5] by Shropshire Local Education Authority after first being proposed in December the previous year.

3.19 As part of the continuing Care Proceedings, two assessments were undertaken in respect of G by a child psychologist and by a child psychiatrist which were filed in court in **March 2007.** The psychiatrist's conclusion was that G was not suffering from any diagnosable mental illness or ADHD. Both assessments formed the view that G was unable to control his

[3] These are court proceedings undertaken to consider a range of information, evidence and assessments regarding whether a child needs to be in the care of the Local Authority.

[4] Children with ADHD generally have problems paying attention or concentrating. They can't seem to follow directions and are easily bored or frustrated with tasks. They also tend to move constantly and are impulsive, not stopping to think before they act.

[5] A Special Educational Needs statement is a legal document setting out the child's special educational needs and the special help that the child will receive. The Local Authority will usually make a Statement if they decide that the special help needed cannot be provided within the school's resources.

behaviour and is reliant on others to do this for him – they also agreed that G was vulnerable to sexual abuse in the future.

3.20 A new Buckinghamshire CSC social worker was allocated to G in **February 2007**, with further changes of social worker taking place in **March, April, May and then October of 2007**. Within the Care Proceedings the service manager was asked to explain the frequent changes of social worker which she attributed to locum staff not remaining in post or not completing necessary tasks. By the **end of 2007**, G had had nine different social workers since being in care – this was over a total period of I year 9 months.

2008

Placements

3.21 The residential unit in Staffordshire that he had joined in July '07 proved to be the longest that G had remained in one care home and this placement ceased in **October 2008.** During his time there it was noted at a Personal Education Plan (PEP) meeting in **May 2008** that G was excellent at Judo, and was a good swimmer and was someone with a good sense of humour.

3.22 For his second placement in this year, G moved to another residential unit in a different locality, though run by the same independent provider. G had been there previously when it had only been a short term unit, but it now met his requirements for a longer term placement, so it was deemed relevant to place him there at this time – he remained there for the rest of the year and into 2009.

Self-Harming Behaviours

3.23 It was recorded that G required restraint on just one occasion during the year, after becoming distressed following telephone calls from his siblings and mother in **November 2008**. Therefore in general throughout this year, there were no recorded attempts at self-harming by G.

Offending Behaviours/Going Missing

3.24 G went missing twice during **May 2008**, on one occasion was found intoxicated, and on the other had participated in anti-social behaviour. These were both for short periods of less than a day, but on each occasion he was with another young person. He absconded from school and was reported missing again in **September 2008**. On each occasion the Police were involved and returned G back to the residential unit.

3.25 In **early June 2008**, he set a fire in his bedroom and as a result, because of the amount of damage caused to this residential unit by G and other young people, the residents were temporarily housed in caravans.

3.26 G was arrested for criminal damage in **July 2008**, again with another young person, and in **September 2008** he was found guilty of the offence as well as three offences of assault, and given a 3 month Referral Order. By **July 2008**, G had become 13 years old.

Professional Interventions

3.27 Apart from the support and interventions by the care staff at the residential units, and those by the Police, there were no other specific interventions. G's annual review of his Statement of Educational Needs (Staffordshire) took place in **January 2008**. The key objectives were; to provide a safe and nurturing educational environment, to develop his functional skills in numeracy and language, in building positive relationships and positive self-esteem. An additional objective was to manage his strong feelings and for him to judge the consequences of his behaviour. G was made subject to a full Care Order on **4th July 2008.**

2009

Placements

3.28 As with the previous two years, G had two placements in 2009, with his current placement lasting eleven months and changing in **September 2009** when he moved to another residential unit back to the Staffordshire area (No.11). In fact since mid-2006, G had been in placements which were all some distance away from his local area – these were in Cheshire, Shropshire, and Staffordshire. G expressed views that he wanted to return to live with his family or at least to return to somewhere nearer to them. Accordingly, a referral was made for foster care in **May 2009** – there was no record of why this was not progressed or did not succeed.

3.29 In **April 2009,** a Strategy Meeting[6] was held because of an incident of inappropriate physical contact with a girl. It was reported that this was consensual activity which did not involve intercourse. It was decided that this did not require Police involvement and that it would be dealt with by increased supervision within the placement. G was aged 13 years 9 months at this time.

3.30 The two LAC Reviews in **January and June 2009** were very positive and were showing that there was improvement in G's behaviours and that he was able to settle into a placement.

3.31 In **June 2009** G was sexually abused by a member of the care staff of his residential unit. The care worker responsible was immediately arrested, admitted the offence and was placed on Police bail not to contact G. A Strategy Meeting was held on the **1st July 2009** with a decision for a police officer and social worker to interview G and report back to Buckinghamshire CSC afterwards**.** The care worker was later (Feb '10) found guilty of the abuse and sentenced to twelve months imprisonment and disqualified to work with young people. Meetings between senior managers from Bucks CSC were held in **July, September and December 2009** initially to ensure that G was safe to remain in the placement, and also to ensure that the care provider had learned appropriate lessons, such as recruitment processes. The reason for the placement move to another area in **September 2009** was at the request of G, following him seeing the perpetrator in local shops.

[6] A Strategy Meeting is called, primarily between Children's Social Care and the Police, although occasionally other agencies such as Health are involved, to consider if a child protection investigation is required and if so how and who will conduct this.

Self-Harming Behaviours

3.32 G's health assessment at the beginning of the year stated that the self-harm problems from 2006 had now been resolved, and whilst it was true that he did not self-harm for the most part of 2009, G presented with significant self-harm behaviours in **late December 2009**, after returning from Christmas leave at home. He made several attempts to hang himself with a T shirt, cut himself and placed a plastic bag in his mouth. G told his GP at this time that he had used a ligature in the last month on four or five occasions. In fact immediately prior to his change of placement in **September 2009**, one report to Education said that G was making attempts to take his own life.

Offending Behaviours/Going Missing

3.33 As with the self-harming behaviours, it wasn't until after the sexual abuse incident and the placement move in **September 2009** that G's behaviour again began to deteriorate. In **October 2009** he alleged a staff member physically attacked him and then G later took a knife and racially abused a staff member- these incidents were not formally reported outside of the care home. A month later a further incident required Police attention when G was extremely disruptive in threatening staff at the residential unit and also threatening to self-harm. At the time G also spoke of using alcohol and possibly solvents.

3.34 G went missing overnight in **late November 2009**, though returned of his own accord. In the next month G was reported to the Police as responsible for the theft of a vehicle – this was a staff member's car that he took and drove around the neighbourhood with another care home resident.

Professional Interventions

3.35 At the start of the year G was allocated an additional worker to undertake life story work and this worker was involved throughout the year. By **August 2009** Buckinghamshire CSC was concerned that G had been having unsupervised contact with his mother and her partner. It was also at this time that G's mother sought a discharge of the Care Order, and in the process of this application being considered, the Children's Guardian wrote to Buckinghamshire County Council in **October 2009** to say that the court were going to be alerted "that an independent review or perhaps a serious case review of this case may be appropriate". This was in relation to the sexual abuse of G by the care worker. In **November 2009,** the children's guardian recorded her intention to refer the case to Buckinghamshire CSC. There is no record of any referral being made and the Buckinghamshire LSCB was never contacted in respect of this.

3.36 **In November 2009,** completion of the Strengths and Difficulties Questionnaire[7] (SDQ) by the carer, revealed G's score at a very high level of the total difficulties score – G said that he did not think about his own safety or behaviour. The LAC specialist nurse wrote to the Buckinghamshire social worker asking if the issues raised by the SDQ were being addressed.

3.37 Following the concerns about the number of self-harm incidents later in the year, G was referred to CAMHS in **late December 2009**. This was presumably the service in Staffordshire, the location of G's placement at that time, but there is no record of any

[7] The Strengths and Difficulties Questionnaire is a brief behavioural screening questionnaire for children and adolescents aged 4 – 16 years. It exists in several versions to meet the needs of clinicians, researchers and educationalists and can be self-completed by an adolescent or there is a modified version for carers, teachers etc.

adolescent mental health interventions as a result.

2010

Placements

3.38 It was reported that "senior staff" in Buckinghamshire CSC decided to move G from his current placement and subsequently he commenced a new placement (No.12) in **January 2010**. This was a residential activity centre in Anglesey, where he stayed for a pre-arranged period of three months, during which it was planned that consideration would be given to where he would be next placed. The Anglesey placement was successful in that G developed good relationships with both staff and young people and gained a wide range of experience in outdoor activities in which he achieved considerable success. In **April 2010** G moved to an independent residential unit, (placement No.13) this time in Northamptonshire. This was seen as a short term placement to await a placement in Buckinghamshire which was due to be available in 5 months' time. G remained there for six months before moving back to the Buckinghamshire area in another residential unit (No.14) from **October 2010** until the end of the year.

3.39 In **July 2010** the Northamptonshire Police missing persons' coordinator expressed strong concerns to CSC in Buckinghamshire about the ability of the local placement (No.13) to adequately care for G. Despite three meetings being set up with the manager of the care home to address the problems, the manager failed to attend although eventually a meeting with senior managers from the care provider led to the care home manager being suspended for gross misconduct. The Police also expressed formal concerns to Ofsted about the manner in which the home was being run and in response Ofsted undertook a compliance visit on the **21st July 2010** following which a "notice to improve" letter was sent on the **3rd August 2010.** The care home's action plan in response to the letter was assessed by Ofsted on **13th August 2010** as providing sufficient information that the home was meeting the statutory requirements set at the previous compliance visit. Buckinghamshire CSC subsequently gave 28 days' notice in **September 2010** to end the placement as it was not considered that G was safe, evidenced by the numerous occasions of G placing himself at risk by going missing and by his behaviours. By the **summer of 2010** was now 15 years old. It was in **October 2010** that G eventually left this placement and was placed in Buckinghamshire where it was considered that G's support needs could be better managed.

Self-Harming Behaviours

3.40 There were significant self-harming behaviours during this year, beginning in **April 2010** after his move to Northamptonshire, and then in **May 2010** which reflected serious attempts to cause himself harm, including cuts to his throat, pulling out electrical wiring, and trying to swallow a plastic bag. There were further incidents in **August 2010** of cutting himself on the arms and then of an overdose of alcohol, cocaine and cannabis. At an urgent psychiatric assessment he was prescribed antipsychotic medication and diagnosed with a "behavioural and emotional disorder with a high risk of self-harm". A local paediatrician also described G as the highest risk young person seen from this particular placement.

3.41 Significant self-harming incidents again occurred **in August 2010**, including him threatening to jump off a bridge, and G tried to hang himself in **early September 2010** and was taken to hospital by the Police. An assessment was carried out under section 136 of the Mental

Health Act[8]. However, it was reported by the hospital that there was no evidence of mental disorder or of suicidal ideation and G was returned to the residential unit. On return he made further self-harm/suicide attempts and arrangements were put in place for 1:1 observation by staff at the home.

Offending Behaviours/Going Missing

3.42 Whilst there were some incidents of concern during the placement in Anglesey, these were infrequent and in general managed effectively by the care staff. In many respects this was a very successful placement. However, during his time in the next residential unit in Northamptonshire, G was reported missing by them to the Police on at least thirteen occasions over a six month period. Each time he was returned home but the episodes sometimes included criminal damage and assaults on staff. On a number of occasions of criminal damage caused by G, for which he was arrested, the residential unit did not press charges, as it was apparently the organisation's policy not to do so. During a period of time in **June 2010**, G was said to be smashing windows on a daily basis. Overall, there was considerable evidence of this being a very troublesome time for G and during the early part of the year he had reacted badly with significant behaviour problems to the 1 year sentence given to his abuser from previous care home a year earlier.

3.43 Incidents of assaults to staff continued into his placement when he returned to Buckinghamshire in **October 2010** and there were also further incidents of him going missing which were often linked with him meeting up and staying with his sibling.

3.44 G attended court in **March 2010** for car theft and related driving offences and was sentenced to a one year Referral Order. He again appeared in court in **mid-September 2010** for Common Assault and for Criminal Damage charges for which he was given Absolute Discharges. In **early December 2010** G attended the Youth Court in Buckinghamshire in relation to two charges of Assault by Beating and for Criminal Damage, which had taken place two weeks earlier. G pleaded guilty and the matter was adjourned for sentencing.

Professional Interventions

3.45 **In February 2010**, Buckinghamshire CSC wrote to Shropshire County Council to request consideration be given to a Serious Case Review being conducted regarding the sexual abuse of G in the care home the previous year. No response was recorded or any follow up by Buckinghamshire CSC, and no such Review ultimately took place.

3.46 Also **during February 2010**, G gave a video interview to the Police in which he disclosed physical abuse by his mother's former partner which had occurred prior to coming into care.

3.47 In **February 2010**, responsibility for G was transferred to the Children in Care 14+ team in Buckinghamshire, leading to another change of social worker. Also at this time the life story work was completed with the worker reporting that she was pleased with progress that G had made. A further change of CSC social worker was made in **May 2010** and this person remained responsible for G until the end of the year.

3.48 Apart from Buckinghamshire CSC, the Northamptonshire Police had very frequent involvement with G whilst he was resident in their area from **April to October 2010**.

[8] Sec 136 of Mental Health Act 1983 enables the Police to move somebody to a place of safety for a period of up to 72 hours, where they can be examined by a doctor and an approved social worker.

Following the Referral Order being made, then Northamptonshire Youth Offending Service (YOS) became involved in order to oversee this, before handing this work to the corresponding Youth Offending Team (YOT) in Buckinghamshire when he returned to live in Buckinghamshire.

3.49 G was discharged from Stafford CAMHS in **March 2010** because of his move of placement, but by that time his situation had improved whilst in the activity centre in Anglesey.

3.50 At his LAC health assessment in **April 2010** G was found to be in good physical health although he was smoking approximately 15 cigarettes a day and it was recorded that he "gets drunk regularly". It was also said that he was sexually active. **During June 2010**, G received some anger management guidance.

3.51 There were two CAMHS assessments in **August 2010** whilst G was in the local hospital in Northamptonshire because of the serious self-harming attempts, at which time G was prescribed Risperidone[9] to aid his management of his strong feelings. There was a further assessment **the following month** under the auspices of the mental health section. (See paragraph 3.41). The Risperidone was ceased in **October 2010** upon the return to the placement in Buckinghamshire (No. 14). With the involvement of the CAMHS in Buckinghamshire as part of a planned package for G, a Care Coordinator was identified for G in **October 2010** and arrangements were set up for him to be in receipt of Dialectic Behaviour Therapy (DBT)[10]. Additionally there was 24 hour Crisis cover for G along with the outreach service, visiting weekly in the latter part of the year.

3.52 Concerns were raised, via an Ofsted inspection in Buckinghamshire at the time, that G's emotional needs were not being met and that insufficient attention was being given to the impact of his sexual abuse by the care worker. A psychiatric assessment was agreed in **October 2010** which took place in **December 2010** when it was assessed that G was not ready for psychotherapy to help deal with his past abuse – the focus of interventions currently was to manage his self-harming behaviours. The assessment did not identify a mental illness but referred to possible ADHD for which medication was then prescribed.

3.53 G was in receipt of interventions from the YOS in Northamptonshire from **April to October 2010** whilst G was resident in their area, and this work then transferred to the Buckinghamshire YOS from **October 2010** after G returned to his home area.

2011

Placements

3.54 Apart from 2006, compared to previous years, 2011 was the most disruptive for G in terms of the number of placements, spending time in five different residential units. (Nos. 14 – 18) His first attendance at the Secure Training Centre early in 2011 was as a result of being sentenced to eight months Detention and Training Order (DTO) although he remained there for 3 months being released in **April 2011** on licence until **mid-September 2011**. At a planning meeting early during his time in the Secure Training Centre, it was noted that there

[9] Risperidone is an anti-psychotic medication which is used to treat schizophrenia and symptoms of bipolar disorder. It is also used in autistic children to treat symptoms of irritability.

[10] DBT is a psychological therapy for people with borderline personality disorder, especially those with self-harming behaviour or suicidal thoughts. In DBT you are taught specific skills to manage and control emotions so as their intensity is reduced and they can be released quicker.

were lots of positives in that G was engaging well in activities such as the gym, cookery, fitness and was contributing in meetings and within his education.

3.55 Upon his release, G then returned to the residential placement in Buckinghamshire but by **early July 2011** was sent to a local authority secure children's home in Essex. This was as a result of Buckinghamshire CSC actions who considered that G's very challenging behaviours at that time met the criteria to apply for a Welfare Secure Placement, which was subsequently granted.

3.56 After a very difficult period in the secure children's home in which he repeatedly self-harmed, there followed a period of stability, and in **November 2011**, G was placed in the "open" component of this children's home for a further period of residential care. This lasted through until the end of the year. In the **early part of 2011**, G only had occasional telephone contact with his mother but fairly regular contact with his family once he had moved into the "open" component of the Unit. This was in line with preparing for his independence which had been agreed in the Planning Meeting in **November 2011**.

Self-Harming Behaviours

3.57 Although in **April 2011** G denied thoughts of suicide and there was evidence of him managing his anger well, unfortunately his self-harming behaviours did then escalate considerably after moving from the Secure Training Centre in Milton Keynes. In fact approximately eighteen incidents occurred, thirteen of which took place **during July and August 2011**, coinciding with the time when he was in the secure children's home in Essex. Mostly, he cut himself, sometimes seriously and persistently, which usually needed hospital attention to deal with the wounds. In **early August 2011,** the named nurse for safeguarding at the Essex hospital wrote to the local mental health team regarding G's recent hospital attendances and requested that the issue of G's safety be raised with the secure children's home. From the **end of August until early December 2011** there was no incident of G cutting himself and it was recognised that he had made progress at this time. However, further incidents took place at the end of the year, again involving cutting himself.

3.58 On occasions, G admitted to the use of solvents and alcohol, with some instances of binge drinking. In the **middle of the year** the YOS assessment of G was that he remained at High Risk of Serious Harm (ROSH).

Offending Behaviours/Going Missing

3.59 G attended Youth Court for three offences of Assault by Beating (relating to assaults on staff in the previous residential unit in Buckinghamshire - No. 16) and sentenced to eight months Detention and Treatment Order (DTO) – his Referral Order was revoked. This sentence led to his first detention in **January 2011** in the Oakhill Secure Training Centre (No. 15) – G was aged 15 ½ years old at this time. He needed restraining early in his detention, and there had been some incidents of threatening staff, although generally he appeared to settle and eventually achieved some stability and complied with the regime, making his early release on license possible.

3.60 Breach proceedings[11] were initiated against G after two months following his return to the Buckinghamshire residential unit, with a pattern of him regularly going missing **during June 2011** and at that time, the staff in the unit were finding it difficult to set and maintain boundaries for G. He was arrested in **late June 2011** for an assault on a staff member whom he threatened with a knife and he also stole a car from the unit and set fire to it. After again going missing and a breach of his license, a Recovery Order and the Secure Order were obtained in **early July 2011**, leading to G's Welfare Secure Placement in Leverton Hall which was a secure children's home in Essex. When he attended court for breaches of his DTO and for an offence of common assault, he received a £20 fine for the breach and a 12 month conditional discharge for the common assault. This was approximately at the time of his 16th birthday.

3.61 G attended Youth Court in Basildon in **November 2011** for a breach of the Conditional Discharge and for Criminal Damage – the outcome was a Youth Rehabilitation Order for one year and an Activity Requirement Reparation. In **December 2011** G was arrested for offences of Criminal Damage at the more "open" component of the secure children's home where he had been placed and by this time he was again going missing.

Professional Interventions

3.62 In **January 2011,** G was prescribed medication for ADHD although it was reported that it was difficult to be sure whether G was consistently taking this, and towards the **end of the year** he had stopped taking it. A new CSC social worker was allocated in **January 2011** alongside an additional worker (although it was not clear for how long). There was a further change of social worker in **July 2011 and again in August 2011.** This social worker then remained with G until the time of his death 15 months later.

3.63 Risk Management and Vulnerability Panels[12] (RMVP) were held from **early February 2011**, when G was considered high risk by all agencies who attended. In total there were nine RMVPs held during the year.

3.64 G received support from the YOS and was seeing a psychologist on a weekly basis in the **early part of the year**. Whilst in the Oakhill Secure Training Centre it was stated that G had "showed a genuine willingness to develop academically" and had taken opportunities to use work experience in the food tech. dept. and a construction course also available on site. He had also engaged in support sessions and therapeutic interventions and was said to be making good progress at that time.

3.65 Upon release from the Oakhill Secure Training Centre in **mid-April 2011**, (for the DTO), the

[11] It is very important that an offender given a community order complies fully with the order and the instructions given by a Probation Trust or a Youth Offending Service. If an offender fails to comply with the conditions of their community order then they face being returned to court where their sentence can made harder by adding additional elements. This process is called a 'breach'. If the breach is serious enough the court may decide to revoke the original sentence and re-sentence the offender which may involve a prison sentence - www.offendersfamilieshelpline.org

[12] RMVP are held on all young people who are assessed as high or very high risk of serious harm to others or vulnerability. This ensures that the Case Manager is given support in devising and delivering interventions for high risk cases and that these are subject to relevant management team support and scrutiny. This is a formal meeting chaired by an Operational Manager. Relevant partner agencies attend which ensures the risk is managed in a co-ordinated way.

plan was to hold G within CAMHS outreach service via the Care Programme Approach[13] (CPA). A structure of interventions and support was set up for G **from April 2011** via CAMHS, which included weekly DBT sessions, access to phone support from the DBT team, to continue under the psychiatric care regarding his ADHD, as well as regular meetings with the YOS worker. CAMHS maintained regular liaison with CSC at this time. There was also involvement from the local commissioned substance misuse service Addaction.

3.66 In **May 2011** a Care Planning Review multi-agency meeting identified that G was cooperating with multiple agencies at the moment but that there was a danger of duplication and professional overload and that G was getting angry at the amount of appointments he had to attend.

3.67 G started to disengage from the DBT work by the **middle of the year** and when he was placed in the secure children's home in Essex, he was seen weekly by a specialist clinical psychologist in order to monitor mood and to find more adaptive strategies to manage difficult emotions. A daily risk management plan was drawn up during **August'11.** This was at the time of regular self-harming. Following an urgent psychiatric assessment at this time it was identified that there was no evidence of mental illness, depression, anxiety or Post Traumatic Stress Disorder (PTSD) but that G had major emotional deregulation, anger management problems, impulsivity and disturbed conduct. It was recognised that he had declined therapy and that although the ADHD medication had helped, he did not want to take it. The opinion offered from a CAMHS assessment in **late October'11** was that a strong professional relationship, not necessarily based on therapy but more on trust and containment, would prove effective in the long term.

2012

Placements

3.68 G was required to leave the "open" children's home in Essex (No.18), in **February 2012**, because of his continuing challenging behaviours and because of a threat he was thought to pose to another resident– an allegation had been made which G strongly denied. He was told whilst he was at home for the weekend, that he was not allowed to return to his placement. A new placement was immediately found in the Northampton area which was an independent residential provision (No. 19).

3.69 Arrangements were put in place for G to spend weekends at home and this was seen as preparation for a possible eventual return home in the near future. However this occurred sooner than planned when at the **end of May 2012**, G refused to go back to his placement in Northampton following a successful weekend at home. At this point he was two months short of his 17th birthday.

3.70 During his three months at home, G was able to find work intermittently and pursued his interest in animals by helping out at a local farm, but due to a G's violent assault on his mother's partner by G, he moved out of home and was placed in a semi-independent living unit in Oxfordshire on the **23rd August 2012.** This was his final placement and his 21st overall. Whilst at this placement he then attended a Training Centre (which was a skills

[13] The Care Programme Approach is a system of delivering community mental health services to individuals diagnosed with a mental illness. The approach requires that health and social services assess need, provide a written care plan, allocate a care coordinator, and then regularly review the plan with other involved professionals.

based training facility for young people who have special educational needs – usually behavioural problems) to give employment experience and preparation for adult life.

Offending Behaviours/Going Missing

3.71 In **late January 2012** G was arrested for causing criminal damage and for threatening his social worker with a knife. He was found guilty in court two months later for Common Assault for which he was given a Youth Rehabilitation Order for 12 months with supervision, and a three month curfew.

3.72 There had additionally been some behavioural concerns with G attempting to set fires, although these did not lead to any significant incident.

3.73 The Police interviewed G in relation to an allegation of sexual assault by G towards a younger girl in the placement, which led to him being discharged from his placement at the time (see Para 3.68). G strongly denied the allegations and the case did not proceed due to lack of evidence.

3.74 In **mid-August 2012**, almost three months after returning to live back at home, G was arrested for the assault upon his mother's partner when he punched and kicked him. G appeared in court on **28th September 2012** for this offence (Assault Occasioning Actual Bodily Harm) and was given an eighteen month Youth Rehabilitation Order with supervision and an activity requirement – there was also an exclusion not to attend home as well as a curfew being imposed. The sentence additionally included some Restorative Justice work with his mother's partner.

3.75 There was just one occasion when G went missing during 2012, and this was overnight from his semi-independent unit and he was found at his sibling's home the next day. It was from **October 2012,** and potentially sooner, that G was allowed to sort out his contact arrangements with his mother and her partner.

Professional Interventions

3.76 **In early January 2012** there was a suggestion from the Buckinghamshire CSC assistant team manager that a meeting needed to be held under the Hard to Reach Protocol[14] although it was decided that a placement planning meeting or a review would suffice. No additional meeting was set up although the LAC Review went ahead a few weeks later.

3.77 Whilst in the three months of his placement in Northampton (No.19), G was in receipt of services from Northamptonshire YOS, primarily to care-take the Youth Rehabilitation Order made in the previous November and to undertake an outstanding Pre-Sentence Report. As part of their interventions, this YOS tried to help G manage his frustrations and anger, and he generally attended his sessions with the YOS worker and was able to respond well to the work. At the completion of their work, the Vulnerability and the Risk Management Plan as well as the Core Asset document were all updated and Buckinghamshire YOS re-established their role with G once he returned to live back in the family home at the **end of May 2012**.

3.78 There was a Transitions Meeting **in March 2012** to consider what processes and resources would be helpful to aid G's transition into adulthood as he was now approaching his 17th

[14] This was a Buckinghamshire LSCB multi agency protocol in force at that time in respect of how to address work with families and young people who were resistant to intervention and thereby unable to achieve change.

birthday. At this meeting it was considered that CAMHS should be asked to reopen G's case. In the LAC Review a few days later the need for preparation for transition to adult mental health services was noted and that G would likely move back to his family once his sibling had moved out. Two days later the RMVP meeting had identified that G was still at high risk in all areas.

3.79 During this year, G at times had said that he wanted help with his alcohol and drug misuse, and accordingly he did accept continuing input by Addaction.

3.80 Prior to G's move back to his family home, plans were made for referrals to be made to CAMHS and in **February 2012** to the Child and Adolescent Harmful Behavioural Advice Service (CAHBS) which did provide a service up until the **end of May 2012** by which time the allegation of inappropriate behaviour with a 13 year old was dropped. At the same time, G moved back to his family. Neither G nor his mother attended the LAC review that had been arranged at the family home. The mother explained in her contribution to the SCR that by this time G had no interest in a further review and did not see the point.

3.81 **By September 2012**, and now in the semi-independent unit, G requested to see CAMHS and restart the DBT. CAMHS followed this up with appointments to assess his commitment to DBT. At one of the two sessions, he attended late and was drunk. He claimed to have had no suicidal thoughts or wish to self-harm but admitted to getting drunk instead.

3.82 Buckinghamshire CSC continued to be involved throughout the year, without a change in social worker. Significant input was provided by the YOS and to a lesser extent by CAMHS, whose last contact was on the **22nd October 2012**. The Addaction worker also continued to be involved.

Self-harming Behaviours

3.83 In the **middle of January 2012**, there was an incident of G punching a wall, needing him to have six stitches as a result. There was no further self-harming incident until **August 2012** when he took an overdose after the assault upon his mother's partner. It was this incident which led to his placement back at home finally breaking down. There was no CAMHS assessment undertaken in respect of this incident as the hospital did not arrange this and G refused to consent to the assessment when asked by the Force Medical Examiner[15].

3.84 Whilst there had been no incidents of G cutting himself since the beginning of the year, **by September 2012**, G was giving himself tattoos, with an acknowledgement by him that this was another form of self-harm. For much of the year, however G had continued using cannabis and alcohol, sometimes to excess.

3.85 In **late October 2012**, in an interview at CAMHS, G denied any suicidal intentions but said that he did not know from day to day how he would feel, saying it was like being on a roller coaster, but never experiencing it in the middle, but always feeling at the extremes.

3.86 There was an occasion on the evening of **Sunday 4th November 2012** when G cut himself, and the wound was noticed at the training centre **the following day** and as a result G was

[15] Force Medical Examiner or Forensic Medical Examiner (FME) is any doctor used by the police in the United Kingdom. There are usually multiple doctors utilized by a police force, and the FME is the one who happens to be on call. Qualified doctors serving as FMEs generally serve as part of a regional pool for the police stations in their area.

taken to the local A&E hospital by the centre's first aider. The first aider described the wounds as a very deep and open one, and the hospital detailed a 12 cm laceration which was an "uncomplicated wound which was closed under normal procedures". Earlier that day the social worker had been informed that G had self-harmed, but that it was superficial – (it remains unclear if this is a reference to the same incident). G was considered by the hospital assessment as having a low risk to self-harming at this time. The hospital said that they attempted to contact the CAMHS outreach team but could not get an answer and felt confident in returning G into the care of the first aider from the college.

3.87 There was a further incident, also on the **5th November 2012** following his return from the hospital, when he had an altercation with a younger female pupil at the training centre when he was said to have picked her up and banged her head against the wall – she retaliated and hit him with a cup which cut his arm. As a result, the training centre gave G time out for the rest of the week. G was said to be shocked by the incident as he had not done this before – he claimed that he had been attacked by the girl and that he was not at fault. The incident had put this placement at the training college in jeopardy and he was made aware of this - the statements he made to his care workers made it clear that he believed that a permanent exclusion would take place.

3.88 Later on the same day, once returned from the training Centre, it was noted at the semi-independent unit that G had sustained an injury to his right forearm as a result of the altercation with the girl at college. As a result, a care worker took him to a local out of hours' medical facility where it was identified that he had sustained soft tissue and associated superficial bruising – appropriate treatment advice was given.

3.89 On the **6th November 2012** G did not go to the training centre as he was now suspended from there for the rest of the week, and later that day the Addaction worker visited him when G spoke of the incidents at the training centre which had upset him. When the contact ended, G was said by the worker to have appeared calm and happy and preparing to meet at the YOS office the next day and to meet with a new CAMHS worker.

3.90 In the early evening G's social worker told staff at the semi-independent unit that the training centre had decided to exclude G permanently and it was agreed that they would tell him in the morning. The social worker asked staff to check on G's bedroom as there were still concerns about self-harming.

3.91 G was seen at the unit at 5.00pm and this member of staff later returned there just before 9.00pm after being updated about the phone call from the social worker. This staff member was aware from earlier contact with G that he was very anxious about being excluded from the training centre and that he felt he was being treated unfairly. It was upon return to the unit that G was discovered hanging from the staircase and then based on advice over the telephone from the paramedic, attempted to resuscitate him until the Police and the paramedics arrived. G was taken to hospital where he was pronounced dead.

4 The Young Person's Experience

4.1 For G to come into care was understandably viewed by professionals as the first step to protecting him from his earlier abusive care and starting to resolve the problems that he had encountered in his life. But for G, his experience in care, and particularly from the outset, appeared to be an additional problem for him to manage and which created further insecurity for him, though of a different nature to that which he experienced at home. Ultimately it created instability, dislocation from more normal daily life and vulnerability to further abuse.

4.2 It is not possible to know the impact upon G of the death of his father by suicide when G was 3 years old, although at that time there was no parental stability within the home which could have provided any emotional support at a difficult time for G. An assessment in October 2010 identified that G's self-harming behaviours may escalate on the anniversary of father's death, so it was apparent that this remained a significant incident for G.

4.3 The fact that the first report of G self-harming was at the age of 10 years, gave evidence of the impact upon him of his home life. By the time he came into care, still under 11 years old, this was with a backdrop of a difficult and deprived childhood.

4.4 It was also apparent while G was in care, that he wanted contact with his family, showed concerns about the well-being of his siblings and his mother, but that these relationships were difficult to sustain in a positive way. They were also ambivalent in that his relationships with his siblings and his mother were variable, both from his perspective and theirs. This must have gone some way to G being unable to settle for longer than a few days in his first five placements. At his first LAC Health assessment, G said that he didn't know what was happening to him.

4.5 G clearly had a strong sense of loyalty to his family and wanted a positive relationship with them, and it was his consistent wish to return to live with them. However contact arrangements were variable and did not always go well. On a number of occasions, contact with his family was a precursor to G's self-harming and other challenging behaviours.

4.6 G experienced living in a high number of placements and his behaviours reflected different experiences in that he could respond very positively or very negatively. He clearly felt able to respond to positive working relationships and was able to achieve practically, academically and emotionally at certain times. It was recorded on occasions that he could present himself very well and could be charming and compliant and had insight into his difficulties. However, these were inconsistent traits. He seemed to experience greater stability when in very structured environments, such as the Anglesey activity centre (No.12) and the Secure Training Centre (Oakhill – No. 15). In contrast, within much freer regimes, it was often reported by those who cared for him that on occasions he would lose control of his actions and it was at these times when he posed the most risk, either to himself or others.

4.7 It was clear that many of the professionals and carers who had contact with G, felt very positive towards him and demonstrated their concern for him, and he no doubt benefited from the positivity and commitment of these relationships. Nevertheless the impact on him of the change of social workers and the change of care staff on the occasions when he moved to a new placement could have meant that it proved difficult for him to develop the sort of consistent relationship with a trusted adult that he needed to help him through this

challenging time in his life. A report by NSPCC ChildLine[16] identified key findings from their work with Looked After Children that moving placements was one of their major concerns, with one young person quoted as saying; "I have been moved between different care homes. I feel angry at having to be in care. I feel isolated and sad due to changes in placement. I feel powerless. I have bottled up my emotions. I cannot trust anyone or build relationships as I am moved about so much". This may well have been the sorts of feelings that G experienced, and often acted on with negative and destructive consequences. In fact it was some of these behaviours which led to placement changes. Another finding from the ChildLine report was that Looked After Children often blamed themselves for the placement change.

4.8 At one stage, professionals involved with G considered that there too many people working with him, and presumably were concerned that this had become counter-productive. It is difficult to know what this meant for G. Distance from home created difficulties for social workers to retain good links with him and for G to sustain positive links with his family. There is clearly an issue for any Looked After Child who frequently moves placement, about how the previous relationships with staff would end or to what extent there could be any continuation, albeit of a less formal nature. In more normal life, important relationships that young people develop with adults do not usually end abruptly, but this was almost always the case for most of the times that G moved placement. This was either a practical matter in that placements were often far apart but more often because it was considered inappropriate to sustain such contacts, so that G could develop new relationships with his carers in the new placement and new area.

4.9 It was apparent that G had the ability to develop good relationships with staff, but the down side of this of course was that it created potential difficulty when this relationship had to end. There was evidence that this was an issue for G, when on one occasion he sought contact with staff from a former residential placement that had ended abruptly, but he was told this was not possible.

4.10 G's experience of sexual abuse at the hands of one of his carers was a traumatic one for him, and this was evidenced by the urgency with which he wanted to move placement to a new area after seeing the perpetrator locally. Although he was generally reluctant to discuss this abuse with professionals, his social workers at the time did offer the time and opportunity for G to do so if he wished. Ultimately however, the impact of this abuse upon G was not really known.

4.11 It is difficult to understand what it was like for G to have been the subject of so many assessments of different types for the duration of his time in care. This was an inevitable feature of being in care and also as a result of his self-harming and offending behaviours. However, what this experience meant to G is difficult to say other than it was a fairly continual process of people trying to understand him and to find the best ways to support and help him.

4.12 The eventual return to family and the breakdown of these relationships following his violent behaviour must have been a further reminder to G that he and his family were still unable to have any consistent positive relationships.

4.13 G certainly had some positive experiences whilst in care, and there were achievements in some of his care homes; he learnt to play the drums, engaged with the church, (particularly

[16] ChildLine case notes – Looked After Children talking to ChildLine – NSPCC 2010

in the Secure Training Centre) and enjoyed the physical challenges posed by his activity based placement in Anglesey. Overall though, it appears as though these were insufficient to counteract the absence of consistent or reliable care as a looked after young person. He often had difficult and confrontational relationships with his peers in care and he usually found it very difficult to acknowledge the impact of his behaviour upon others. Although there were some calm periods, G's self-harming behaviours never really ceased throughout his period in care, and nor was he able to manage his use of alcohol and drugs in any consistent way. Generally he managed this lifestyle with anger, frustration, defiance and for some periods, compliance, but overall his experiences in care did not appear to be able to give him sufficient opportunities to develop and maintain enough positive self-esteem to go confidently into adulthood. It was also the case that G was often unable to take advantages of opportunities within the care system to improve his sense of self-worth and maintain achievements.

4.14 When G moved into his final semi-independent placement, workers who knew him well recognised that this was a very different experience for him in that he no longer had peer relationships with other young people in care, who had similar needs and issues to him. In the more independent environment and at the training centre, he for the first time experienced the challenge of making and maintaining friendships which were not based on the shared experiences of being in care. Adapting to a world outside of the residential and secure care environment was an unforeseen consequence of living in residential care for a long period of time and a substantial challenge for G.

Analysis

The understanding of the harm that G suffered prior to March 2006 and how any knowledge of this previous harm informed later actions and decisions once he came into care.

5.1 Buckinghamshire CSC had considerable records which identified abusive care that G and his siblings received at the family home for a period from 1998 when G was just three years old. The CSC IMR reported that the scope and quality of information gathered and analysed was however questionable. To what extent this knowledge informed the first placements in care is difficult to tell as CSC quickly became preoccupied with managing the placement failures and G's disturbed and very challenging behaviours.

5.2 Nevertheless, it was apparent that the key components of this background information were shared with a number of key agencies. For example the main health agencies, (GP, CAMHS, health visiting) all held this information. Similarly Buckinghamshire YOS and the Thames Valley Police held relevant background information. However, LAC Health assessments did not have information covering the year before G came into care, which was concerning. After coming into care, G was registered with nine different GPs and whilst they were all informed of the background, with the practice of each surgery summarising the records, on subsequent occasions that G was seen, the GP would have been less aware of the details of the past history.

5.3 CSC did appropriately undertake/commission assessments to inform their initial decisions about G's early placements, so in this way there were attempts to make the links between G's past experiences and how his needs should be met within his care placements. However as G changed placements and moved around the country, sometimes quickly, this

background information rarely followed in any detail and it was primarily the Buckinghamshire agencies which retained this information. It was understandable that it was more pressing at times of placement change to focus on the recent information in terms of previous placements and G's experiences within them. However, most care providers considered that they were provided with the most recent information and concerns, if not about his life before coming into care. When appropriate the Buckinghamshire YOS transferred information to the YOT in the area where he was temporarily living.

5.4 Generally, the different placements and agencies involved were responding to G based on his most recent care experiences rather than knowledge of the cumulative impact of the environment that he was brought up in. This potentially meant that there was less understanding of the causes of his difficulties, and how to deal with them most appropriately. However, the longer the placement and the more that care staff and specialist professionals needed to work with G, then the greater the need to seek out and understand that past information in order to consider how to most appropriately meet his needs and understand his behaviours and attitudes.

5.5 Whilst, apart from the Secure Training Centre in Milton Keynes, (No.15) there was no apparent record in each placement of G's social history being known or acted upon, it seems likely that the direct contact from the Buckinghamshire CSC social worker filled in some of those gaps. However as his time in care increased, with it being noted in the CSC IMR that G's file was very disorganised, it would have proved very difficult to summarise all that had happened to G and of the range of interventions he had received, and thereby have been able to give the necessary detail to a new placement.

5.6 The link with his past became most significant when contact arrangements with his family were either being made, monitored or restricted. In this way, the background information should have informed those decisions. However, when decisions about contact were made, insufficient weight was given to the extent and knowledge of the problems that G had experienced before he came into care.

5.7 It was clearly CSC's expectation from the outset that contact should be supervised and monitored although CSC expressed concern at the discovery in August 2009 that G had been having unsupervised contact with his mother and her partner "for some time". CSC managed their response to this well but clearly the lapse of knowledge about contact should not have happened in the first place. It was less clear how or if purposeful decisions were made to reduce the need for any contact to be supervised as G progressed into his teenage years. In late 2011, there were at least two occasions when G was very disturbed following contact with his family, although by early 2012, G was placed back with his family, until this broke up following a violent incident with his step-father.

5.8 Certainly there had been a need for preparations to be made to appropriately support G as an increasingly independent young adult, and this had included arrangements for contact with family, and potentially for him to move back there, something which G had always wanted. However to what extent the success of these contact arrangements was linked to the agreement for him to return home was less clear. The timing of the arrangements to return home seemed to be in part driven by G's wishes rather than to any objective assessment that the time was appropriate to return to his family. Clearly however it was also appropriate for the practitioners to respond to his hopes that his family could provide something positive. However the lack of structure and monitoring of family contact whilst in semi-independent care was evidenced within G's Pathway Plan in October 2012, when

contact arrangements appeared to be left with G to decide, as it was recorded that G stated that he saw his mother but did not stay overnight, and that he occasionally saw his siblings.

Assessments of need and risks, specifically in respect of self-harm and potential suicide

6.1 G was subject to an inordinate range of assessments, reflecting the twenty one placements that he had and because of the range of challenging anti-social, criminal and self-harming behaviours that he displayed during his time in care. Whilst it is difficult to be clear about the exact numbers of assessments undertaken, in summary these included:

- Mental health assessments (Buckinghamshire CAMHS) - (x6)
- Psychiatric assessments (x2)
- Mental health assessments following hospital attendance/admission - (x4+)
- Educational Psychology assessments
- Strengths and Difficulties questionnaires (SDQs) - (x4)
- Assessments at admission to new residential units (variable in number and type)
- ASSET[17] assessments - (x6)
- Risk of Serious Harm assessments (ROSH) by YOS (x6)
- Substance misuse screening assessment (SMU) (e.g. x2 – Oakhill)
- Suicide and self-harm assessment tool (SASH) (Weekly meetings whilst in Oakhill)
- Missing person risk assessments (numerous undertaken by three Police Forces following G gong missing).
- LAC health assessments - (x5+)

When collated in this way, these different assessments demonstrate how the in-care system functions and additionally how different presenting behaviours automatically trigger different assessment processes. The key issue however is the extent to which they collectively or individually contributed to increased understanding of G's needs and of the interventions to address them. In order to explore this, the different components of the assessment processes are analysed.

Looked After Child Assessments and the role of the GP

6.2 In total, 5 LAC health assessments[18] were recorded as being completed whilst G was in care. There was no record of a health assessment for 2007 and this was evidence of how the placement moves around the country had some impact on the required system of annual health assessments for children looked after.

6.3 At the time of his first health assessment in May 2006, 6 weeks after coming into care, G was described as being in good physical health but his emotional health and self-esteem appeared low. Although a CAMHS referral was suggested, potentially in the future once G was in a settled placement, no specific action was taken in respect of this. It appeared at this time that G's behaviours and emotions were being exacerbated by being in care and he was bewildered about what was happening to him. A referral to CAMHS at this time may

[17] "ASSET is a structured assessment tool that is used by YOTs in England and Wales with young people who come into contact with the criminal justice system. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances – ranging from lack of educational attainment to mental health problems – which may have contributed to such behaviour.

[18] The aim of a health assessment for a looked after child is to enable the child to have their health needs assessed holistically and to develop a plan to meet those needs. The assessment should include a comprehensive review of physical health needs and attention should also be paid to the child's behavioural or emotional development including evidence of risk taking behaviours.

well have been appropriate with the evidence that a settled placement was unlikely at this time. It was unfortunate that an opportunity was not taken at this early stage for greater understanding of G's mixed emotions and fears.

6.4 Overall, the LAC health assessments did not have a specific focus on mental health issues, although when these were apparent, they referred to specialists or other agencies such as CAMHS to deliver those services. The LAC and CAMHS teams in Buckinghamshire came under separate health organisations and as a result information sharing appeared to be compromised in this situation. Therefore when CAMHS did later become involved with G, there was limited sharing of the outcomes of such interventions with the Health LAC Reviews, or whether mental health interventions were continuing or effective. Essentially this information needed to be coordinated, but with the changes of placement as well as the changes of social workers, and interventions by CAMHS in other parts of the country, it was easy to see how information sharing between physical and mental health assessments was adversely effected. Furthermore it is clear that health professionals were not always made aware of all information known to CSC which may have impacted on G's emotional wellbeing and would have been important for any risk assessments or management plans. Health professionals of course could have been proactive in seeking out information which they thought was important to their involvement with G. Furthermore, there appeared to be no process for unpicking what appeared to be conflicting information, when for example in April 2010 at a LAC Health Review, G was identified as being sexually active and getting drunk regularly, but there were positive reports from his recent placements (Anglesey, No 12, and Staffordshire, No 11).

6.5 The respective IMR reported that LAC health assessments and subsequent findings were shared via copies of the summary and Health Plan being sent to the social worker, GP, carers, young person and birth parent. Changes to this distribution process now ensures that the Independent Reviewing Officer (IRO) receives a copy of the summary and Health Plan. This addition to the distribution list has been in place since 2010. As G had a consistent IRO then this would have been most beneficial in G's particular circumstances. This change of distribution should not only improve the exchange of health information but also enable decisions to be made based on their findings.

6.6 In 2008 the government introduced SDQs as a performance indicator for looked after children and young people. The LAC health team scored and interpreted this for CSC until 2012. At times, the total difficulties score for G were high or very high, indicating significant emotional difficulties. Follow up questionnaires were then sent to G's school and to himself for completion. All scores of borderline or high were discussed between the LAC doctor and nurse and a consultant clinical psychologist, and following these discussions a recommendation was sent to the social worker. It was then the social worker's responsibility to act on the issues/concerns raised by the SDQ and ensure that if necessary, appropriate actions were taken or referrals were made to other agencies. However, the LAC team did not regularly receive feedback of the outcome of any interventions or how the issues from the assessment questionnaire were being addressed. Clearly this again meant that the LAC health team were working in a degree of isolation in their assessments of G and that subsequent health assessments were not sufficiently informed about the other aspects of G's care. There was limited reference in CSC records to any direct link being made between the score from a SDQ and the generation of new or different interventions as a result. In this way it was difficult to see how the SDQ process informed interventions.

6.7 As a matter of routine, the GP received the summary and plan from the LAC Health

assessments (as well as relevant reports from the SDQ process and mental health assessments undertaken) and yet there was no clear documentation at most of the surgeries where G was registered, which noted G was a Looked After Child. Interventions by GPs were generally reactive to presenting problems and crises and only focussed on the here and now, with limited or no reference to G's past history. It needs to be further recognised that with all the changes of placement, by the time the information arrived from the previous GP, G could have already moved to another placement in a new area. It is clear however that even if there were limited records in GP notes of G's LAC status, at times of his presentation to a GP, it was generally made known by his carers that he was in care.

6.8 However, the GPs were not central to the provision of assessment of G's health, nor did they make very much use of assessment findings from other health disciplines. However, there were some important occasions when GP assessments led to effective referrals to CAMHS being undertaken – this occurred in November 2006 in Shropshire and again in December 2009 in Staffordshire and these were appropriate responses to G's serious self-harming behaviours at that time. With such a high number of GP practices involved, this was probably all that could be expected of GPs in that it was not apparent that there was any occasion when actions or inactions by a GP compromised G's health or development.

6.9 Although G was assessed at times by A&E departments in different parts of the country, there was no formal way of LAC Health staff knowing the details. The lack of any IT links would not have helped with this. For example, G attended hospitals in Northampton, Essex and Buckinghamshire as a result of his self-harming behaviours, although the LAC team in Buckinghamshire appeared to be unaware of their involvement. In addition, staff treating G in A&E had no way of knowing about previous attendances unless they had occurred in the same hospital.

6.10 In summary therefore, whilst the LAC health assessments were generally undertaken in line with procedures and were able to address and assess G's health needs, they did not have a central role in driving or coordinating the health interventions with G. This was primarily because G's health needs were fairly minimal as he was quite a healthy young man and because there were information sharing problems linked with placement changes. Additionally there were minimal links with mental health services because of some of the organisational issues previously mentioned.

Assessments regarding Self-Harm

6.11 A health assessment at the beginning of 2009 stated that the self-harming problems from 2006 had now been resolved although this proved to be premature and overoptimistic as significant self-harming behaviours occurred again during 2010. In Northampton, the local CAMHS were involved in response to his behaviours (April '10) although they assessed G as having no suicidal intent. G was seen at the local A&E hospital (Kettering) on three further occasions due to self-harm in May and August of that year. On each occasion, he was kept overnight in hospital and referred to the paediatric team and CAMHS for assessment the following day. This was appropriate practice in ensuring that there was a CAMHS assessment immediately after a serious self-harm incident had led to G being seen at A&E departments. The assessments did not identify any mental illness and advised that G was not suitable for admission to a mental health ward although arrangements were usually made for increased supervision in the care home.

6.12 Similarly, following numerous A&E attendances for self-harm in Essex in July and August

2011, G was discharged back to his carers though he was not seen by the on-site psychiatric team, with the expectation that the carers (the secure children's home in Essex on this occasion) would provide the necessary input. It has been found that patients who discharge themselves (or are discharged early) from A&E before completion of an initial assessment have been found to be three times more likely to repeat self-harm compared to those who received assessments by a psychiatrist or specialist nurse before discharge. The hospital's named nurse wrote to the safeguarding lead for the mental health team to express concerns and also contacted the local Children's Social Care team – ultimately the named nurse was reassured that G was being managed as well as possible in the secure children's home. With the concerns high at this time, the local CAMHS became involved and set up a daily risk management plan for G in conjunction with the home. This was a useful initiative, involving input by a clinical psychologist, which did help to reduce the self-harming for the remainder of 2011.

6.13 When G again self-harmed in 2012 by taking an overdose following the assault on his step father he was seen at A&E and discharged from the hospital as medically fit. As he was under arrest for the assault, the Force Medical Examiner (FME) assessed G as medically fit to be detained and interviewed. However before leaving hospital, G should have had a CAMHS assessment as per the local written guidelines[19] which state that "those aged 16-17 (who self-harm) should ideally be admitted, particularly if they are vulnerable; in cases where they are not admitted they should have a psychosocial assessment prior to discharge from A & E". This did not happen because the hospital did not arrange this and whilst the FME did consider a referral to CAMHS, it was noted that G declined this. The guidelines also state that the young person needs to give their consent to an assessment. Generally incidents of self-harming were incident focussed and related to stress experienced by G, and it was on just one occasion that the Mental Health Act was invoked although this was solely in terms of the Police appropriately seeking a mental health assessment following serious self-harming in the summer of 2010. Other assessments had not identified any mental illness and so the lack of any initiative to seek an assessment under the Mental Health Act was understandable in the circumstances.

6.14 G's self-harming was sometimes linked to offending behaviour, and hence the need for Police involvement at such times generating the benefit that an additional medical assessment that the FME could provide. On an earlier occasion in Northampton, the FME did the assessment of G (although a psychiatrist was apparently also in attendance) and confirmed that he could return to his residential care unit. The relevant NICE guidelines states that "All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm"[20].

6.15 Overall therefore these assessments, when they took place, dealt with the immediate situation and of the current risk that G posed to himself – this was their main purpose. Information from these incident focussed interventions needed to be collated to help identify patterns of behaviour and to inform any more holistic assessments. It was during August and November 2012 that G attended the local Buckinghamshire hospital A&E following an overdose and for the later occasion for a deep laceration to his arm. On the first of these occasions (after the assault on his step father) there was no CAMHS assessment and on the second occasion the A&E doctor tried unsuccessfully to contact CAMHS and did

[19] "Self-Harm – Guidelines for assessment and treatment in CAMHS" – Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust. February 2011

not set up an assessment with a paediatrician, psychiatrist or suitable mental health practitioner. Once again therefore, G returned to his placement without a formal assessment of his risk of further self- harm. The main reason for this failing in the first example was that the A&E doctors reported in interview for the respective IMR of being unaware of the relevant policy. There was also no reference in the records to G being a young person in care.

Mental Health Assessments

6.16 There were 6 assessments by Oxford Health CAMHS, (who provided the service in Buckinghamshire.) and these included Care Programme Approach[21] (CPA) reviews. A helpful assessment whilst G was in placement in Northamptonshire (October 2010) identified the potential for his challenging and self-harming behaviours to escalate, especially on the anniversary of his father's death and when his abusive carer was released from prison (in about two months' time). An assessment a year later by a forensic psychologist identified three prominent personality scales as "oppositional, unruly and doleful", and also suggested that G was unlikely to benefit from therapy until he was sufficiently motivated. Whilst CAMHS did try to engage G in therapy, especially DBT, this was not consistently achieved, with G often refusing CAMHS contact. The recommendation from this latest assessment suggested that what G needed was a strong relationship based on trust and containing, rather than therapy. There was no evidence that any particular strategy was then pursued in this respect. Prior to this assessment there had been a life story worker who had provided an element of this sort of input, and certainly it was a positive piece of work. From the summer of 2011 G had a consistent social worker and this would have gone some way to addressing the need for consistency for G and an opportunity to build up the sort of trusting relationship that he needed. However, the administrative and coordinating role of the social worker, alongside the number of out of county placements, would have made it difficult to undertake the level of intensity of relationship that the assessment was suggesting.

6.17 There were a range of assessments undertaken whilst G was resident in different placements, and all done so as to ensure appropriate care of him whilst in the placement. Whilst these appeared successful in some places, e.g. in the Secure Training Centre where SMU and SASH assessments identified the level and intensity of care and support G needed, in others, they had limited effect. For example, in the Essex secure children's home (No. 17), whilst there was a psychology assessment, it did not successfully identify the best way to manage G whose behaviours escalated at this time.

6.18 The success or failure of assessments, (particularly those relating to mental health), and their influence on subsequent interventions with G, tended to suggest that if G was feeling motivated, he would respond well, but if not, then they appeared to have limited influence and impact. Even when he did respond, this tended to be short lived.

6.19 Overall the different mental health assessments did not help significantly in the long term work with G. In some instances mental health assessments immediately following a self-harm incident identified that the crisis had passed and that there was no mental illness and no risk of further self-harm. These findings often became part of the record and were treated as though they had a longer shelf life than had originally been intended. There seemed to be no specific agreement via LAC reviews or placement plans about how agencies

[21] The Care Programme Approach (CPA) was introduced in 1990 to provide a framework for effective mental health care for people with severe mental health problems

should collectively respond to self-harming incidents, leaving individual agencies/practitioners to respond to each event as it emerged and upon their perception of need at the time. There was a need for greater acknowledgement of the need for a consistent and coordinated response to these events and identify how the pattern of self-harming could be addressed.

Assessments in respect of Youth Offending

6.20 A number of assessments were integral and required as part of the work of the YOS teams in Buckinghamshire, Telford and in Northamptonshire. ASSET assessments were completed by Buckinghamshire YOS in a timely fashion on each of the four occasions required, and two ASSET assessments were completed by Shropshire YOS. The work of the Northampton YOS was initially less efficient in that the assessments were not updated with relevant recent history and opportunities to create a new core ASSET assessment were not taken. Because G moved from Northampton back to Buckinghamshire, then the full background information was not an issue as it was already held by Buckinghamshire, but if G had been transferred to a different location, that YOS would not have had the benefit of earlier updated assessments. Whether the poor quality of assessment activity was related to the temporary nature of their involvement is not clear but this may have been a factor. Whilst to some extent the transfer of information was compromised by different YOS teams not having compatible case management systems, this could not necessarily account for the lack of completed assessment activity in Northamptonshire.

Missing Person Risk Assessments

6.21 Police activity to search for G as a missing person were based on initial risk assessments of the situation in terms of potential for self-harming, to commit offences, and his vulnerability or risk of harm to others. Sometimes the information given by the care home at the time was limited or contradictory and therefore did not always assist with the completion of an accurate initial assessment of risk to G. This was no doubt because of the different members of care staff involved and what they knew of G's recent background. Thames Valley Police assessed all occasions of G going missing as "medium risk"[22] which appeared appropriate in the circumstances. Similarly the Northamptonshire Police assessed most of the missing person incidents which they were involved in as "medium", although there were a few occasions when the risk was deemed as "high" and this appeared to have reflected an immediate concern that G would self-harm. There was the potential that risks to G could be downgraded simply because the high number of incidents may have led to a sense that a predictable pattern had developed, in which G was not ultimately coming to harm. However this was avoided by the Northamptonshire Police addressing this issue proactively with the care home and setting up an action plan with them about how they needed to respond. There was also a local protocol to ensure that repeat missing persons are identified at higher risk and dealt with accordingly. In this way there was a clear link between the assessments undertaken and a plan of action as a result.

6.22 In current practice, nationally the Police have introduced a new definition of "missing" and a new category of "absent". This new definition refers to the act of going missing as being out of character, when this was certainly not the case for G. Therefore care would be needed to ensure that in the future the pattern of going missing for young people in G's situation is not inappropriately minimised.

[22] "The risk posed is likely to place the subject in danger or they are a threat to themselves or others

6.23 Eventually a warning marker in respect of G was logged on the Police National Computer (PNC) which identified G in late 2010 as "violent", "suicidal" and "self-harm" and so this sort of information was able to be retrieved and utilised as part of the later Police risk assessments. It was nevertheless not easy for Police to acquire relevant information about a young person who moves into their area with a background of offending and self-harming behaviour, and little preparation for the actions they are likely going to have to make in responding to him. Whether a young person with a history of going missing, alongside serious self-harm or attempted suicide, could be automatically assessed as "high risk" thereby warranting the attention of a senior police officer, is worthy of consideration. However, all three Police Forces involved in this SCR have made recommendations in their respective IMRs to improve the way that they manage and risk-assess missing person reports regarding young people in care.

6.24 Furthermore none of the Police forces were informed that G had moved into their area and whilst there was no procedural requirement for this to be done, it could have forewarned the local Police force and potentially given greater opportunity for the local care provider and the Police to liaise and consider the most appropriate way to respond to G's behaviours. More generally, this can be appropriately achieved by a close working relationship being generated between care providers and the local Police, and such working arrangements could be a consideration within commissioning arrangements at times of placement change.

Summary of Assessment Activity

6.25 If the overall purpose of assessment is to inform interventions, then the high number of assessments undertaken would suggest that practitioners were well informed about how they needed to intervene with G. The degree to which assessments changed and informed interventions was however variable in that whilst there were some successes in the short term relating to specific placement situations, ultimately G's challenging behaviours continued without resolution in the long term.

6.26 To be subject to so many assessment processes poses the question about the effectiveness of them and of how they were received and perceived by G. There were difficulties because of the placement moves, of the transferability of assessments and of the learning from them being communicated to the next placement or to professionals providing direct work with G. It was the role of the LAC reviews to coordinate and monitor the assessments needed and to be completed, so as to ensure that G was receiving interventions and care appropriate to his needs. The respective CSC IMR provides limited analysis of the effectiveness of the LAC reviews.

6.27 Overall what was needed was to identify which assessments were useful for specific services or placements and which could provide a more holistic picture of G's needs and how to try to meet them, particularly to commission appropriate placements and to try to address his offending behaviours, self-harming and his substance misuse. Again this would fall to G's social worker and his/her managers, and the role of the LAC Reviews to identify which assessments were the most informative in the long term. The challenge for the local authority was how to do the thing that most parents do without thinking i.e. hold a cumulative history and to bring it to bear when making decisions. Because they were usually managing or responding to crises, neither the managers nor the LAC review process regularly achieved this.

6.28 Most of the mental health assessments identified little that was new. At times the

diagnosis of ADHD gave a clear direction alongside the use of medication, but this did not remain a consistent or clear diagnosis. Whilst the medication used had some short term successes overall it appeared to have a limited impact on G's behaviours – this was not helped by G not regularly taking medication prescribed.

6.29 Whilst G's self-harming behaviours were often assessed and professionals were able to identify what sort of factors influenced this behaviour, overall there was limited success in preventing its recurrence other than via stringent supervision arrangements being put in place in particular care homes that had the resources to do so. On occasions CSC financed the care home to provide additional staff in order to provide additional supervision of G.

6.30 What was lacking was a holistic assessment which could have given a broader picture of G's life in care up to that point and to help direct future placement arrangements. For example if Buckinghamshire CSC had identified that a stage had been reached when it was recognised that the provision of care for G was failing him, then a fresh assessment of the situation and of G's direct experiences of his time in care, could have been commissioned.

6.31 Similarly, assessments could have been updated to help create a more meaningful understanding of patterns of concerns and behaviours and of their relevance to the prevailing situation**.** It could have also helped with the difficulty experienced by the earlier changes of social worker. Also a more holistic assessment could have drawn on the wealth of information and assessment material already gleaned, and represented a professional need to stop and review what had been happening, in order to consider and decide upon what new initiatives or innovative interventions were now required. In effect a more radical review of the Care Plan was needed.

6.32 This probably did not happen because professionals felt that there was already assessment activity going on. But in G's case, when concerns were worsening, stepping back and making a more holistic multi-agency assessment might have paid dividends. If the Care Plan had been improved, the number of incident based assessments might have been reduced. It is striking that it is not a requirement or common practice to update a core assessment on a child in care. When the care episode continues for many years, this would undoubtedly be of value.

The Adequacy and Effectiveness of Service Provision

Placements

7.1 It was clear very early on that being in care was generating high levels of anxiety and stress for G, and that whilst it was protecting him from harm from abuse at home, his early experiences in care showed that his aggression towards others and self-harming meant that he was still at serious risk of harm, albeit of a different form. G's first year in care was very significant for him in the way that he moved foster placements so rapidly, which did nothing to help him feel that he was being presented with a secure and stable environment. Although his first residential placements were a little more successful, they still tended to end in a negative and abrupt way because G's behaviours were unmanageable. There seemed to be little planning at this time, but rather a sense of responding to crises.

7.2 These early concerns were reflected in the decision to call a Legal Planning Meeting in July

2006 although it was rightly identified that a secure placement was not appropriate for a 10 year old and it was considered that his next placement for children with complex needs was more appropriate for him. Although this placement (in Telford – No. 10) was able to retain G for a year and demonstrated some success in caring and managing G, it was here that he had his first serious suicide attempt. It was not until his next placement, which was his ninth overall after being in care for approximately 15 months that the move was undertaken in a planned and purposeful way. The reasons for this were that there always appeared to be an issue of urgency in the need to make the next placement, and in this way there was little that the local authority could have done other than to ensure the next placement was as appropriate as it could be in the short time available to consider it. The following table (Figure 2) identifies the reasons given for each placement change.

7.3 It was concerning that G had so many different placements for the period of over 6 years that he was in care, which reflected an inability of the Local Authority to consistently meet G's complex needs. The very challenging and highly concerning behaviours which G demonstrated cannot be underestimated, along with finite resources in respect of placements which could meet all of his needs. Nevertheless, the high number of placements meant that G was unable to establish any roots or to feel secure in his care or about his future, and this in turn no doubt helped to generate his challenging behaviours, so in this way something of a vicious circle developed.

7.4 Hindsight makes it much easier to identify points when there was a need for a fundamental review. However, even as events unfolded there were times when it should have been clear that a fresh approach was needed although there was little evidence of this happening. One example was of the local authority returning G to the same previously unsuccessful placement such as the residential unit in Buckinghamshire (Nos. 6, 14 and 16).

Figure 2

No.	Time Period	Placement	Reasons for change to a new Placement
1-4	13.3.06 – 6.4.06 (24 days)	4 x foster placements	Recognition that G's violent behaviour made foster care unsuitable
5	7.4.06 – 10.4.06 (3 days)	Chesham – residential unit	Used as a temporary placement to change from foster care provider – Move to a therapeutic placement – reasons and timing unclear
6	11.4.06- 8.6.06 (2 months)	Residential Unit Buckinghamshire	Gave 48 hours' notice to the Local Authority to end placement due to extensive damage caused by G
7	9.6.06 – 13.7.06 (1 month)	Residential Unit Cheshire	Gave 48 hours' notice to the Local Authority to end placement – concern they were unable to keep staff and G safe
8	14.7.06 – 8.7.07 (1 year)	Residential Unit Telford	Planned move as this had originally been viewed as a short term placement. Next placement was considered more able to meet G's needs
9	9.7.07 – 7.10.08 (15 months)	Residential Unit, Staffs.	Difficulty in managing G's behaviours led to temporary arrangements being made. Agreed to return to Telford unit which now had a long term remit.
10	8.10.08 – 26.9.09 (11 months)	Residential Unit, Telford	Following abuse by carer, G insisted on a move – threatened to set fire to unit if not arranged.
11	27.9.09 – 4.1.10 (3+ months)	Residential Unit Staffs.	Unclear reasons other than placement said to have broken down and needed an emergency placement. "It was decided by senior staff to

			move G from his current placement"
12	5.1.10 – 3.4.10 (3 months)	Residential Activity Centre, Anglesey	Move needed as this was a structured 90 day placement. Most favoured new placement not available so next placement chosen as short term until a new resource opened in Buckinghamshire in 5 months' time. In all, four therapeutic residential placements were considered.
13	4.4.10 – 10.10.10 (6 months)	Residential Unit, Northamptonshire	Growing concerns from July '10 that placement was not able to care for G safely – the Care provider was given 28 days' notice on 9th Sept '10 that placement would need to end. Plan was to move to Buckinghamshire and ensure that other agency support was available by the time of the move. Three local providers were considered.
14	11.10.10 – 17.1.11 (3 months)	Residential Unit Buckinghamshire	Sentenced to 8 month Detention and Training Order
15	18.1.11 – 18.4.11 (3 months)	Oakhill Secure Training Centre, Milton Keynes	Released on license – placed back to his previous placement following care planning process
16	19.4.11 – 1.7.11 (2 ½ months)	Residential Unit Buckinghamshire	Legal Planning meeting decided that continuation of G's challenging behaviours met the criteria for an application for a Welfare Secure Placement
17	2.7.11 – 31.10.11 (4 months)	Secure Children's Home, Essex	Following improved behaviours, G requested move into the "open" unit – seen as part of G's exit strategy from secure care.
18	1.11.11 – 15.2.12 (2 ½ months)	Open section of secure children's home, Essex	Following allegations that G had inappropriate sexual contact with a 13 year old girl, the placement immediately ceased. It was agreed that he could return home for a few days before move to his next placement. Reasons for decision about the next placement not known.
19	21.2.12 – 29.5.12 (3 months)	Residential Unit Northamptonshire	Decision to defer to G's wishes and allow him to return home
20	30.5.12 – 22.8.12 (3 months)	With mother and step father & with sibling from 10.7.12	Could not return home following an assault on his step – father. Whilst the plan was for G to return to residential care, G did not want this so it was agreed to make a referral for supported living. Several were considered before the provider was chosen
21	23.8.12 – (2 ½ months)	Semi Independent unit, Oxfordshire	G died.

7.5 In consideration of all the residential care placements, there was evidence of some planning and preparation for new placements on just six occasions. Five of the residential placements ended abruptly and at some crisis point, leaving limited preparation time for planning in respect of the next placement. An important issue therefore was whether the placement failings were related to an inappropriate matching of G to the placement in the first place. This has been difficult to identify from the information provided to this SCR, but to have so many failed placements must reflect on the efficiency and effectiveness of the planning process and the placement choice. There were opportunities when G was in placements for known fixed time periods, allowing time for planning and preparation of the next placement,

but such opportunities were not fully taken.

7.6 Following the end of the successful three month placement in the Anglesey activity centre (No.12), G was placed in a residential unit in Northamptonshire which was acknowledged as a short term placement, whilst awaiting a placement back in Buckinghamshire in 5 months' time. Whilst this demonstrated some evidence of planning, but to start off by selecting a temporary placement from the outset was not sending a good message to G and did not reflect the mounting number of placement changes that had already taken place by this time. It transpired that the Northampton placement (No. 13) lasted six months, and had to end because of the consistent inability of the care home to manage G and care for him safely. In this way an opportunity was lost to build on the successes that G achieved in Anglesey, and to have used these to try to enhance his self-esteem further and maintain some stability, potentially by ensuring that some of his most recent positive experiences and learning could be incorporated into a new placement experience. It was most unfortunate that the Northamptonshire placement proved to be one of the most unsettling periods of time for G, with significant offending behaviour and self-harming. Better planning during his time in Anglesey would have generated a greater chance of a more stable follow up placement.

7.7 Similarly, the minimum period of time that G would be in the Secure Training Centre in early 2011 was known to the local authority, and eventually G's compliance with the regime was reflected in an early release. The Secure Training Centre's report on his release stated that "there was no reason to believe that 'Child G' would not have a successful transition into the community and engage and continue with the work commenced within the centre." Therefore there was clear learning that the Centre's very structured regime created the right sort of boundaries for G and in turn seemed to enable him to develop emotionally and achieve academically.

7.8 Prior to this, an Ofsted inspection of Buckinghamshire LAC services in late 2010 expressed concern whether the placement back in Buckinghamshire (Placement No. 14) was able to meet G's emotional needs, and there was no evidence that this previous experience was fully taken into account in that he was returned there (as placement No. 16) in April 2011 following his three month period in the Secure Training Centre. Of course, the culture and environment of a Secure Training Centre could not be recreated, but it had generated some useful learning and so it would have been appropriate to have considered a placement which contained some of the structured components which had proved so helpful to G in managing his behaviours, as well as once again trying to build on and transpose some of his positive achievements within the Secure Training Centre, into a new care setting.

7.9 Once again the period of relative stability in the Secure Training Centre was unfortunately followed by one of significant instability, and the lack of using the opportunity to plan more effectively no doubt had a part to play in this. Within three months of his return to the Buckinghamshire placement, because of G's significant escalating behaviour problems, the local authority had little choice but to then obtain a Welfare Secure Placement in respect of him, and then place him in a secure children's home in Essex.

7.10 During the early part of his stay in Essex, G's self-harming behaviours increased significantly. It was clear that the placement in Essex, whilst a secure provision, did not provide anything like the level of structured regime that existed within the Secure Training Centre. After a period of very intensive intervention, G's behaviours improved, which enabled him to move onto the "open" unit, which was agreed following a request from G to do so.

7.11 There were two occasions when a placement move was based on G's expressed wishes and that was when he insisted (in Sept '09) on a move away from the placement where he had been sexually abused, and when he asked to be returned back to his family in mid-2012. The rationale for his return home was not clear in the records and how this was going to meet his needs at this time. Certainly it had been a generally constant theme for G to want to return home, but this was often against the backdrop of failed care placements. Unfortunately before May '11 the LAC Review notes did not list who attended, so it was not recorded if G managed to attend all of these. Little has been said in the respective IMR about the degree of involvement that G had in the choice of his placements other than the Independent Reviewing Officer (IRO) explaining that she was aware that G did not always want to contribute to his reviews but that overall she did her best to encourage him to do so.

7.12 In his mother's contribution to this SCR, she wondered why greater attention was not given to G's interests, particularly in respect of his love of working with animals and his keenness about cooking. There was limited evidence of detailed consideration of these factors and to what extent G's interests could be accommodated within a placement. Whilst these were clearly not the overriding factors regarding placement choice, they nevertheless had the potential to make a significant difference to whether G could settle or not.

7.13 G's behaviour and emotional wellbeing undoubtedly suffered because he had so many placements and in this regard, greater steps should have been taken to address this problem. Although all LAC Reviews and care planning processes were in place, their quality, their use and their value in decision making about placements are not clear. For the three years from 2010, following G's move from the residential care home where he was sexually abused, G had ten placements with an average stay of just 3 ½ months. Whether G's inability to settle was related to the impact of his sexual abuse is not known. One of the possible reasons why the pattern of placement change was allowed to continue may have related to the generally high turnover of social workers, and the lack of a strategic oversight by senior managers.

7.14 The process for selection of new placements out of county was based on a referral to the Access to Resources Team who then would provide options for the social worker (and presumably the operational manager) who in turn would consider these and select the most appropriate. Therefore there was a great deal riding on the social worker's knowledge of G's background and of his assessed social, emotional and developmental needs, which with limited involvement with G by some of the earlier social workers, would have been challenging. The lack of an updated or holistic assessment, as well as some of the urgency with which placements were needed would also have made it difficult to always make informed placement choices.

7.15 The ability to make appropriate placement decisions must also have been compromised by poor case recording of G's time in care. The CSC IMR refers to the difficulty of collecting and collating information for this SCR and of the muddled set of records that existed, making it difficult to identify decision making processes for new placements. This must have compromised the ability of a new social worker or first line manager to access past information to support new decisions.

7.16 On some occasions a reactive stance was needed to make urgent changes of placement and there may not always have been a placement available at short notice which could meet all

of G's needs. In this way it can be seen how some pragmatic decisions were made in terms of placement moves for G, although if this was the case and the placement was not the most appropriate, it needed to be rectified as soon as possible.

7.17 It is important to acknowledge that there was no evidence that financial considerations impacted negatively or inappropriately on placement decisions despite the fact that the nature of G's placements and the level of supervision he sometimes required, made them very expensive. However the level of financial commitment should have meant that more senior management scrutiny was applied, although it was not apparent that this was consistently the case. If it had been, it would have brought greater objectivity and likely challenge to the pattern of placement changes as well as generate potential alternative approaches.

7.18 The very fact that G had so many out of county placements was a considerable challenge in itself for both G and the professionals who were trying to support him. For the Buckinghamshire social worker to have an active contribution to G's day to day care and to develop an effective trusting relationship with him was always going to be compromised by the distances involved in attending the care homes, not only to see G, but also to assess how well the placement was meeting G's needs. It also meant that other local agencies such as the Police, hospitals, CAMHS and YOS teams became involved, which added to the complexities of communication and information sharing. If there needed to be a change of direction to halt the pattern of failed placements, then one new principle could have been to ensure that whatever placement was needed, it had to be reasonably local, in order to support its effective management by Buckinghamshire CSC.

7.19 So what options were available to bring about a change to the worrying pattern of placement failures and placement changes? The relevant health trust IMR could find no documentation to indicate that CAMHS were involved in discussions about the quality of placement decisions. Whilst CSC were responsible and accountable for these, to involve the mental health specialists may well have added another perspective to placement review and decision making. However CSC retained their care and legal responsibilities without seeking support and advice from CAMHS in particular or more generally from other agencies. Again this was a reflection of expected and established practice whereas this case required some innovative approaches.

<u>Multi Agency Meetings</u>

7.20 Whilst there were some references to "professionals' meetings" in the CSC IMR, these tended to involve social workers and managers only. At one stage in January 2012, the social worker proposed a meeting under the multi-agency High Risk Hard to Reach protocol, which would at least have been a different way of trying to address some of the intractable problems which were developing at this time. However, the initiative was not taken because the senior manager responsible deemed that other meetings being held as part of the LAC process could address the current problems in the case. As there had been numerous meetings taking place throughout G's time in care, it would seem to generate overload to add another, but what was needed was to step out of the current systems and processes and look at the situation from a different angle. Instigating a hard to reach meeting may have done that and potentially have involved a wider group of practitioners and placed accountability at a sufficiently senior level across the participating agencies.

7.21 Furthermore, at one time it was recognised that there were too many professionals involved in delivering services to G and that this was likely having a counter-productive impact on the work with him. However there was no evidence that this recognition sparked a different approach to G in reducing the numbers of professionals and in trying to think innovatively about how this could be done.

7.22 There was a responsibility on other agencies to express an opinion or give advice to CSC about the quality of placements or about the need for placement change. The Police were the most active in expressing views about the adequacy of placements for G and for example Thames Valley were strong in their expressed view to CSC of the adequacy of the residential placement in late 2011 and requested that he not be returned there following a number of incidents of him going missing. However a placement change did not happen, although more staff were allocated to the care home to manage G. Similarly the Northamptonshire Police expressed concerns that residential staff in the local care home were not adequately trained to manage G. When the Police failed to get a response to their concerns from the care provider, Ofsted were informed who challenged the poor standards in the home, and subsequently monitored improvements made. Overall this was good persistent action by Northamptonshire Police. The placement was changed as a result of the concerns that were raised.

<u>The Role of the Independent Reviewing Officer</u>

7.23 The IRO provided consistency to the monitoring process of G's time in care, and essentially this is a role which is independent of CSC so as it can bring appropriate challenge to the decision making and actions of CSC and to other agencies. Therefore, here was an opportunity within the LAC process to challenge the adequacy of placement provision for G and enquire whether the time had come for a fresh approach to the problem. The CSC IMR states that if the IRO "had any concerns regarding the conduct of the Local Authority or any of the establishments charged with the care of G, she would have reported them in an appropriate manner". This statement needs to be balanced with one of the core duties of an IRO; "As part of the monitoring function, the IRO also has the duty to monitor the performance of the local authority's function as a corporate parent and to identify any areas of poor practice. This should include identifying patterns of concern emerging not just around individual children but also more generally in relation to the collective experience of it's looked after children of the services they receive"[23]

7.24 These duties were upgraded in late 2010 although the role of independence and the ability and expectation to provide an objective perspective to LAC Reviews has nevertheless always been in evidence. It is understood that the later regulations have made a positive difference in Buckinghamshire.

7.25 Perhaps the key questions here was to what extent the actions of the Local Authority could be viewed as "poor practice" as referred to in the guidance, and therefore warrant the necessary challenge by the IRO. From an operational perspective it could be argued that the local authority was managing the best they could with a very challenging young person and within the organisational context at the time. Also all processes such as care planning, placement planning meetings and reviews were conducted in accordance with procedural requirements. However, even if the processes were correct, it was the outcomes which were poor. It was this that needed addressing in a constructive way. This is supported in a

[23] IRO Handbook: Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review of looked after children- December 2010

recent inspection report[24] which states; "We saw little longer-term planning and too many reactive decisions. In these circumstances, we were surprised that we did not see more challenge by Independent Reviewing Officers. It is their job to assess the quality and effectiveness of local authority planning and support for children and young people. They have a crucial role to play in ensuring that the local authority fulfils its responsibilities as a 'corporate parent'."

The Role of Senior Managers

7.26 There was an additional option from CSC's perspective to involve senior management and to alert them of the need to help generate a new initiative and to somehow break the pattern of placement changes. The CSC IMR identified "clear management of the case" and determined that when serious issues arose, senior managers were notified and that relevant advice and instruction was given. Whilst this was clearly important and reflected a supportive management style, it was apparent that on these occasions senior management involvement was related to specific issues or urgent concerns rather than reflecting a need to take a new strategic and holistic overview of the case, specifically of the reality of its progress and ability to address G's continuing complex needs.

7.27 The first legal strategy meeting soon after G came into care was an appropriate intervention to try to address G's alarming start to life in care and to instigate a change in approach. However there were later occasions when there appeared to be compelling evidence to again intervene and formally identify and review all that was happening and of the impact upon G. Potentially the Strategy Meeting held in June 2009 to consider the response to G's sexual abuse by a carer was an opportunity to also request the CSC to urgently review the appropriateness of G's placements. Both of these initiatives were nevertheless led by events and were incident focussed and did not encourage a wider review of G's life in care.

Education Provision

7.28 Apart from the LAC Reviews, there were also meetings to review G's Personal Education Plans as well as reviews of his Special Educational Needs (SEN) – these statutory functions were appropriately carried out. However, it was concerning that G had not progressed over time from the top junior school level and had never been in main stream secondary education.

7.29 The many placement moves did not help and although it was formally recognised that education was an important contributor to long term outcomes, it was always a secondary consideration in any placement change decision. As early as 2006, soon after G came into care, the SEN Statement identified that he would need 1:1 or even 2:1 support, but it would appear that the placements which followed were unable to deliver on this expectation.

7.30 There was also the challenge of a lack of consistency about how education information was transferred between carers. This has been considered within the relevant IMR recommendations. For example it was unclear if all care providers knew of G's SEN status and even when they did, the Statement was premised on stability and education happening in a predicted and regular way. Furthermore, it was unclear why Buckinghamshire maintained a Statement of SEN when for long periods he was placed out of county. The position was generally unclear in terms of relevant government guidance whether it should

[24] "Looked After Children: An inspection of the work of the Youth Offending Teams with children who are looked after and placed away from home - A Joint Inspection by HMI Probation, Ofsted and Estyn – Dec'12.

be the "home" authority (i.e. Buckinghamshire) or the area in which G was resident, (the "host" authority) who should have responsibility for maintaining the Statement. A more recent guidance in 2009 suggested that this responsibility should be the host authority. However it was probably appropriately pragmatic in the circumstances that Buckinghamshire retained the responsibility to issue a succession of SEN statements. However as G was not registered at a school it was unclear when or how statements would cease. Clearly for a young person in G's situation, this lack of clarity was not helpful and required resolution.

7.31 It was beneficial that the team leader for the Virtual School service, who was responsible for overseeing the case, did so throughout the full period, and this provided a level of continuity and helped to address some shortfalls in information sharing.

7.32 Whilst education services in Buckinghamshire did all they could to engage G in education when he was living locally, they were restrained in what could be achieved when he was residing in therapeutic settings. In this way the Virtual School played a tracking role rather than an influencing one. However they were a resource to potentially be used by out of county placements to support educational initiatives and they worked consistently and creatively to support G despite the moves and disruptions that the placement changes created.

7.33 After he was 16 years of age, G was unable to gain a services course at college because his numeracy and literacy skills were not strong enough. This also proved to be a significant challenge for him when he attended a training centre in late 2012. This unfortunately reflected how G's education suffered as a result of the earlier numerous placement changes and how educational attainment appeared to be lower down the priority needs list when compared with the need to contain G in terms of his offending and self- harming behaviours. Whilst this was understandable in this context, a more holistic assessment to try to stem the pattern of short term placement changes could have included innovative ways to help increase his educational attainment alongside future placements and in doing so bring education up alongside other priority needs. When in the Secure Training Centre and the Essex secure children's home, G did engage well in education, and interestingly, when he moved from the secure to the open part of the latter unit in Essex, he chose to no longer engage in education.

<u>Response to self-harming and suicidal behaviours</u>

7.34 Psychiatric and mental health assessments conducted throughout G's time in care, did not find that G had any mental illness or note any suicidal ideation at the particular time of the assessments. Nevertheless, most professionals working with G appeared to be clear about the continuing risk of self-harm and others had experienced concerning incidents of suicidal attempts. For example in October 2010 CAMHS involvement in Buckinghamshire assessed G as high risk of self-harm and suicidal behaviour. At that time the Buckinghamshire CAMHS outreach team (Outreach Support for Children and Adolescents - OSCA) provided services to G to try to address his self-harming behaviours over a 14 month period.

7.35 This seemed a very appropriate response and was successful in engaging G in regular sessions (19 during the period) and there appeared to be some reduction in the self-harming behaviours for part of this time. These services were also provided at times when G was not living in Buckinghamshire, which was important in trying to apply much needed consistency of intervention. The OSCA team closed the case however when G moved to Essex in the

middle of 2011, and it was from this point that there was a significant increase in self harming. Whether there was any potential for the OSCA team to have provided greater input to G, even though it was out of their area, was unclear but potentially this could have been attempted to at least try to make some links with what had been relatively successful for G just prior to his move to Essex. More importantly there was limited preparation for his move from the secure children's home in Essex and it was not apparent that there was any mental health input at that time. This reflects how when crisis led decisions are made it is issues such as therapy which suffer and yet it is these which have the potential to deliver the greater long term benefits.

7.36 Despite therapeutic services such as DBT being offered when back in Buckinghamshire, G did not generally access these. Similarly when therapeutic provision was included within the services available in particular care homes, generally G would not access these in any consistent way. Overall however, these were appropriate attempts to support G when back in Buckinghamshire and to try to address his emotional needs, and for example, much work was undertaken to try to engage G in the DBT work.

7.37 Overall therefore without G's commitment to accept support and therapy, the involved agencies had limited ways to address his self-harming other than to increase supervision arrangements. Also the placement decisions needed to reflect this. An example of the difficulty in trying to help G stop self-harming, occurred in his secure children home placement in Essex when on the occasions when staff attempted to intervene, G would either escalate the self-harm or become violent towards the staff member. Those practitioners who worked with him regularly said that G's anger and violence, whether towards himself or others, could flare up instantaneously, and this clearly reflected the challenge of working with him and trying to curtail his aggressive instincts.

7.38 Even with access to all the records and with the benefit of hindsight it is difficult to understand the links between G's self-harming and his alcohol and drug use. It was apparent that on occasions G had insight into his problems and could link substance misuse to self-harming, but he never was able to develop his insight via therapy in order to exert controls over his behaviour.

7.39 Addaction, as a specialist service were utilised over a number of years to help manage G's substance misuse, and Buckinghamshire YOS had overall management of the work. However, the practical arrangements within the care settings, and particularly those outside Buckinghamshire who did not have the local support of Addaction, should have been able exert some controls on access to drugs or alcohol, although his pattern of running away clearly made this difficult. A psychology report in respect of G in July 2011 identified "how the alcohol and drugs helped him to forget" his traumatic life experiences. Because G had such a range of problems which must at times have felt overwhelming to the professionals working with him, and no doubt to G as well, perhaps a priority for intervention should have been the substance misuse issue – to achieve success in this may well have impacted on other aspects of his behaviours. Instead one gets the sense that attempts were made to tackle G's problems on all fronts, when perhaps a more measured and focussed approach with fewer practitioners could have achieved better success...

<u>The Management of Risk and Vulnerability</u>

7.40 There were occasions when Risk and Vulnerability Panels were held by the YOS teams in

Northampton and also in Buckinghamshire as means of managing G's risk taking behaviour as effectively as possible. Even though G had been assessed as "high vulnerability" when he was first being supervised by Northampton YOS from April 2010, a Vulnerability Management Plan was not enacted. It appeared as though there was an assumption that he would not need this as it was recorded by the service that "this aspect of safeguarding is being undertaken by Social Services" (presumably Buckinghamshire CSC). This reflected some of the complicated communication issues of a Looked After Child being placed out of county and also needing to be supervised by a local YOS. Later RMVPs in Northampton identified G at high levels of risk although some issues about inefficiencies in updating the plans within Northampton compromised their effectiveness.

7.41 From February 2011 until September 2012, RMVPs were undertaken on a regular, often monthly basis by either Buckinghamshire or Northamptonshire YOS, dependent on where G was living at the time. The meetings held in Buckinghamshire after G returned to live there were generally well attended and it was reported that all actions agreed at the meetings were undertaken. This was evidence of some good inter agency practice, although regular social work involvement was not always possible, with no CSC representative in the latter two RMVP meetings in September and October 2012 when their role was significant. This presented a challenge in that whilst the RMVPs discussed risk and vulnerability, to be effective, these needed to be linked with the day to day work of the social worker and the LAC Review process which had overall responsibility for G's welfare. However whilst the role of the RMVP should be exactly the same whether the young person is in care or not, there was an added component for a Looked After Child in that the role of the social worker was pivotal alongside other formal processes that need to be enacted. This was recognised in a recent relevant inspection report[25] which identified that: "Agencies often fail to work effectively together, concentrating on their own procedures and failing to work with the child or young person in a coordinated way". Whilst there was committed work at this time from both the YOT worker and the social worker in respect of G, endeavouring to match up separate systems and processes to ensure a coordinated approach, nevertheless proved challenging.

7.42 The RMVPs were the means by which the YOTs managed the levels of risk presented by young people in receipt of their services, although it was difficult to see what success they ultimately achieved in respect of G. Even though he appeared to engage with YOS, Addaction and CSC, G refused to engage with CAMHS services in a consistent way which were offered to address his vulnerabilities. As the judgement that G's risks and vulnerabilities were always assessed as "high" or "very high", then a review of the process to identify why it was not helping to reduce the vulnerability levels was needed. Whilst the RMVP process was embedded in practice with G, positive outcomes for him were much less evident.

7.43 The social worker needed to attend a high number of meetings, perhaps just in respect of G, but it was apparent that a greater number of meetings did not always equal improved communication. To some extent the plethora of meetings worked against effective practice in this situation, which reflected how unintended consequences resulted from structured processes. There was also potential confusion about which agency was taking lead responsibility. There was a clear need in G's case to rationalise the number and function of meetings, and whilst this would have been challenging, this was not considered as an option.

[25] "Looked After Children: An inspection of the work of the Youth Offending Teams with children who are looked after and placed away from home - A Joint Inspection by HMI Probation, Ofsted and Estyn – Dec'12

Response to the sexual abuse of G in care

7.44 In June 2009 G was sexually abused by a care worker whilst at placed in Telford (No. 10) and the abuser was immediately arrested and removed from his post. Up to that point, reviews of this placement by CSC had been positive and so G remained at the placement. CSC held three senior manager meetings to consider and review the placement situation and had initially been reassured that actions had been taken by the care provider to prevent the likely recurrence of such an incident. It was considered that the care provider had failed to provide the level of staffing which they believed they were funding but subsequent arrangements were made to address this. Whilst there was a reference at this time that Ofsted had been notified, it has not been possible to confirm this. There was also a suggestion at the time that an independent review or Serious Case Review (SCR) should be initiated in respect of the abuse, but there was no record that such action was ever initiated or that Buckinghamshire LSCB was ever informed of the situation. Although the abuse took place in Shropshire, "the local authority looking after the child (i.e. Buckinghamshire) should exercise lead responsibility for conducting the SCR"[26]. Buckinghamshire CSC made contact with Shropshire LSCB in February 2010, but there is no record of what transpired as a result. It was also unclear why this contact was not made immediately after the sexual abuse occurred, although its timing was probably linked to the conviction of the offender. Certainly no SCR was undertaken.

7.45 Overall it is concerning that records cannot identify what further multi-agency action, if any, was taken to more formally review the circumstances of G's abuse by a professional. In fact it would have been discretionary for an LSCB to have undertaken a Serious Case Review but nevertheless should have been considered under the criteria within the guidance at that time. As Buckinghamshire LSCB were not informed, then this poses the question of whether Buckingham CSC were aware of requirements within the Working Together guidance in this respect that it was Buckinghamshire LSCB's responsibility to commission any SCR.

7.46 In order for G to have received the most appropriate form of follow up and support to address the impact of his abuse, then it was important for relevant professionals to be aware of the events. However, the Healthcare Trust responsible for the provision of the LAC Health reviews was not informed of G's sexual abuse until 2 years later, which only occurred due to an Ofsted inspection. It is difficult to understand why this significant information was not shared with them at the time, meaning that the impact on G of his abuse was never considered within the context of G's subsequent health assessments. Because the CSC IMR stated that the abuse and its ramifications for the placement was considered at senior manager meetings, it is difficult to understand why steps were not taken to ensure that all relevant professionals and processes which supported G in his placements, were informed of the abuse. It was as if the health processes were considered as existing separately and independently to the social care involvement, when to be most effective, a more coordinated approach should have been taken. It was similarly concerning that the GP records held no reference to G's abuse by the care worker. This appears to support the position that the health assessments were being treated as a procedural requirement rather than understood as being central to planning and delivery of health care.

7.47 At the time of the abuse, G's placement was in Telford and then he moved to a placement in Staffordshire three months after the abuse. Following this move, a psychiatrist who had previously worked with G asked whether G could be provided with counselling support

[26] Paragraph 8.13 – Working Together to Safeguard Children – Department for Children, Schools and Families March 2010

during the period leading up to the criminal trial of the perpetrator, and the response from West Mercia Police was that this would be acceptable. Apparently at this time, G had been asking for therapeutic help, so it was important that a positive response was given.

7.48 Although not recorded in any detail, it was apparent that some counselling and support for G did take place but its extent and its impact is not known. The progress and impact of this work should have been recorded much more fully as it would have been useful to potentially help practitioners understand some of his later self-harming behaviours. It was noted that G would occasionally refer to this abuse as a source of difficulty for him, so its importance and relevance to later interventions was clear.

7.49 Once again, G's general reluctance to discuss the abuse made it difficult for therapeutic interventions to be undertaken in any consistent way. For example the Buckinghamshire YOS workers identified in their work with G that attempts were made to look at thoughts, feelings and behaviours and the impact on decision making, of his abuse. In the mother's contribution to this SCR, she considered that G did not receive sufficient help to deal with the impact of his sexual abuse and, whilst recognising G's reluctance to accept such help, she considered that greater attempts should have been made by professionals to engage G in this work.

7.50 It was perhaps significant that it was following the sexual abuse, that the placement changes began to change with short term and concerning regularity. Up to that time he had been in the placement for almost a year and the two previous placements had been for periods of one year and fifteen months respectively (Nos. 8 and 9). Therefore the sexual abuse may have had a greater impact on G and his ability to settle into new placements than was known or realised. If G had felt more able to engage in therapy, then this may have been addressed.

7.51 G's sexual behaviour was raised as a concern when there was an allegation against him whilst he was resident in Leverton Hall which led to the immediate cessation of the placement, leaving G to stay temporarily with his mother before moving to a new placement. G denied the allegations but in effect the decision had already been taken to remove him from the placement as a precaution. This was unfortunate because it generated the most negative of endings for G, particularly as he felt wrongly accused. Because it was thought that this disruption may lead to an escalation of self-harming behaviours, the YOS referred to the appropriate Child and Adolescent Behaviours Team for advice in February 2012.

<u>Offending and violent behaviours</u>

7.52 In terms of the Police response to G's offending behaviours, then all of the three involved Police forces reported via their IMRs that overall, instances of offending behaviours by G were dealt with robustly, with each allegation being investigated. The periods of the separate Police force involvement was generally for the periods: -
West Mercia Police – October 2006 – December 2009
Northamptonshire Police – April 2010 – Oct 2010
Thames Valley Police - October 2010 and November 2012.

7.53 G's offences continued throughout much of his time in care, with some offences including violence and threats to harm well into 2012. This tended to reflect the complex reasoning for G's offending behaviour, and that the experience of being in care itself may have created

an environment of offending.

7.54 On all but one occasion G was charged following arrest and put before the court on the occasions when Thames Valley Police were involved. Similarly the West Mercia Police investigated offences and brought the matters to logical conclusions, whether this was a reprimand or charging G with the offence and putting him before the court. This practice was more challenging however in Northamptonshire when all the incidents of offences occurred in the residential unit (No.13) and they had a policy to not prosecute residents for incidents of criminal damage. This meant that on occasions G was arrested but was not charged because this was not supported by the residential care home. Also it was not apparent that all incidents were reported to the Police with the care staff choosing to manage behaviours when they felt able. Therefore, different care providers did not always take the same stance about offending behaviour. Nevertheless, apart from the experiences with the Northampton placement (No.13), in the other Police areas, G was left in little doubt of the result of his criminal actions and of his responsibility for these.

7.55 On occasions when G was arrested the Police were not always aware of G's previous or recent self-harming behaviours and the amount of information shared by care workers at the time of arrests, was variable. Also the PNC does not store detailed information but can give warning markers such as "violent" or "suicidal". In effect the Police would have limited options anyway in that once the offence had been dealt with, the person must be released. With so many repeat offences by G and their connections with self-harm then more proactive and consistent sharing and coordination of information by the social worker and care providers in relation to these could have assisted risk assessments by the Police.

7.56 The work of the YOS was crucial in helping G manage his offending behaviours. Northamptonshire YOS were involved with G for six months in 2010 and again for a brief period in 2012 when G temporarily moved back to their area. There were committed attempts by Northamptonshire YOS to develop effective relationships with G and he generally maintained reasonable contact with his YOS worker.

7.57 When G became known to Buckinghamshire YOS in March 2010, the worker who was allocated at that time, remained working with G shortly before his death. For the period of YOS involvement, there was good collaborative working with CSC and with care providers, particularly earlier with the Secure Training Centre. To have a consistent worker was clearly important for G, and the YOS input of ASSET assessments alongside regular RMVP meetings helped to develop a useful overview of the offences and other incidents of concern in G's life at that time.

7.58 Overall however G's self-harming and sometimes violent offending behaviours related to the use of weapons, unpredictability, loss of control, recklessness and poor problem solving skills, made it difficult for any YOS worker to try to reduce his offending behaviours. Although G clearly did not manage his behaviours well, his lack of take up of input from CAMHS or other therapeutic input meant that there was little else that was trying to deal with his behaviours. The joint working between YOS and CSC was helpful and additionally by this time the CSC social worker was also a constant figure in G's life. Therefore during 2011 and 2012, this represented much greater consistency of key professionals working with G, yet the continuing change of placements at this time no doubt negated some of the benefit of this continuity of key professionals from Buckinghamshire.

Working Together Across County Boundaries

7.59 Some of the difficulties created by G's numerous placement moves around the country have already been referred to as impacting on the quality of information sharing and communication between professionals. Overall however there was a strong commitment from professionals to work together as much as was practicable, it being evident that no one agency could hope to address G's complex needs.

7.60 When the CAMHS service in Buckinghamshire were involved in delivering services to G, there was evidence of good inter agency working. This was no doubt helped by the fact that at such times G was residing in Buckinghamshire or relatively nearby and this enabled the local agencies to coordinate their interventions. However during earlier out of county placements, the level of involvement of mental health services to address G's self-harming behaviour, was for example, not known to the local YOS work being undertaken at that time.

7.61 In terms of agencies who delivered services to G in other parts of the country, then this clearly impacted on communication and aspects of inter-agency working. Examples of this existed in relation to the provision of services by Northamptonshire YOS on behalf of Buckinghamshire YOS. Northamptonshire YOS considered that there was a lack of clarity about case responsibility and that for someone like G who experienced a range of placements in different localities that this created a level of disruption to the sort of supervision that YOS workers could provide. This in itself seemed to create a sense for the YOS worker of not having full responsibility for the case. This may have explained some of the inefficiencies of the services provided by Northamptonshire in their early involvement. It was the view of the Northamptonshire YOS IMR that there was a "lack of clarity recorded about the responsibility and accountability of professionals during the period that G was resident in Northamptonshire and that the YOS management was affected by this lack of clarity". In effect there is clear guidance from the Youth Justice Board about this, so it is difficult to understand the difficulty, although there was a lack of information about the care plan from Buckinghamshire CSC. The later involvement by Northamptonshire YOS was however well managed.

7.62 The supervision of young offenders who are placed out-of-county will reside with the host YOS (I.e. in the new location), but this would not mean that the home YOS no longer had a role, as this could be fulfilled by attending LAC reviews and in liaison with the social worker. Generally this was undertaken and there was good communication between the two YOTs, and the YOS worker in Buckinghamshire retained an overall monitoring role from 2010.

7.63 The Buckinghamshire CSC IMR identifies that there was "ample evidence of cross boundary working" and that the IMR author was "unable to identify any situation whereby G was adversely affected in terms of service provision by his moves". However, based on broader information from the experiences of health, Police and youth offending services, it would appear that the numerous placement moves did compromise the quality and level of services that G received. This may well have been despite the committed work of the Buckinghamshire social worker in working to try to monitor and coordinate interventions from mid-2011, but prior to that the change of social workers impacted on the ability to achieve this with any consistency. The numerous placement moves led to too many occasions when professionals inevitably tended to "start again" with G and this must have been frustrating for him.

Direct Work with G

7.64 Frequent placement moves and the fact that most were far from Buckinghamshire meant that it was hard for social worker's to see G at more than the statutory six weekly intervals and to make brief visits. This limited their ability to develop positive working relationships with G and limited opportunities to share his thoughts, wishes and feelings, and so be able to influence his care plan directly. The CSC IMR gives little other analysis of the content and impact of the direct social work contact with G but recognised that the social work role in these circumstances reflected a more administrative perspective in the form of a care coordinator role.

7.65 The direct work with G therefore largely fell to those professionals providing his day to day care and it was apparent that G was engaged in one to one support and therapy in a number of the placements. For example, in the Essex placement, the clinical team managed to engage G in some therapeutic work by using a flexible and informal structure to this work in the acknowledgement that formalised therapy was something that G found uncomfortable. Other care providers also described how G formed positive relationships with staff based on mutual trust and respect. It was also apparent that G was involved in reviews and peer group meetings to help address his problems. The fact that overall it appears as though G had the ability, and presumably the desire, to engage in positive and trusting relationships with professionals in his residential placements, then the more disconcerting it was that these relationships, because of their short term nature and possible abrupt endings, were not able to develop into the sort of relationships that could have helped to achieve change in G's attitudes and behaviours.

7.66 Although G was often aggressive and controlling, local authority practitioners and first line managers remained committed to helping and supporting G. He was also sometimes vulnerable, needy and caring. The issue was how to use these aspects of his personality effectively to provide caring support to him but also to use one to one work to address his inappropriate behaviours. It was not apparent that this was achieved with any degree of success, largely because of the short term nature of many of the placements, the changes of social worker and the inability of the LAC social worker and CAMHS services to engage him therapeutically.

7.67 Work by the YOS in both Northampton and Buckinghamshire undertook direct work with G and in addition to work on his offending behaviours, the work often related to more welfare, support and advice, and which responded to the various crises that occurred in G's life. Both YOS teams used sessions with G to work on conflict resolution and the longer term work in Buckinghamshire focussed on him taking responsibilities for his actions and in trying to develop his self-esteem. Whilst this seemed an appropriate focus, considering G's needs at the time, to what extent was the work of others from CAMHS and the LAC social worker also trying to deal with these issues? The potential for overlap was clear as was confusion by G about when and with whom he should commit to developing a supportive and positive relationship

7.68 **"**Life Story" work was undertaken by a CSC worker for a period of a year from 2009 and this was viewed by CSC as being an important and consistent relationship for G. It was not clear from the records what the particular focus was for this work and how it linked with other interventions, but it was something that G valued. Whatever its impact upon G, the most beneficial aspect of this was probably the availability of a constant person for a reasonable period of time to focus solely upon him and his experiences.

7.69 Despite the early changes of social workers, those who later became involved worked hard to retain and develop positive and strong relationships. Once one social worker moved into a supervisory role, some contact with G was nevertheless maintained in order to provide some useful connection for the new social worker. The drugs and alcohol worker with Addaction also sustained an important and constant relationship with G up until G's death which included making links with G's placements. It was also apparent that a very important and fairly consistent relationship had developed and had been maintained with the Bucks YOS worker.

7.70 In summary therefore, there were numerous workers and opportunities which were presented to G to form useful one to one relationships, but overall although some workers, (particularly those from Bucks YOS and from Addaction) endeavoured to maintain contact with G in out of county placements, these connections tended to be compromised by the placement moves and G's changing commitment to therapeutic work. Also it was unclear if the care planning process effectively addressed what the major needs were for G in respect of direct work and therapy. Each new placement put into place its own style and structure of one to one work and this would have meant the need for G to accept and work with different types of intervention and then to potentially change again when a move to a new placement took place.

7.71 Views of involved practitioners interviewed as part of the SCR process considered that G's commitment and involvement in his later LAC reviews were limited and that it was sometimes a question of keeping him in the room as long as possible, which meant going through the motions and that G did not really pay much attention to the agenda or objectives. This however was not the experience of his earlier LAC Reviews in which it was considered he contributed appropriately, but these reviews may have reflected less relevance for him as he got older and was moving towards some form of independence. It thereby posed the question about what impact these later reviews would have, if anything upon G. This has to be balanced with the professional view that these reviews are pivotal to the management of a child in care, and yet in this case, particularly after so many had taken place, another meeting had perhaps become anything but pivotal for G. In the mother's contribution to this SCR, she considered that G had little enthusiasm for the LAC Review undertaken whilst he was living back with her in 2012, feeling that he no longer found them useful or significant. G did not attend the LAC Review at that time.

8. Diversity Issues

8.1 Overall from the local authority's perspective, they did not identify any needs for G in relation to any diversity that warranted requirements or issues to be raised with his placements. G was a young man from a large, white working class family. He was also brought up in a small village community. It is not clear to what extent, if at all these factors figured in placement decisions. As he progressed in the care system, it would seem that the more pressing need of managing G's presenting behaviours was the greater determinant of the sort of placement needed.

8.2 Whilst in the Secure Training Centre, G was very serious about exploring his faith and accordingly regularly attended Chapel and was baptised before leaving for his next placement. He also attended church whilst in the secure children's home in Essex. However, CSC workers, in their dealings with G, did not consider religion to be a significant issue for G in that he gave no indication that it was important to him once outside the secure

placements, and therefore it did not figure in placement decisions or in respect of any impact on interventions which were delivered.

8.3 Furthermore, no other agency was aware of the religious aspects of G's personality and needs, which was surprising considering the commitment he put into these whilst at the Secure Training Centre and the secure children's home. This issue was clearly important to G at these times, and whilst the fact that on both occasions he was in a secure environment may have been coincidental, it may have been that this somehow freed him up to pursue religion. This element of his religious commitment should have been considered within follow up placements as it was potentially a resource which he could use to calm his behaviours and generate reflection. However practitioners considered that outside of the more secure care environments, G showed no interest in religion. Nevertheless, the LAC reviews were a good opportunity to explore these needs with G, but it was not apparent that these were discussed. This could have been an opportunity to develop a different and potentially effective means of helping G to manage his behaviours.

9. Management and Organisational Factors

9.1 Generally, the IMRs did not identify significant management, supervisory or organisational factors which adversely affected interventions with G. Nonetheless this SCR has demonstrated that much greater management oversight was needed, especially at a senior level within Buckinghamshire CSC, to try to halt the alarming pattern of placement changes and lack of progress in managing G's behaviours in a consistent way. The senior management role was often incident and crisis focussed with broad responsibility for the case always being delegated back down to the team manager. A greater and more consistent direct involvement of senior management was needed to enact the accountability of the local authority as Corporate Parent within a complex case, where from the time that G came into care the outcomes being achieved fell considerably below the aspirations that the local authority ought to have for a child in its care.

9.2 The high turnover of social workers allocated to G in the early periods in care was clearly unsatisfactory and there was an appropriate response from CSC management at that time to allocate an experienced social worker when relevant concerns were raised by the Children's Guardian. Unfortunately this social worker then unexpectedly left, although generally from that point there was improved stability of social workers with five social worker changes from 2008 – 2012 in contrast to nine changes in his first two plus years in care. Nevertheless, to have fourteen different social workers allocated to G for his six plus years made it difficult for G to manage his experiences without consistent support and a social worker as a constant reference point. What difference the greater stability of an allocated social worker would have made for G is difficult to judge, but the pattern of placement changes and changes in social worker mirrored and reinforced one another to create a most challenging care experience for G.

9.3 The CSC IMR is clear that G's case was well managed and that G's welfare was always at the centre of their concerns and interventions, alongside clear evidence of good local management overview of the case. However senior management involvement to provide additional objective scrutiny was missing. The fact that this has not been recognised in the respective IMRs tends to reflect the stance that all was being undertaken appropriately from a procedural perspective and that the situation therefore did not require senior management oversight. The case should have been viewed more broadly from a senior

management perspective with a move away from incident focussed assessments and interventions to a greater need for strategic overview. The particular circumstances of this case, which involved significant financial commitment, two periods of care in secure establishments and an unacceptable rate of placement breakdown and change, should have projected the case onto a more senior management agenda.

10. The last six months of G's life

10.1 G was in a residential placement in Northampton from February to May 2012, and generally this placement went well – for example there were no reported self-harming incidents or incidents of offending behaviour. However, G was apparently not happy there and although he wanted to return to the Buckinghamshire area, he was unsure whether he wanted a new placement or to return to his family. As G was now a few months short of his 17th birthday, he considered that he was sufficiently adult to make his own decisions, despite being reminded of the existence of the Care Order and that he could not just leave the placement. Nevertheless this was in effect what he did and he returned home – the view of CSC was to defer to his wishes because there was a view that such a placement needed to be tested as it continued to be G's wish to return home and there was also the issue of G's age and needing to move out of the care system and into more independent living.

10.2 Once G was back home at the end of May 2012, there was regular contact with the social worker and Buckinghamshire YOS needed to become re-involved to manage his court order meaning that they had three times a week contact. Both the YOS worker and the Addaction worker had known G for some time and had gone to great lengths to maintain contact even when G resided outside Buckinghamshire. G now had three local professionals who knew him well and who were clearly committed to working with G, even though they recognised the difficulty of effecting sustained changes in his behaviours. The commitment of these workers also demonstrates the fondness that they held for G and of his ability to sustain these relationships with them despite the difficulties he presented.

10.3 It was not clear what interventions were deemed necessary or undertaken in order to support the placement at home although neither G nor his mother attended the LAC Review arranged to be held at the family home in late June 2012. Overall this was a very different set of circumstances for G and whilst there would have been regular reports from the previous placements, clearly this now ceased. Therefore there was greater need to monitor how G was settling into living back at home. Certainly it was the case that G had shown a reduction in his offending and self-harming behaviours over recent months, and whilst this may have led to a sense of reassurance that G was now maturing and managing his emotions better, it had always previously been the case that contact with his family had been fraught and had sometimes led to self-harming.

10.4 The pattern of professional involvement was from the three key professionals, included some home visits, sometimes jointly, and so in this respect this would have been a fairly regular pattern of professional intervention that G had not been previously used to. However, two key workers, the YOS worker and the CAMHS worker left their posts or were absent in the weeks leading up to G's death. Whilst G was not engaging well with CAMHS at the time, the change of YOS worker may well have been significant for G. All of the professionals appeared to recognise the likely fragility of the placement at home, but in reality it seemed there was little option but to give it a sustained try. In the mother's contribution to the SCR, she has a different recollection of professional involvement at this

time, and considered that there was insufficient professional contact in terms of home visits to see not only G but also to see her and to see how she was managing.

10.5 Following the serious altercation with his step-father in August 2012 when G was arrested and charged with offences of assault, he urgently needed a new placement. The decision to place him with a semi-independent unit in Oxfordshire was linked with the need for a placement relatively near to home and for the support services he was accessing. G's social worker and manager were confident that this placement would be able to meet G's needs although once again this was a new venture for G, so it needed careful preparation. The CSC IMR did not consider that the urgent need for the placement undermined the decision to make the placement because the care provider had been used previously by Buckinghamshire and had previously been considered as an option for G. However there were views by the practitioners who knew him well, that it was a struggle to know where to place G. The same applied to his commencement at the training college which was viewed as a positive move, but in reality the options were limited.

10.6 The next LAC Review took place at the end of October 2012 and seemed to reflect that all was generally well with the placement. It was appropriately seen as positive that G was saying that he would now engage in DBT with CAMHS. However he was drinking excessively and was smoking cannabis. His Addaction worker was focussing on this with G but nevertheless was aware that chances of achieving any real change were very limited. It was also agreed in the review that G remained a high risk in terms of reoffending and self-harm – he had started tattooing himself which he recognised as a form of self-harming.

10.7 G was still hoping to return back to the Buckinghamshire area, and his social worker was intending to set up some arrangements to expedite this and so in some respects the semi-independent placement was not expected to take him up to his 18th birthday. The Pathway Plan at the time was not clear about the process or timing of any future move back to Buckinghamshire. The fact that the Pathway Plan included broad generalisations such as for G "to engage and to contribute socially and economically to society" was unlikely to give any real direction for the social worker of for G himself. The fact that the same plan recorded that G "had no plans for the future, sees no point of working and would be better off on benefit" hardly matched the overall desired outcome.

10.8 Generally the semi-independent unit considered that they were an appropriate placement for G and that in his time with them, he had progressed and demonstrated some abilities in his transitions to independent living. It was also not far from Buckinghamshire so family links could be maintained. However they did have concerns about self-harming (primarily by his tattooing) and did request additional funding for staff supervision, but this was declined by CSC. G was in fact the only resident in the unit (apart from one short period of a placement from another authority) although staff were present for periods during the day and there was always someone staying overnight with him. Following G's death, the manager of the unit raised concerns that whilst they had been given information about his self-harming; the placement plan report had stated that there was no evidence of mental health concerns or of suicidal ideation. However, he had regularly self-harmed in previous placements and whilst it was true that there were fewer episodes during 2012, practitioners were aware that G could react recklessly to stress, and his behaviours could not be predicted. The reference to no suicidal ideation and no mental illness therefore tended to give a false sense of reassurance. This reflects the way in which earlier assessments retained a lasting impact when in reality they had only focussed on G's mental state at the time of particular incidents.

10.9 Recollections by the YOS worker and the Addaction worker were that G found it difficult to adjust to life outside the different regimes of residential care, and that establishing peer friendships, for example within the training centre, proved more difficult than he had been used to. There was a sense of professional frustration over the last few months of G's life in the recognition that there were no ideal options for G – his fantasy about returning home was no longer viable. Also he had put some commitment into his attendance at the training college, but the altercation he had with a fellow student there meant that they were going to exclude him, which therefore again generated another significant disappointment for him and for which there was no contingency in place.

10.10 Although additional support hours were requested by the semi-independent unit in late 2012, these were not agreed by the local authority as it was considered that the current 6 hours per day was sufficient. However at this time G was on a curfew from 9pm – 7am Monday to Wednesday and all other days from 7pm – 7 am, which would have meant that for periods during the evenings that he was on his own, as there was no other resident in the unit. This could have been quite an isolating environment particularly when considering his experiences of care homes full of staff and other young people.

10.11 On the 4th of November 2012, G cut himself on the arm with a razor blade and when he showed it to the first aider at the training centre on the following day, it was clear that the severity of the cut required hospital attention and accordingly the member of staff immediately took G to Stoke Mandeville Hospital. The self-harm risk assessment tool was not used on this occasion (it has not been possible for the SCR to establish a reliable account of what that was) although the level of risk of re-harming was considered as low. G was treated in the A&E dept. and did not see a paediatrician. The attending doctor reported that he tried three times unsuccessfully to contact the CAMHS crisis team (It was Monday lunchtime) and so instead urged G to keep his arranged appointment with CAMHS for three days-time. The doctor was reassured by the positive way that G presented and the support which was being provided by the first-aider, but these professionals did not know G well and were not aware of the extent of G's self-harming history and of the positive way he had often presented following such incidents. It was a procedural expectation that G should have been seen by a relevant mental health practitioner to assess his risk of further-self harm.

10.12 Immediately after his return from hospital there was an incident at the training college when G had a violent altercation with a younger adolescent girl which led to him being asked to leave the college and remain away for the rest of the week. G was very anxious about this. The social worker reported the self-harm incident to CAMHS on the same day and it was apparent that there was agreement between them that it was sufficient to ensure that G attends his appointment in three days – there was no urgency considered. The Addaction worker responded to the situation by undertaking a home visit on the next day although G would not discuss his reasons for the self-harming. In the social worker's contact with the semi-independent unit later on the evening (5.30pm) of the 6th November, staff were informed of the incident at college with the female student and that G was being suspended. In this way there was a coordinated response to alert all professionals of the presenting situation for G at this time of crisis for him. Nevertheless it was in these circumstances that G took his own life.

11. Summary

11.1 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.

11.2 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.

11.3 The high number of placements nevertheless presented a 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 innovative 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.

11.4 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[27]. 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

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

should have been made to address such difficulties.

12. Areas for Learning and Development

A Looked After Chid with Complex Needs

- When a young person's circumstances and problems become more protracted and complex, more professionals tend to get involved and there are more procedural requirements about how interventions are coordinated and planned. The evidence of G's case is that this in itself does not lead to more effective interventions and that there needs 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 are required.

- There needs to be professional confidence to sometimes move away from established processes, meetings and structures which are showing evidence of leading to unhelpful and "unintended consequences" which can in turn mean that young people remain at high levels of risk.

- If there is no process for updating assessments, as is the case for Looked After Children, or in completing a holistic assessment of a young person in care, then there is less chance of implementing appropriate interventions and being left with a plethora of assessments which have a short "shelf life" but are nevertheless later used out of context.

- There needs to be a recognition that adherence to LAC procedures will not in themselves provide the full amount of protection for a young person in care or be able to fully assess his needs. There is a danger in a sense of inappropriate reassurance developing by professionals simply because procedures are being successfully applied.

- Professionals need to have the capacity to stand back and undertake a fundamental reappraisal of a case which has become protracted. As it is currently constituted and managed, the 6 monthly LAC Reviews did not provide the sort of forum to achieve this.

- When a child has been in care for a long period of time, then a move to semi-independent living would be a most significant step. Therefore a thorough assessment at the time of transition should always be undertaken to identify the different components of support that would now be needed.

- Processes and pro-formas such as those for "Pathway Planning" appear to have met more of an administrative need rather than being able to provide real meaning to the services needed and a means of engaging a young person in the plans and interventions.

Self-Harm Pathway

- The local Self-Harm Pathway was not being applied in practice. In particular the management by hospitals of adolescents who self-harm needs reviewing in that the failure to respond in line with the Pathway could otherwise place vulnerable young people at risk.

- Hospitals usually rely on carers and parents, but with a Looked After Child who has a complex history this is not a reliable approach. Professional carers such as residential staff seem more reliable but they are unlikely to know all the relevant history and hence the need

for the Self-Harm Pathway to be adhered to, so as a more in depth assessment can take place

- If professionals do not fully understand the role and limitations of the Force Medical Examiner's role, the involvement of the Police in incidents of self-harm can add potential confusion to the Self-Harm Pathway.

Out of County Placements

- Regular placement changes, especially those out of county will have considerable negative impact on the ability of a child or young person to achieve positive attachments, good self-esteem, educational attainment and appropriate social relationships. Professionals need to recognise the impact of regular placement changes on the young person, of the significant limitations it places on social work interventions, and how it can compromise information sharing.

- Steps need to be taken in order to seek to achieve a meaningful reduction in the number of out of authority placements as well as reduce the overall the number of placement moves. Additional risks are associated with placement out of the authority area and it is therefore necessary to build steps into practice to mitigate them

- Greater clarity is needed for Children's Social Care staff via professional guidance about how to work in the most effective way with young people in care who are placed out of county.

- Greater proactive sharing of information to agencies in the new area that a young person is moving to, will generate better opportunities for those agencies to provide more informed and coordinated services when required to do so.

The Independent Reviewing Officer

- The role of the IRO needs to demonstrate independent challenge, and be a strong and effective advocate for a young person if the placement arrangements are generating unnecessary difficulties and instability for the young person.

- There is a need for an IRO to be able 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 have been unsuccessfully applied before.

Health of a Looked After Child

- The effectiveness of health assessments has been shown to be compromised in a complex case like this, 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.

- If there is more integrated working in respect of health LAC assessments and LAC reviews, then there is greater chance of a more coordinated and effective set of services being offered to a young person in care.

- It would be beneficial that chronologies and updated information (including significant

events e.g. sexual abuse by professionals/ offending behaviours/ involvement of other professionals) is available prior to annual LAC health assessments and to GPs at the time of registration with a practice to ensure that these professionals have a full and clear picture of the young person enabling the health professional to be proactive in addressing the health issues arising from this information.

Recording of Decisions and Actions

- Commissioning and decision making processes need to be clear and recorded as part of the young person's file and to reflect their "journey" though the care system.

- Care must be taken to avoid an incident-focussed culture which will not only miss patterns of concerns emerging but will also restrict opportunities to involve senior managers in addressing system issues, particularly if a case is stuck and unable to progress.

- Senior managers in CSC must take a more long term hands-on role in order to give objective strategic direction to complex cases such as this one, rather than only being engaged at a time of crisis or when substantial financial decisions are needed.

Young People at Risk of Harm

- When a young person who is at risk of self-harm is involved with a number of agencies there is a greater need for regular and more coordinated use of risk of self-harm assessments and of an agreed way for agencies to respond on a collective basis is needed to provide confidence to care providers regarding their management of such events.

- A clear agreement between the LAC process and the YOS in terms of its risk and vulnerability function is needed in regarding how they are going to work together and which forum is responsible for what function.

- Improvements are needed in the way in which a young person's access to alcohol and drugs whilst in care is understood and managed and that substance misuse assessments need to inform service delivery and Care Plans.

13. Recommendations

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

13.2 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.

13.3 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.

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

13.5 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.

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

13.7 A review should be conducted of the information available to inform LAC review health assessments.

13.8 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.

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

13.10 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.

13.11 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.

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

13.13 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

20 March 2014