

# Plymouth Local Safeguarding Children Board

## Serious Case Review for 'RDP' Executive Summary February 2007

# Introduction

The purpose of this document is to provide an overview of the outcomes and recommendations of the serious case review commissioned by Plymouth's Local Safeguarding Children Board (PLSCB) into the death of a child.

The aim of a serious case review is not to assign blame, but to ensure that lessons are learned and recommendations are made to the agencies involved in order to avoid similar situations reoccurring in the future.

In the interest of public immunity names will not be used in this document. Instead an individual's title or the position they held will be sited, for example, mother, child or children's services, police.

If you would like further information about serious case reviews and how they are conducted, please refer to the 'Working Together to Safeguard Children' document published by the Department of Health (ISBN 011 322309 9).

## Brief case history

The young person at the centre of this case was found hanging in a public place in December 2004. The death was deemed to be suicide.

Following meetings by the then Plymouth Area Child Protection Committee, it was agreed that a Serious Case Review would be undertaken. An independent overview report author was commissioned in June 2006 by the Serious Case Review Sub Group of the now Local Safeguarding Children Board and terms of reference for the review were subsequently agreed in July 2006. Specific considerations for this review were considered to be as follows:

- The role that the Child and Adolescent Mental Health Services (CAMHS) had in clinical management of this patient
- The interface between the CAMHS service and other agencies including children's social care services

In the full serious case review report information about family history was included in order to provide the background leading up to the incident. A chronology of events from June 1999, when the family arrived in Plymouth, to the young person's death in December 2004 was also included in order to provide an account of the work and interactions of the professional agencies involved.

It was from this evidence that the recommendations and lessons to be learned highlighted in the serious case review were identified. Those recommendations form the content for this summary.

## Lessons learned and recommendations

There is very little information about the young person and his/her family. It appears they moved from Wolverhampton to Plymouth in 1999, as the family felt they could make a better life in the West Country.

His/her childhood was marked by severe asthma, eczema and impetigo and multiple allergies, for which he/she received Consultant Paediatric care at the request of the parents.

The young person attended primary school in Plymouth and had a successful transition to secondary school. He/she was accepted into the sixth form.

His/her schooling seems to have come to an abrupt end when he/she failed to take some GCSE exams and therefore found it difficult to join the sixth form.

Throughout schooling, the young person was considered to be a regular student with friends of both sexes.

The young person was finally excluded from school for an incident that started out as a prank, for which he/she took full responsibility.

He/she was admitted for observation and then referred to the Young Person's Centre at Mount Gould Hospital, where he/she became a voluntary in-patient.

Prior to his/her self-presentation at Accident and Emergency in June 2004 with a cut wrist and forearm, and overdose of painkillers, there were no indications that he/she was a troubled young person. He/she stated to hospital staff that they had self harmed before, but had not told anyone or sought help.

He/she was considered to be suffering from depression with suicidal ideation, which was complicated by personality problems. A plan was put into place for treatment as an inpatient for five days a week with support from his/her family at the weekends.

He/she began to form therapeutic relationships with staff who identified that his/her perception of educational under

achievement, difficult family relationships, failure to achieve goals with his/her football skills, alcohol misuse, self harm and threats to kills themselves were all relevant factors in his/her current distress. The parents were said to be shocked at the young person's self-harm and indicated that they had seen no warning signs.

The young person refused to be interviewed with his/her parents and refused to allow them to visit. His/her relationship with staff 'blew hot and cold'. His/her attendance at the Young People's Centre was unpredictable and his/her whereabouts were often unknown, refusing to go home at weekends.

He/she was supported to engage with The Foyer and Clear Springs Housing projects in order to find a stable place to live. He/she was provided with a flat, which was used on some weekdays and at weekends. Despite fluctuating moods, he/she was making progress, engaging with school, enjoying football and friendships.

The recommendations below highlight the key areas for improvement identified in the serious case review report:

### **Individual agency recommendations**

#### **Recommendation for Devon and Cornwall Constabulary**

- Information obtained following the return of a missing person of their whereabouts needs to be recorded either as intelligence, attached to the individuals nominal screen, or on the 121A (reporting documentation) on every occasion. If this is not done, the reasons why need to be recorded.
- 121A's need to be input on every occasion that a child goes missing and additional efforts made to ensure that children's social care services, or other relevant agencies are informed directly.

#### **Recommendations for Plymouth Hospitals NHS Trust**

- Senior Management should accelerate the process by which tier 4 CAMHS (Child and Adolescent Mental Health Services services) are developed at a single site within the far South West peninsula, thereby providing the option of more locally based 7 day a week inpatient treatment for young people,

considered at significant but not necessarily imminent risk from serious self harm and suicide.

- Clarification should be sought within a multi-agency framework, on the role of social services and other agencies in the provision of supported accommodation for young people over the age of 16 years, who do not require residential mental health facilities, but need continuity and the security of supported accommodation, to facilitate recovery of their mental health, in situations where their parents or carers cannot provide this.

## Conclusion

Prior to the first incident of self-harm, there was no significant indication that the young person was in distress. One letter from a professional described him/her as “very private and determined to achieve by his/her own means and not to be reliant on others for help”. This character trait was confirmed by his presentation at the Young Person’s Centre, when he/she could appear calm and then go out of the unit and self-harm.

The care that he/she received from Children and Adolescent Mental Health Services was of a high standard. Assessments were appropriate as was care planning and treatment. There was significant interagency liaison, particularly in the most critical period of his/her life.

The police responded appropriately to the periods when he/she was reported missing. It would have been helpful if the agencies had spoken to him/her on return about where he/she had been and then updated the police intelligence. This may have helped to locate him/her if he/she went missing again. However, this had no impact on the possibility of the prevention of his/her death.

The issue that arose from this review was the lack of appropriate and supported accommodation for the weekends when the young person was not in the Young People’s Centre, as he/she refused to return home. There is no information on the view of his/her mother and stepfather or his/her father about this situation or whether they were involved in finding a solution that would keep him/her safe. There is very little information about their involvement in his/her care beyond the assessment at the Young People’s Centre. This may have proved difficult as the young person refused to see them and was said to be angry when they were interviewed. However, his/her mother, and possibly father, still retained parental responsibility.

To conclude, the interventions by agencies were appropriate and the young person received good support.