

Plymouth Local Safeguarding Children Board

Serious Case Review for 'LB' Executive Summary June 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 child at the centre of this case died on 1 September 2002 as a result of hanging.

The child was accommodated by Plymouth City Council at the mother's request on the 11 May 1994 following an incident of physical abuse by his stepfather. The child had been in care for over eight years since the age of seven at the time of his death.

An inquest held at Plymouth Coroners Court in 2003 recorded an open verdict. The Coroner is reported to have said: "*There was nothing anyone could have done to prevent it.*"

A strategy meeting in 2003 concluded that a Part 8 enquiry would not be necessary.

In 2006 Plymouth's Safeguarding Children Board reviewed the decision that had been made not to undertake a serious case review and decided that one was necessary.

Terms of reference were subsequently produced by the Serious Case Review sub-group of Plymouth's Safeguarding Children Board and an independent overview report author was commissioned. Specific considerations for this review were considered to be as follows:

- To be co-ordinated independently by the commissioned authors
- To be conducted as quickly as possible with a first draft published by mid-February 2007
- To cover the period of time outlined in the chronologies supplied by individual agencies
- To address the conduct of agencies individually and collectively in the care, protection and support of the child during his/her lifetime
- To draw conclusions and make recommendations as necessary to Plymouth's Safeguarding Children Board Serious Case Review sub-group and the DFES through the production of an overview report, consistent with the requirements of 'Working Together to Safeguard Children'.

In the full serious case review report information about family history was included in order to provide the background leading to the family being involved with various agencies in Plymouth. A chronology of events from 1985 to 2002 was also included in order to provide an account of the work and interactions of the professional agencies involved. Interviews with the members of staff and some family members/carers were also conducted.

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

The child in this case was born in 1986 and lived with mother, father and two siblings. The child's mother alleged to a health visitor that the child was conceived as a result of marital rape and she divorced the father in 1987. He was subsequently killed in a car accident in 1994.

The child moved home between twenty to thirty times from birth to the age of seven. The mother reported to Social Services that she found it difficult caring for her children and stated the child was aggressive to the other sibling.

Between 1988 and 1994 Social Services received twelve referrals about the children from various sources that related to child protection concerns.

The mother remarried in 1993 and the child was accommodated by Social Services in 1994 at the mother's request and following a disclosure of a Schedule One Offence taking place.

The child was made the subject of a full care order in 1995. The intention of the care order was to secure stable, permanent care for the child, either through adoption or through long term foster care. The Court agreed that contact with the mother should be four times a year to maintain the relationship without destabilising the placement.

Whilst in the care of Social Services the child had intermittent contact with the immediate and extended family. Throughout the child's eight years in care, he/she continued to hope to return home to the mother.

Whilst the child wanted to return home to the mother, contact arrangements were never regular, stable or consistent. There were periods of many months when the mother would not stay in contact with the child and during 1999 she was not in contact with the child at all. There were periods when she requested rehabilitation at home but later said that she did not want this. The child tried to maintain contact with her but would sometimes be unable to contact her or find that she had gone abroad without informing the child.

During the child's time in care, he/she lived in eight foster placements, eight respite care placements and two residential placements. Seven of the foster placements broke down and only three lasted longer than seven months. The child also experienced eight respite placements and two periods of residential care. One was a local children's residential unit intended to be a short-term placement where the child remained for over a year. The other was an out-of-city residential unit commissioned for the child in order to comply with court directions but the child remained there for a further four months after an acquittal on a charge of rape in January 2002.

The child's educational provision varied between mainstream schools, home tuition, and a school for pupils with emotional and behavioural difficulties. Plymouth City Council issued a Statement of Special Educational Needs in 1997, which was amended in 1999.

Two Educational Psychologists wrote reports about the child, which they shared with Social Services and Health professionals. The child also received services from Children and Adolescent Mental Health Services (CAMHS) during three periods in 1992, between 1996-1999 and 2001.

A Clinical Psychotherapist was involved in the second period of CAMHS involvement and a social worker in 2001. Records for CAMHS first period of involvement were unavailable but the Social Services chronology makes clear that a Therapist from CAMHS was involved in 1992 and made a child protection referral to Social Services.

From June 2000 onwards, the child frequently went missing from foster placements and school. The child usually returned later in the day or the following day but on some occasions was missing for longer. Police were almost always informed when the child went missing, and occasionally he/she was identified and returned to his/her placement.

There is evidence that during these times the child misused alcohol, cannabis and heroin and there were reports that he/she was sniffing aerosols. On at least three occasions when the child was missing and misusing alcohol or drugs he/she presented or

was taken to the Hospital A&E Department and on two occasions detained overnight.

As there were a number of agencies involved in the child's life, it is important to see if lessons could be learned that may have prevented the child's death. The recommendations in the next section highlight the key areas for improvement identified in the serious case review report.

Recommendations

Agency	Recommendation	Actions/Tasks
Liaison between Health/Hospital and Children's Social Care	Plymouth Health Trust should pass all relevant information to Plymouth Children's Social Care, and if practicable, the child's social worker whenever they are aware that a looked after child presents at A&E. This action should be taken, even when the child or young person is accompanied by their carer.	To be incorporated into A&E guidelines but is dependent on 1.2.7 being put in place
Liaison between Health / CAMHS and Children's Social Care	At the point of case closure by CAMHS, the social worker must request a report detailing the therapeutic input and outcome of the service, which must be kept on the child's file.	A briefing note has been produced to inform all relevant staff of this recommendation. There is now a specialist CAMHS team for looked after children which is located with the LAC service, which aids communication in assessment and planning.
Agency specific recommendation for Children's Social Care	<p>Child protection processes Plymouth Children's Social Care should ensure that:</p> <p>Any judgement as to whether a S47 enquiry should be made is taken in the light of any previous allegations received and not solely on the referred concern.</p> <p>The threshold criterion for S47 enquiries is one of "suspicion" of risk of significant harm. It is for the subsequent enquiry to determine the strength of evidence.</p> <p>Where rehabilitation home is being considered for a looked after child an updated core assessment should be completed which takes account of all previous child protection concerns and</p>	<p>Child Protection processes have been implemented and are working robustly.</p> <p>Chronologies are now on every child's file and are taken account of in assessment, planning and review.</p> <p>Where a Looked After Child is being rehabilitated home and there are child protection concerns, Children's Social Care re case conference.</p> <p>All S47 allegations about foster carers are conferenced by an Independent Reviewing Officer.</p> <p>Child Protection concerns are recorded within the</p>

	<p>consider whether they have been resolved. This is especially important where children were placed on the child protection register and their names only removed after they were accommodated.</p> <p>Where the abusive partner is no longer part of the household consideration is also given as to the extent to which the child was safeguarded by the other carer and also their attitude to the abuse before any decision is made to rehabilitate a child home.</p> <p>S47 threshold criteria are applied to allegations made against foster carers.</p> <p>Child Protection allegations are highlighted on the file with cross-referencing of dates on which actions have been taken.</p>	<p>Chronology which is part of the Integrated Children's System.</p>
<p>Agency specific recommendations for Children's Social Care</p>	<p>Children Looked After</p> <p>Care planning</p> <p>Team Leaders should ensure that:</p> <p>Where permanency plans have been agreed managers should ensure that these are not changed or undermined between reviews and that if any significant changes are required an early Statutory Review is requested.</p> <p>When significant changes occur to the child's care plan the social worker must request a statutory review meeting. Social workers understand the importance of making a relationship with children.</p>	<p>These actions are now routinely completed. The Independent Reviewing Officers have a clear responsibility; please refer to "Role of Independent Reviewing Officers".</p> <p>Children's Social care staff have been instructed that "direct work" must take place, by Social Workers, with all Looked After children, additionally statutory visits must be adhered to.</p> <p>Team Managers are accountable for all the work on the duty basis.</p> <p>A Permanence Panel has been implemented, to ensure Fostering Link workers are kept aware of issues.</p>

	<p>There is a system in place to ensure that when a case is dealt with by a duty social worker in the absence of the allocated worker the case is brought to the attention of a manager who should record their view on file and detail any action points.</p> <p>Fostering Link workers should be invited to part of all Statutory Reviews of children awaiting permanent placements to ensure that Review members are updated on the progress of the placement search and that the Link worker is updated on any changes to the child's/ young person's needs.</p> <p>A chronology of involvement and key decisions must be completed on all case files and should be updated and carried over to each subsequent file.</p> <p>Plymouth Children's Social Care should have monitoring systems in place to ensure that:</p> <p>A comprehensive social work assessment under the DoH Framework for Assessment Part 2 must be completed by the social worker for all new LAC cases and presented to the 4-month Statutory Review meeting in order to inform Permanency Planning.</p> <p>Where a child or young person is subject to a care order and the plan is for over 24-hours staying contact at home, the social worker will complete the Placement with parents Regulations for approval by the Assistant Director of Children's Social Care services.</p> <p>Young people are appropriately matched with carers Disruption meetings are held when a child or young person's</p>	<p>All children awaiting placement are taken to the Resource Panel for consideration. This Panel is chaired, by the Assistant Director, Children's Social Care.</p> <p>A Chronology is routinely kept, which is part of the Integrated Children's System.</p> <p>The Quality Assurance role is undertaken by the Independent Reviewing Officers. Team Managers have implemented the Supervision Policy from 2006.</p> <p>This information is routinely sent to the Assistant Director, Children's Social Care.</p> <p>A Permanence Panel has been implemented, which considers disruption issues.</p> <p>Support to assist carers is now provided by the CAST Team.</p> <p>Independent Reviewing Officers routinely consider the appointment of an independent visitor. This is part of the IRO checklist under "record of discussion".</p> <p>This information is monitored on a monthly basis by the</p>
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	<p>placement has broken down to assist with future planning for the child / young person and to provide information for the Fostering Service about the skills and abilities of the foster carers and / or to identify any training needs Support is put in place to assist carers when placements are under pressure as a result in an escalation in a young person's challenging behaviour.</p> <p>Consideration is given by IROs when making LAC Review decisions to the appointment of an independent visitor for a child or young person in situations where there is intermittent contact from family.</p> <p>Whenever staff in Children's Social Care receive information that suggests that a LAC child or young person is misusing drugs or alcohol, this is addressed within their care plan.</p> <p>Statutory visits are completed within timescales and increased visits are offered to children / young people and their carers where the placement is under pressure or facing disruption.</p>	<p>Assistant Director and informs KPI's. The information is input by IRO's.</p> <p>Social care staff (Social Workers) have been instructed that it is necessary for statutory visits to be completed. This is monitored by IRO's and the Team Manager</p>
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<p>Agency specific recommendation for Children's Social Care</p>	<p>Children missing from care</p> <p>Line managers and Independent Reviewing Officers should ensure that staff are familiar with the <i>'Multi-Agency Protocol for Children and Young People Missing from Local Authority Accommodation'</i> and in particular their duties to:</p> <p>Ensure that risk assessments are completed for all children and young people who go missing</p> <p>Risk assessments are included in care plans and / or placement plans</p> <p>That the child or young person is spoken to by the social worker or other independent person on their return to their placement.</p> <p>The child or young person's medical condition is assessed on their return and a medical opinion sought if the child/young person appears to be under the influence of alcohol or any illegal substance.</p> <p>Recording practices as outlined in Section 16 of the Protocol are followed</p> <p>Give a copy of the Protocol to workers / carers from organisations outside Plymouth when a child is placed with them and request that Devon and Cornwall Police are notified if a child or young person placed outside the city goes missing in line with Section 14 of the Protocol.</p>	<p>A multi agency missing young people Team has been set up to undertake risk assessments</p> <p>The young runaways project is currently been assessed, as a pilot.</p> <p>The new multi agency Protocol is nearing completion and will be distributed to all staff.</p>
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<p>Agency specific recommendation for Children's Social Care</p>	<p>Supervision of staff</p> <p>The Team Leader must check through supervision what actions the social worker has taken on each case and record actions and agreements on file. Supervision practice guidance should be issued to ensure that social work line managers closely monitor social workers' actions in the following areas:</p> <ul style="list-style-type: none"> • Use of appropriate and timely assessment processes • Responses to child protection allegations in line with the Child Protection Procedures • Completion of actions on the decisions agreed at Statutory Reviews. • Compliance with statutory timescales for statutory reviews and statutory visits to Looked After Children. • Compliance with the 'Multi-Agency Protocol for Children and Young People Missing from Local Authority Accommodation.' <p>Guidance should be developed for social work staff to ensure that timely information is given to out-of-hours social workers to assist them in making appropriate decisions on cases. In situations where a child's plan for permanency has not been achieved and / or when a child is experiencing frequent placement moves serious consideration should be given to the appointment of an Independent Visitor.</p> <p>Consideration should be given by Plymouth Children's Social Care as to whether an application should be made to the Department for Education and Skills for participation in their funded pilot project on a "<i>Multi Dimensional Treatment Foster Care</i>" (MTFC). (See paragraph 8.4.25)</p>	<p>All of these recommendations have been implemented following the launch of the new Supervision Policy and Standards 2006.</p>
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<p>Agency specific recommendation</p> <p>Health</p>	<p>The CAMHS service should review its record-keeping process to ensure that it meets both Trust and professional standards for record keeping. Recommendation 10.2.5 (above) should be included in the scope of this Review.</p>	<p>Audit of CAHMS records to ensure compliance.</p>
<p>Agency specific recommendation</p> <p>Health</p>	<p>The CAMHS service should ensure that all staff adhere to PHT policy for the retention and destruction of records.</p>	<p>Audit of CAHMS records to ensure compliance.</p>
<p>Agency specific recommendation</p> <p>Health</p>	<p>A formal multi-agency process should be developed to ensure agencies take timely actions to safeguard children about whom there is a significant concern, but who do not meet the threshold for a S47 investigation.</p> <p>This relates in particular to children and young people who go missing from care, who misuse substances and/or whose behaviour frequently brings them into contact with the police and puts them at risk of entering the Criminal Justice System.</p> <p>Research findings relating to the safeguarding of children and the needs of Looked After Children should be regularly and purposefully disseminated to key professionals in all agencies.</p> <p>The CAF should be used across all agencies.</p> <p>Recording guidance for staff in all agencies should be developed to ensure that all contacts and communications with and about looked after children/young people are recorded on</p>	<p>The FFA should be firmly embedded as part of the child in need process across all areas of PHT in Plymouth who work with children</p> <p>Current findings to be incorporated into Child Protection Training for staff</p> <p>CAF awareness sessions to be carried out.</p> <p>Relevant areas within PHT to review their record keeping guidance to staff in relation to LAC.</p> <p>A chronology of significant events sheet to be kept in the notes of complex /cause for concern cases</p> <p>To be incorporated into A&E guidelines but is dependent on 1.2.7 being put in place</p>

	<p>files; facts are separated from opinion in these recordings; the purpose of visits; telephone calls and all communications are stated clearly; a chronology of significant events is kept on each file and regular summaries compiled.</p> <p>PHT should pass all relevant info to Children's social care whenever a LAC child presents at A&E. This action should be taken even when the child/young person is accompanied by their carer.</p> <p>CAHMS should ensure that Plymouth Children's Social Care are aware of any service that CAHMS professionals are providing to a looked after child /young person.</p>	CAHMS need to consider how best to ensure Social Care are fully aware of LAC under their care
Agency specific recommendation for Children's Lifelong Learning	Children's Lifelong Learning should develop an electronic system of recording on case files, which enables all officers, school staff and other professionals to input actions and information and read files relating to children looked when appropriate.	The Common Assessment Framework has been tasked to implement this recommendation
Agency specific recommendation for Police	The Police should ensure that there is clarification for staff as to the circumstances in which Form 121as are completed. Form 121a should be completed and disseminated to external partners whenever a looked after child comes to their attention.	Achieved

Agency specific recommendation for Police	The Police implement a review of the way in which form 121as are recorded and disseminated to external partners to ensure that they are promptly shared and at the appropriate level of seniority.	Achieved
Agency specific recommendation for Police	The Police develop a process by which information contained within the form 121a can be risk assessed by suitably trained staff to ensure the appropriate level of response and information sharing and to ensure that concerns are not left unattended.	Achieved
Agency specific recommendation for Police	Cases of children who repeatedly go missing or abscond should be addressed through Plymouth's Multi-Agency Protocol for Children/Young People Missing from Local Authority Accommodation.	The Multi-Agency Protocol for Children/Young People Missing from Local Authority Accommodation is currently the subject of review.
Agency specific recommendation for Police	The Police should explore the possibility of putting a system in place to share information relating to looked after children across neighbouring constabularies.	Being piloted

Conclusion

To conclude, this was a tragic incident that could not have been predicted by the agencies involved. However, there are lessons to be learned from this case.

In particular, the recommendations relating to communication between agencies must be implemented in order to improve partnership working. Each agency must have the most relevant and up-to-date information about what action each is taking so that a child-focused co-ordinated intervention is achieved.

Each agency should implement the recommendations relating to file recording, which will inform the decision-making processes for child protection issues and when contact with a biological parent is detrimental to a child's welfare and development.

There are some lessons to be learned by each agency in this case, which have been outlined in the recommendations section of this report, but it is clear that this incident could not have been prevented by the intervention of any one agency.