EXECUTIVE SUMMARY

AUGUST 2005
Chapter 8 Case Review: A

1. Executive Summary

1.1 This is the Executive Summary of a case review commissioned by the Norfolk Area Child Protection Committee (ACPC) on 10 September 2004 into the life and circumstances of the death of A.

1.2 In 2004 A sadly died when, in his mother’s absence, he took drugs at his mother’s house. A was thirteen years old at the time. A had demonstrated behavioural difficulties from an early age and these included self-harm, alcohol and cannabis use, challenging behaviour to those in authority, and criminal behaviour in the form of thefts and assaults. At the time A was a Ward of Court and in the care of Norfolk Social Services Department. He was accommodated in a residential children’s home at Welney.

2. Data Protection Act

2.1 It should be noted that much of the information relating to A is both confidential and classed as personal data under the Data Protection Act 1990 and therefore caught by the restrictions under the Act. It has therefore been difficult to ensure confidentiality and data protection and, at the same time, provide a detailed coherent summary of A’s family background. The information set out below reflects these tensions.

3. Review process

3.1 The case review was conducted in accordance with Chapter 8 of Working Together to Safeguard Children (1999). The purpose of such a review according to Working Together (1999: 8.2) is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence,
- To improve inter-agency working and better safeguard children;

3.2 The Norfolk ACPC Serious Cases Review Group oversaw the work of the Review, with members drawn from the constituent agencies of the ACPC. Specific Terms of Reference were drawn up to guide both individual agency management reviews and the Overview Report. A professionally qualified and experienced author, independent of the
Norfolk ACPC and constituent agencies, was commissioned to prepare the Overview Report.

3.3 In addition, A’s family were invited to first meet with the Chair of the ACPC, and then subsequently with the Chair and the Overview report writer. In addition, family members and the psychologist for The Cottage made written submissions, which were passed to the independent Overview report writer.

4. **Terms of Reference**

4.1 To provide a detailed chronology of the care and protection of A from his birth in 1990 until his death in 2004

4.2 To consider A’s life history, both in the context of his family and under the care of the Local Authority, Norfolk County Council.

4.3 To consider the decisions that were taken during A’s life that related to his safeguarding and care by the agencies and by the Courts.

4.4 To consider the meeting of A’s special needs in respect to his offending behaviour, containability and controllability, educational experience, his mental health and potential for self-harm.

4.5 To consider the circumstances of A’s care and control at the time of his death.

4.6 To consider A’s experience when in residential care.

4.7 To establish whether there are lessons to be learned from this case about the way in which local professionals and agencies work together to safeguard children.

4.8 As a consequence of identifying such lessons, make recommendations for action and improvement in safeguarding and inter-agency working.

5. **A brief life history of A**

5.1 A was born in 1990. Although A experienced an increasingly troubled life as he moved from childhood to adolescence, he was also seen by many to be a warm and, at times, engaging boy with many interests. He felt a strong commitment to his family and a responsibility for them when he perceived them to be vulnerable. A’s family felt strongly that A’s problems should be dealt with within the family.

5.2 For the purposes of this executive Summary events began in 1991 with the involvement of Social Services in the family life.
5.3 There were other subsequent instances of professional involvement during A’s early life.

5.4 Between the years 1997 and 2000 there was limited contact between the family and support agencies. A referral was made to a Children and Family Centre in respect of A being bullied.

5.5 The next key period in A’s life commenced in the early months of 2002 and during the consequent year a range of concerns about A’s welfare were highlighted. He was then eleven years old.

5.6 Between February and July 2002 the Norcas Youth Team were involved to provide assistance with A’s own drug and alcohol difficulties. These concerns culminated in an initial child protection conference held on the 15 July 2002, but A’s name was not placed on the child protection register on this occasion.

5.7 During August and September 2002 there were further reports of A being bullied by other boys and of incidents of ‘self-harm’. A became involved with the local psychiatric services, was admitted to hospital on two occasions for treatment to self-harm injuries, and was excluded from school. For the first time, A expressed fear about threats from his father.

5.8 A’s father died in 2002 and in the period following that significant event many factors in A’s life became very confused and turbulent.

5.9 It was agreed that A’s name be placed on the child protection register on the grounds of neglect and that he should stay with his paternal grandmother. There were however issues about the level of cooperation and consistency of care by his family and legal advice was sought concerning the securing of a safe caring solution for A.

5.10 By February 2003 the Norfolk Social Services Department concluded that A should be looked after by the local authority. A became subject to an interim care order and his name was removed from the child protection register. Although it had been decided that A should be accommodated there remained difficulty in finding a placement that would suit his needs. A vacillated in his desire to be accommodated away from his family, and this ambivalence was compounded by his family’s determination to have him returned to their care. There were occasions when A returned to his family’s care in an unplanned manner. The local authority was required to make applications for two Recovery Orders to have A returned to their care. A became involved with the Norfolk Youth Offending Team in July 2003.

5.11 A was placed with his paternal grandmother in August 2003, initially under emergency fostering regulations, but ultimately as a placement when A was made a Ward of the High Court. The next few months saw a deterioration in A’s behaviour leading to his permanent exclusion.
from school. There was a higher reported frequency of A’s use of cannabis and alcohol, and he was again charged with theft. At that time A expressed his wish not to stay with his grandmother.

5.12 Between February 2004 and his death later that year, A experienced three different placements. The first was a brief foster placement and then a further brief residential placement at River Cottage children’s home. Finally, A was moved to The Cottage, a Fenland Care residential unit at Welney. During this period, a Statement of Special Educational Needs was completed, and there was agreement by Social Services and Education about the funding of future placements. A’s behaviour was periodically a cause for concern, and he exhibited self-harming behaviour and required Police intervention to calm him down.

5.13 At the start of this period, A had no contact with family members, as he had expressed a desire not to, but then was angry at not having contact. Although there was a period of almost three weeks when A did not abscond from the placement, he began absconding again, mainly to his grandmother. There was discussion between Social Services and A’s grandmother on the occasions of A’s absconding, and agreement reached on how to manage his return. It was in the course of implementing such an agreement that A ran off from Fenland Care staff for the last time. He sadly died as a result of drug ingestion at his mother’s house, in her absence, in 2004.

6. What did we learn from this case?
6.1 This was a very complex case with many dimensions. A himself had wide ranging problems including self-harming behaviour, criminal behaviour, aggressive behaviour, unresolved grief, substance misuse, and concerns about being away from his family, while feeling loyal and, at times, responsible for them. His mother and paternal grandmother did not accept the need for his being in the care of the local authority, and their antipathy to his being looked after, coupled with A’s own ambivalence, impeded his being able to settle to begin to work on the many underlying difficulties. This was further exacerbated by a continuing lack of clarity about the type of long term placement that would meet his needs.

6.2 A was out of education for a considerable period of time, and the lack of educational provision and the delay in establishing his educational needs compounded difficulties in identifying suitable short term and long term placements for him.

6.3 The Cottage experienced difficulty in establishing an overall care package for him without guidance from the psychiatric services. Their attempt to involve an independent psychologist to assist them in addressing A’s psychological needs was frustrated both by A’s non-engagement and by a professional acceptance of his non-engagement.
6.4 Initially, when A’s name was on the child protection register, the structure of child protection conferences and core groups drew professionals together to assess his needs and formulate multi-agency plans on a regular basis. When his name came off the child protection register, when his needs were no less, the looked after children review system remained the only multi-agency planning forum for him.

6.5 There is evidence that the looked after system was applied appropriately, with well-chaired and minuted meetings to establish the plans for A in his placements. However, a review of the minutes of the looked after children reviews indicate that they achieved neither the frequency nor the comprehensive professional involvement of the planning structures within the child protection system.

6.6 The internal management review of Legal Services identified the lack of legal strategy meetings as a gap in the service provided. This was merely one aspect of the lack of strategy for the overall management of this complex case.

6.7 The pace of incidents to be managed was great, and day-to-day decisions were usually sound. However, although there clearly were attempts to undertake assessments on which to base long term plans, there is little evidence of clear conclusions arising from assessment activity.

6.8 Of particular note was the plan to assess family members as potential long-term carers for A. In practice, only the paternal grandmother and her partner were engaged in an assessment of their ability to provide long-term care for A. The conclusions of this assessment cannot be deduced from the subsequent long term planning. Within the context of A’s allegiance to his family, their antipathy to his being in care, and the wide range of A’s needs, the delay in concluding whether a placement within his family remained a viable option for him kept active his, and his family’s, challenge to any alternative plans, both within Court proceedings and in day to day issues.

6.9 The difficulty in finding suitable placements for A, which could provide for his social, emotional and education needs, persisted throughout the period of his being looked after. The Resource panel had agreed funding for his placement, and although options were being looked at for him, in preparation for the final Court hearing, no decision on a suitable placement had been made by the time of his death.

6.10 Clearly, within legal proceedings the final outcome is the responsibility of the Court, and Social Services are only able to implement plans during the period of proceedings, in discussion with the Children’s Guardian and by agreement of the Court. The ambiguities that are evident in the planning for A would soon have come to a conclusion as the Court was due to reach a determination of the long term plan,
based on the proceedings launched by the local authority and the application for a Residence Order by the paternal grandmother.

6.11 Given the complexity of this case, there was a clear need for a strategy to be developed to provide an overall structure to achieve clear planning for A that could deal with the challenges on a day to day basis while maintaining a focus on his future. This could not have been achieved within the context of a legal strategy meeting alone, as there would also have been a need to engage with other involved professionals to discuss and plan a coordinated approach to both short term and long-term issues. The looked after children reviews were able to go some way with this planning, but required to be supplemented with a wider range of professionals and with managers with the authority to make decisions about the future direction of the overall case. It is therefore recommended that a system be developed for providing strategic direction on particularly complex cases.

6.12 There was a lack of adherence to regulations in respect of children’s placements. It is recommended that Social Services staff are reminded of the regulations that apply to children’s placements.

6.13 Making A a Ward of Court to circumvent the Fostering Regulations and enable A to remain with his paternal grandmother provided an opportunity for A to remain supported by his direct family. Most agencies experience some confusion about the implications of his being a Ward of Court as this is now a relatively rare option for a child looked after by the local authority. All agencies were aware that the Court was in a position to make decisions for the child, but there was a lack of clarity about the day-to-day decisions that could be taken without Court direction. This was particularly troublesome for the staff at the Cottage. It is recommended therefore that in the unusual event of a looked after child being a Ward of Court that written guidance is given to all agencies on the implications of wardship in the particular case, to be updated as required throughout the period of wardship.

7. Conclusion

7.1 Whilst it was clearly recognised that there were many risk factors in A's life, there is nothing in the analysis of the internal management reviews to indicate that the circumstances of A’s death could have been predicted, or that it could have been prevented in that timeframe. Clearly, he had absconded from being looked after by the local authority, and all agencies were alerted to that fact and aware of the plans to deal with that contingency.

7.2 The decision making to permit him to remain with his paternal grandmother was consistent with the more recent approach to managing his absconding, by agreeing to requests for him to remain in a known environment with his family. This approach was felt to have reduced the risk to him, and in the period of his absence from his
placement leading up to his death, there is clear evidence of agencies working together to agree the best approach with a view to reducing the risk of his absconding to an unknown and unsupported environment.

7.3 A more strategic approach to the overall management of the case, given its complexity, may have achieved much needed clarity and established parameters for his future placement at an earlier stage, and this may have provided an opportunity to work with A to recognise his needs and engage him in the process of finding the most appropriate placement to meet these needs.

7.4 However, the influences on A were strong and the legal process was long. As a thirteen-year-old boy who had experienced so much, and whose needs were so great, the continued uncertainty with which he lived created a context in which his needs were waiting to be addressed when his future was established. His tragic death came before the opportunity to draw all the competing strands together in the final Court hearing, and before he was given the opportunity of the certainty he needed.

8. Recommendations for action.

8.1 Recommendations from the Overview Report

8.1.1 Children’s Services

1 Children’s Services to review current guidance on section 47 assessments to ensure that it takes account of section 120 of the Adoption and Children Act 2002, and that when a section 47 assessment is undertaken as a result of a domestic violence incident that the timescales of the Assessment Framework are adhered to.

2 Children’s Services should give a response/appropriate feed back to any person or agency making an allegation that a child may be being abused.

3 Children’s Services should review their adherence to the Regulations that govern placements for children.

4 Any assessment of family members by Children’s Services when they are being considered as a suitable carer for a child who is subject to an (interim) care order must be documented with a clear outcome to the assessment.
5 Children’s Services should consider the need for a policy on the management of complex/protracted cases that includes the involvement of senior managers to give strategic direction to supplement the existing planning process.

6 Children’s Services must keep under review their ability to find suitable placements for children in a timescale that meets the child’s needs.

7 Child protection conferences should be held in a timescale to meet the needs of the child, and must be held within the timescale set by Working Together to Safeguard Children.

8 Children’s Services should consider how decision making about kinship care placements both within and as an outcome of care proceedings can be scrutinised to ensure that appropriate standards are met.

9 It is recommended that in the unusual event of a looked after child being a Ward of Court that written guidance is given to all agencies on the implications of wardship in the particular case, to be updated as required throughout the period of Wardship.

8.1.2 Child and Adolescent Mental Health Services (CAMHS)

1 Practitioners who are receiving or making referrals should take the opportunity to discuss with each other an appropriate action if parents fail to present the child at an appropriate appointment.

2 The CAMHS Service should review its process for initial assessments and consider the implementation of a triage system to prioritise urgent referrals.

3 A full record of all consultations, assessments or examinations that take place when a child is an in-patient should be available on the ward to all staff.

8.1.3 Legal Services

1 Legal strategy meetings should be held on complex cases.

8.1.4 Norfolk ACPC
The ACPC should consider the practice that has developed to remove children’s names from the child protection register when they become subject to the looked after review system to conclude if there is a need for Protocol 22 to be amended to ensure that when children’s names are removed from the register that the structures to review and implement plans are as robust as those within the child protection system.

The ACPC requires to finalise the policy on children who go missing. This should include the need for a strategy to be agreed by the relevant agencies when it is known that a child is a persistent absconder.

8.2 Additional recommendations from internal management reports

8.2.1 Health

1 All professionals should ensure that they work in a way that facilitates children’s ability to present a view and that this view is fully documented and passed on to other workers with the family.

2 There must be a clear assessment process with regard to the risk of serious injury or suicide in children who are self-harming.

3 The source of information must be referred to in all record keeping or note taking.

8.2.2 Children’s Social Services

1 When uniformed Police are involved in an incident of domestic violence between adults and there is a significant concern for a child within the household, this should be conveyed to the Police Child Protection Team by telephone so that a Strategy Meeting or discussion can take place with Children and Families Social Services in order to respond to the concern in a timely way.

2 There should be a clear Policy or Procedure in Children and Families Social Services about responses to domestic violence and Police forms C39. This should address individual referrals and make clear that the response should be according to the possible seriousness of the information and not to cumulative concerns.

3 Consideration should be given about how better to safely inform families that a referral about domestic violence has been received so that the victim feels able to respond safely.
All significant events should be recorded on the case files. Any suspicion of abuse should be recorded, and identified as being unsubstantiated by evidence if that is the case.

Significant descriptions should be given about families and individuals and the circumstances in which they are living and functioning.

There should be more clearly defined processes for senior management to be informed about cases of such high risk and to engage in decision making. This could be done by reporting of “hot spots” to the Head of Service on a weekly basis in writing, with a copy to the Director.

Cases of such complexity should be taken to a Resource Panel at an early stage. If the Resource Panel is multi-agency, this can be helpful in determining resources and placement.

If secure accommodation is being suggested or considered in any case, this should take place in the context of an At Risk of Secure Accommodation or a Legal Planning Meeting. Even where a young person is believed to meet the criteria, participants sometimes come up with creative alternative solutions.

When concerns about the need for a child to become Looked After are being expressed by a number of professionals, a meeting should take place of all those professionals with an interest in the child to best identify placement possibilities. This is particularly important where CAMHS or other health professionals are closely involved. Again, this is not to determine funding but to look at what all those involved can offer after placement.

The range of meetings currently in existence in Norfolk to consider the circumstances of children should be reviewed and, if necessary, rationalised. This should include consideration of Child Specific Meetings and Action Group meetings.

Where there is a high level of complex concerns about an adult service user, as there was in relation to A's mother, again a meeting of all those professionally involved should be convened to assess needs and identify services. This could form part of the Core Assessment process in relation to children.

Where there are concerns about protection of a child, and there is a decision not to take the case to conference, it should be a requirement rather than staff being encouraged, that they confer with Child Protection Conference chairs.
Chronologies should be used to inform planning and assess risk. They do exist on these files but were not used as a tool for analysis and were not completely updated.

Notifications of domestic violence should be considered as they are received and there should not be a reliance on building up a cumulative picture if any one notification suggests a risk of significant harm to children.

The response to such notifications should be timely - families are unlikely to respond to a letter inviting them to come in to the office if it sent some time after the event - this does not suggest a sufficient level of concern from Social Services.

Consideration should be given to the wording used in letters responding to notifications of domestic violence so that service users do not feel intimidated but encouraged by receipt of such a letter.

All case recording should be signed and dated, with the author’s name and designation printed.

Social Services should ensure that any difficulties in accessing legal advice out of hours is brought to the attention of legal Services.

8.2.3 Education Services

All schools need to have their own clear checks and follow up procedures in place to ensure a pupil returns to school after a fixed term exclusion. Schools need to notify PA&SS Attendance Team (formerly NPAS) immediately when a pupil does not return after the fixed term period and make enquiries of other agencies and services if contact with parents does not provide the necessary information.

PA&SS Attendance Team need to ensure that there is written evidence in the case file that the procedures have been followed, following a C39 report; identifying the action taken and that they communicate the implications of the information contained therein to other LEA Specialist teams within PASS and with the relevant school as appropriate. This should be monitored by the Attendance Team Leaders.

The Educational Psychology and Specialist Support Manager (EPSS) and the Education Officer (Attendance) should ensure there are procedures for staff to refer onto Child and Adolescent Mental Health Services, in close liaison with the designated social worker where children in public care require that type of
support. Procedures should be agreed at Child and Adolescent Mental Health Services Advisory Group (CAMHSAG) and the adoption and implementation monitored by managers.

4 Minutes of all child protection and review conferences should be included in the Attendance Team child file and the school’s file. The Area Child Protection Committee (ACPC) sends copies of minutes to all invitees and copies should be kept on all relevant files.

5 The Education Officer (Child Protection) should ensure that school procedures for maintaining and storing such minutes are strictly adhered to and that she monitors their compliance, reporting this to ACPC and her Line Manager accordingly.

6 EPSS (formerly NPS) need to ensure referrals for counselling are actioned, including when the pupil is out of school.

7 LEA Specialist Services and schools need to prioritise the needs of Looked After children, because of their recognised vulnerability in terms of educational outcomes, but to do this procedures for inter-agency working must be clearly understood, followed and monitored.

8.2.4 Norfolk Legal Services

1 In the light of the findings in this review, Norfolk Legal Services should review its requirements and procedures for file and documentation management (including filing, initialling of attendance notes, recording of instructions, retention of emails, and identification of material sent by fax).

2 Norfolk Legal Services should issue guidance to staff on the use of informal language in email.

3 Norfolk Legal Services should consider having readily available templates and guidance for child care applications which are rarely made (for example, collection orders and injunctions under the inherent jurisdiction).

8.2.5 CAFCASS

1 The importance of a chronology should be emphasised to those involved in proceedings particularly when the activities of a young person appear to be escalating. (This may have assisted the professional involved to consider the merits or otherwise of a secure accommodation application in a more structured way)
The involvement of a child’s solicitor should be considered in Chapter 8 reviews.

The view of the Court should be sought in Chapter 8 reviews.

CAFCASS as an organisation should ensure local management of all Children’s Guardians irrespective of whether they are contracted employees or bank.

8.2.6 Fenland Care

1 Procedures need to be updated to comply fully with the National Standards.

2 Senior managers must ensure that managers are enabled to supervise staff to the required standard. This matter has been raised by the CSCI inspection report for “The Cottage” of 12th July 2004.

3 House managers must ensure that files are organised and kept up to date and that decisions made are clearly recorded.

4 Care Plans should be clearly translated into weekly plans based on the Assessment Framework categories, in order that staff and young people have clear targets to work to.

5 When young people move internally within Fenland Care this should be treated as a new referral in terms of the regulations and paperwork completed accordingly.

6 There should be additional training on self-harming adolescents and mental health issues.

7 There should be in built support to staff teams by a mental health professional as a matter of course.

8 Managers should be encouraged to put in writing any concerns to placing authorities.

8.2.7 Norcas

1 To undertake risk assessments for the transporting of young people.

8.2.8 Norfolk Youth Offending Team
1 Ensure that the current Unit practice is compliant with YJB National Standard 2.9.

2 Ensure NYOT compliance with expectations regarding post-arrest services at the Police Station.

3 Ensure the continued provision and recording of high quality evidence to support assessments and provide clear indication for the content of intervention plans.

4 NYOT Case Managers and caseworker supervisors are encouraged to continue to balance the ‘welfare’ and ‘justice’ aspects of their role and responsibility to ensure that unevidenced decisions are not made about the ‘welfare’ needs of young offenders being met by other agencies.

5 Improve quality and clarity of case recording on YOIS.

6 Strengthen arrangements to communicate with family when a young person is charged by the Police.

7 Develop a system for regular recording of updates on Asset and attributing comments to individual staff members.

8.2.9 Police

1 Child Protection (CP) file notes made on the C40a and continuation sheets must be completed properly with the continuation sheet and referral number completed.

2 CAD’s should be updated with the final action taken whether it is negative or otherwise.

3 CAD should not have written, unsigned for, entries made on them.

4 The CAD’s and other material placed in a CP file should be listed on the file log (C40A b).

5 Care must be taken to ensure that the correct dates are recorded on C39d’s and file notes.

6 C39d’s must be submitted on every occasion where a child is at risk in accordance with Force policy.
7 Relevant CAD’s and C39d’s should be received and recorded in the Child Protection Unit’s files.

8 C39d’s should be completed in full in accordance with Force policy.

9 C40a’s must be legible.

10 When a child is abducted by parents, and a Court Order issued for the immediate return of the child, no matter what the circumstances are, Police must do all they can to act positively in dealing with the abductor and locating the child. The child must also be seen and checked when located to ensure he/she is well.

11 When a child is reported as possibly being home alone, the house where he/she is supposed to be must be checked and effort must be made to locate the child. A C39d must also be submitted.

12 CAD results must be more specific in relation to the action taken. A mechanism must be put in place to ensure that when a JLO form is mentioned as being submitted on a CAD it is actually checked by a supervisor through records of work to ensure quality and submission.

13 A C39d must be completed when a child is arrested.

14 When a child is reported missing and then found some hours later, the Police must visit the child and check his/her welfare.

15 Consideration must be given to the Police being involved in placement decisions or at the very least be informed when and where the child at risk has been placed.

16 The appointment of an independent author must be considered for future cases where the author is the line manager of the staff subject to review.

17 Administrative support should be provided to authors.