



STAFFORDSHIRE SAFEGUARDING CHILDREN BOARD

LSCB Independent Chair – Ken Black

NS10 SCR Panel Independent Chair – Chris Few

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

(Under Chapter 8, Working Together to Safeguard Children, 2010)

In respect of the death of one young person and

the attempted suicide of a second

Overview Report Author: Alan Ferguson, Independent social worker

Presented to Staffordshire Safeguarding Children Board on

Thursday 7th October 2010

Author's Details

I am a qualified social worker and registered with the General Social Care Council.

In March 2009 I retired from the post of Service Development Manager (Safeguarding & Quality Assurance) within Worcestershire County Council after a career in child care stretching back 35 years.

Within that role I have written numerous management reviews on behalf of Children's Services as well as overview reports on behalf of the Local Safeguarding Children Board.

Since retirement I have become the Director of an Independent Social Work Consultancy offering a range of services including consultancy related to Serious Case Reviews.

In this period I have served on numerous Serious Case Review Panels as both Panel member and Chair and, in recent months, have taken advantage of Regional and National events to further extend my knowledge in this area and to keep abreast of recent developments.

I have no professional or personal connections with Staffordshire Safeguarding Children Board or its partner agencies.

**Alan Ferguson
Independent Author**

Serious Case Review – Executive Summary

1. Introduction

1.1. Circumstances leading to Serious Case Review

- 1.1.1. In March 2010, the body of a 14 year old girl was found by her mother when she attempted to wake her in the morning. Initially the circumstances of her death were unexplained.
- 1.1.2. During a search of the young person's bedroom, Crime Scene Investigators discovered written and text messages indicating that she had taken her own life and that another young person, referred to only by her first name, intended committing suicide at the same time.
- 1.1.3. The other young person was identified by the school which they both attended and police and ambulance were immediately despatched to her address where they found her alive but critically ill. After a period of intensive care in hospital she made a full physical recovery and, following an assessment by the Child and Adolescent Mental Health Service (CAMHS), she was transferred to an in-patient facility where she could receive expert counselling and support.
- 1.1.4. It was quickly established that both girls had ingested a significant quantity of methadone. It is believed the deceased young person had taken this from a store within the home.
- 1.1.5. It was also established that both young people and their families were well known to local agencies although, in the case of the deceased young person, there had been no referrals of concern for some years despite her parents' personal problems. Both families are known to be White British and from working class backgrounds; there are no known issues relating to race, language, religion or culture.
- 1.1.6. In view of the circumstances surrounding this incident, the Serious Case Review Panel of Staffordshire Safeguarding Children Board (hereafter referred

to as the Board) met on 26th April 2010 to consider whether to recommend that a Serious Case Review (Chapter 8 of Working Together to Safeguard Children 2010) should be held.

- 1.1.7. In the case of the deceased young person, the Panel agreed the criteria were met, i.e.,

A Local Safeguarding Children Board should always undertake a Serious Case Review when; 'A child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family.'

- 1.1.8. In respect of the surviving young person, the Panel also agreed that a Serious Case Review was indicated although under a different criteria i.e.,

A Local Safeguarding Children Board should always consider whether to undertake a Serious Case Review where a child has sustained a potentially life threatening injury through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children.

- 1.1.9. Consideration was given as to whether it was appropriate to undertake two separate Serious Case Reviews i.e., one for each young person, but the recommendation of the Serious Case Review Panel was to hold a single Review in view of the clear connection between the two incidents.

- 1.1.10. These recommendations were endorsed by the Independent Chair of Staffordshire Safeguarding Children Board on 3rd May 2010, at which point Ofsted and Government Office West Midlands were notified of the decision to proceed with the Review.

1.2. **Serious Case Review Panel**

1.2.1. To oversee the process of this review a Serious Case Review Panel was established with an Independent Chair, Independent Author and Senior Manager Representatives from the key statutory agencies. These Managers had no direct contact or management involvement with the case and were not the authors of the Individual Management Reviews (the reports submitted by agencies to this Review).

1.2.2. The Independence of the Panel and thereby the Serious Case Review process, was further enhanced by the inclusion of a member of the Board not affiliated to any of the agencies involved in this Serious Case Review, i.e., the Divisional Welfare Support Officer from the Army Welfare Service.

1.2.3. **Independent Panel Chair - Chris Few, Safeguarding Children Consultant**

Chris Few M.Sc. B.A. (Hons) works independently as a safeguarding children consultant and as Chair of a Local Safeguarding Children Board. His background as a police officer includes safeguarding children policy development as well as leadership of child abuse investigation functions and homicide enquiries. Mr Few has chaired Serious Case Review Panels, undertaken agency management reviews and prepared overview reports for a number of Local Safeguarding Children Boards and their partner agencies. He has chaired one other Serious Case Review Panel on behalf of Staffordshire Safeguarding Children Board but otherwise has no personal or professional connection with any agency in Staffordshire.

1.2.4. **Overview Report Author - Alan Ferguson, Three Towers Consultancy** (details on page 2).

1.2.5. **Panel Members (by Designation and Agency only)**

Divisional Welfare Support Officer, Army Welfare Service (Independent Panel Member)

Detective Chief Inspector, Staffordshire Police

Head of Safeguarding, West Midlands Ambulance Service

Community and Partnerships Manager, Lichfield District Council

Assistant Director, Directorate for Children, Young People and Families

Assistant Director, Education Transformation

Chief Executive, Connexions Staffordshire

Head of Safeguarding, Werrington HMYOI (Independent Panel Member)

Head of Neighbourhoods, Homezone Living

Designated Nurse (Safeguarding Children), South Staffordshire PCT

1.3. **Parallel Processes**

- 1.3.1. Staffordshire Police have conducted an extensive criminal investigation into the circumstances surrounding the death of C1 and the attempted suicide of C2.
- 1.3.2. There were no criminal proceedings undertaken following a decision from the Director of Public Prosecution.
- 1.3.3. Also still ongoing are Care Proceedings in respect of C2 who is currently the subject of an Interim Care Order. It is unlikely that these proceedings will materially affect the outcome of this Review other than to confirm that the Directorate for Children, Young People and Families, and its partner agencies, are taking appropriate action to promote and safeguard the welfare of this troubled young person.
- 1.3.4. Appropriate internal action has been undertaken in line with disciplinary proceedings.

1.4. **Family Involvement**

- 1.4.1. Staffordshire LSCB have always been committed to inviting the surviving young person, her parents and the parents of the deceased young person to participate in this Review, but this was only possible once the police investigation was complete.
- 1.4.2. The surviving young person was spoken to by an Officer of the Directorate for Children, Young People and Families who explained the nature and process of a Serious Case Review. However, she has chosen not to participate.
- 1.4.3. A letter has been sent to her by the Independent Author explaining that she can still change her mind, but no response has been received.
- 1.4.4. Her mother accepted the invitation and was interviewed on 14th September 2010 while the parents of the deceased young person also accepted and were seen on 17th September.
- 1.4.5. All three made helpful contributions to the author's understanding of the situation and also stressed how totally unexpected the suicide and attempted suicide were. Neither young person had given their families any small clue as to their state of mind that weekend.
- 1.4.6. While being critical of the actions of some practitioners from agencies involved, neither family felt that more could or should have been done to prevent the events in March 2010.

2. **Summary of Events**

- 2.1. Although, as stated earlier in this report, it has been agreed to conduct one Review into the circumstances surrounding the suicide and attempted suicide, it was also agreed by the LSCB to consider different periods of time for each child in recognition of their different levels of contact with agencies.
- 2.2. For the deceased young person, who did not come to the attention of agencies other than her school since early 2007, it was agreed that the Review would address the period 1st September 2009 to the 12th April 2010.
- 2.3. For the surviving young person, who had extensive contact with the Directorate for Children, Young People and Families and CAMHS over a number of years, it was agreed to consider the period 20th June 2007 to 12th April 2010. The 2007 date was recognised as being the first occasion on which agencies became aware of her self-harming behaviour.
- 2.4. This Review is a story of two young people who were clearly unhappy with their lives to the extent that they entered into a pact to commit suicide. However, the background to their unhappiness and the way in which it manifested itself could not have been more different.
- 2.5. For the young person who died there were a number of factors in her life that must have impacted negatively upon her emotional wellbeing, including the knowledge that both her parents were misusing substances.
- 2.6. Despite this family background, her presentation, achievement and behaviour in school were good and she was described as a quiet, polite young lady. Whatever her problems were at home, she was able to conceal them from her teachers and to function at an average to above average level without drawing attention to herself.
- 2.7. The other young person in the suicide pact also had a number of concerning factors in her life, but she acted them out in a challenging and sometimes bizarre manner and was a constant source of concern for some professionals.

- 2.8. In the period designated for this Review, the young person who survived the suicide pact first came to the attention of the Directorate for Children, Young People and Families in 2007 when she made allegations that she had been sexually abused over a long period. However, upon interview with a police officer and social worker, she retracted her allegation.
- 2.9. In subsequent months she repeated the allegations several times to professionals indicating that she had lied to the police and social worker under pressure from within her family and in order to protect her alleged abuser. None of these later allegations were reported back to the police or re-investigated.
- 2.10. Throughout 2009, this young person's behaviour at school deteriorated significantly, with behaviour that included escalating self-harm. The school made strenuous efforts to engage other agencies in providing support to her, but these efforts were frustrated by the family's hostility and resistance to any intervention.
- 2.11. In September 2009, her GP (General Practitioner) made a referral to CAMHS because of her reported bizarre behaviour, but before this was progressed a further significant incident of self-harming occurred in October, and the Minor Injuries Unit arranged an urgent appointment for the following day. CAMHS remained involved until December but closed the case as the family refused to engage. This was a pattern previously noted by CAMHS in this family, in respect of an older sibling and indeed earlier referrals concerning this young person.
- 2.12. The Directorate for Children, Young People and Families also became involved in October 2009, having received a referral from the school which included details of the young person having suicidal thoughts. The case was allocated to an experienced social worker for assessment and the case remained open to them until the point of the young person's attempted suicide.
- 2.13. There was much contact between the social worker and the school over the subsequent six months as the young person's behaviour continued to deteriorate.

There is evidence of unresolved conflicts of opinion between the school and CAMHS on one side, who considered that the young person had serious emotional problems and was at risk of significant harm, and the social worker who did not agree that there were any child protection concerns and that issues simply related to a young person's difficulties at school. In this view, the social worker was supported by the young person's mother who considered all the young person's problems to be 'school based'.

- 2.14. This conflict of opinion remained unresolved at the time of the young person's attempted suicide.
- 2.15. Some five days before the attempted suicide, the young person made a disclosure to a teacher that she and a friend had made a suicide pact whereby they would die before they reached 16 years of age, at this point they were 14 years old. This information was shared with the social worker on the following day, but professionals did not identify the other girl, whose first name was mentioned, and the senior practitioner did not make any response prior to the tragic event that ensued.

3. **Key Issues Arising From The Case**

3.1. My analysis of the reports and information submitted in the course of this Review indicates there are seven key issues:

- the difficulties for practitioners from all agencies in working with hostile or highly resistant families;
- how practitioners, particularly social workers, manage the oversight and review of cases in the light of changing circumstances and new information;
- how social work managers develop and maintain quality assurance processes and practices that minimise the likelihood of inadequate assessments being allowed to have disproportionately negative impacts upon the lives of children;
- issues relating to the safe storage of methadone in patients' homes and the responsibilities of prescribing doctors in establishing this;
- the need (or duty) to undertake assessments of children living with drug-using parents even where the significant harm threshold does not appear to be met;
- the need to understand the incidence and any potential warning signs of suicide pacts in adolescence and;
- the need to have clear arrangements for dealing with differences of professional opinion relating to the safety of a child or young person.

3.2. The first three bullet points arise primarily from the practice of the social worker who held responsibility for the surviving young person's case from October 2009 until her attempted suicide in March 2010. However, it is also clear that assessments undertaken by other social work staff did not meet Directorates standards and were not picked up by current quality assurance measures.

3.3. In the opinion of the author, one of the most compelling reasons for these weak assessments was the hostility and resistance of the family of this young person, notably her mother, which deflected practitioners from focussing upon her needs.

- 3.4. During the course of the Review I became increasingly concerned at the ease with which the father of the deceased young person was able to stockpile significant amounts of methadone with inadequate attention being paid to safe storage, particularly given the presence of young children in the household. It is also a matter of some concern that the prescribing GP was unaware that the father had previously been caught hoarding methadone, a fact known to the police and the Substance Misuse Team. Such knowledge would surely have influenced the assessment of risk in this situation and may well have led the GP to insist on daily collection of methadone at a local pharmacy.
- 3.5. One of the saddest features of this case is that no family members, no teachers and, as far as we know, no friends were aware of the unhappiness experienced by the young person who took her own life; an exception being the young person who entered into the suicide pact with her.
- 3.6. As there was no evidence that she was suffering significant harm i.e., the trigger for compulsory intervention by the local authority, any support to her could only have been on a voluntary basis and with the co-operation of her parents. However, these issues were never even considered as no-one suspected that there were any problems. For the author this raised the question as to whether all children of parents who misuse drugs should be subject to assessments even where significant harm is not suspected. Such an approach has implications for legislation and resources, particularly as the 'Hidden Harm' report of 2003 suggested that there were then over a quarter of a million children in that position, a figure that must surely have increased in the subsequent seven years.
- 3.7. Suicide in adolescents is the subject of much research and has been dramatically highlighted by the number of reported 'copycat' suicides, most recently in the South Wales area. Suicide pacts in adolescence are thankfully rare but it is essential that any professional who receives information suggesting that young people may be contemplating such an action should urgently seek advice from their senior managers on the appropriate level of response required.
- 3.8. Staffordshire have had a number of adolescent suicides in recent years and two of them have already resulted in Serious Case Reviews. A concerted multi-

agency response would seem to be indicated which gives clear guidance to professionals who will come into contact with such young people, to hopefully reduce the incidence of adolescent suicides in Staffordshire.

- 3.9. Finally, there is significant evidence that, between September 2009 and March 2010, there were significant differences of opinion between professionals on the way to manage the case of the young person who survived the suicide attempt.
- 3.10. It is clearly a weakness in local arrangements for safeguarding children that no formal process exists for resolving such issues and this should be resolved as a matter of urgency.

4. **Priorities For Learning And Change**

- 4.1. It is my conclusion that the death and attempted suicide of these two young people were both predictable and preventable.
- 4.2. Predictable because one young person told a teacher that they were planning to do it, although she confused the issue by saying that it would happen before their sixteenth birthdays, which in both cases was eighteen months away.
- 4.3. Preventable, because I consider that a robust response to this disclosure would have alerted families and professionals to the acute distress of both girls (which was completely unknown in respect of the deceased young person) and led to greater vigilance. It should also have resulted in co-ordinated multi-agency plans to assess and address the complex needs of these two young people, plans that may have deflected them from the tragic route that they took only a few days later.
- 4.4. It is of course entirely possible that prompt intervention may have simply delayed their action and perhaps changed the method by which they attempted to take their lives, but that does not change the reality that no attempt at intervention was made.

4.5. The purpose of any Serious Case Review is to see what lessons can be learnt to improve services for safeguarding children and the following are what the author believes are the key learning points from this Review:

- working with hostile or highly resistant families can deflect social workers and other professionals from focussing upon the needs of children in such families;
- practitioners' assessments of children and families must be evolving pieces of work that can be developed or changed by new information that comes to light;
- poor quality initial and core assessments within Children's Social Care represents a significant danger to children's welfare and safety, and greater scrutiny by managers is essential to identify and address such weaknesses;
- arrangements for the dispensing and safe storage of methadone to drug using parents must be subject to careful assessment by the prescribing doctor and protocols should exist to ensure that they have access to all relevant information when making that assessment;
- the children of drug using parents may well have significant problems whatever their presentation to the outside world;
- practitioners working with children and young people need greater understanding of the issues related to self-harm and suicide in these groups and a multi-agency framework within which to address the problem and;
- all agencies working with children and young people must have a mechanism for resolving disputes that relate to the safety of a child or young person.

5. Recommendations

5.1. There are seven recommendations arising from this Review as follows:

Recommendation 1:

- 1a) **That the LSCB commission or undertake work to develop definitive practice guidance to support practitioners working with families who are highly resistant to intervention, using the evidence from this and other Serious Case Reviews to promote the guidance.**

- 1b) **That the LSCB undertake a consultation with local agencies to identify a sample of those families that currently meet the definition of ‘highly resistant’ and confirm that the welfare of children in those families is adequately safeguarded notwithstanding the difficulties experienced in working with their parents.**

Recommendation 2:

That the Directorate for Children, Young People and Families undertakes further work with its frontline managers to ascertain what, if any, are the barriers to supervision of practitioners being a reflective process that enables them to consider the implications of new information.

Recommendation 3:

That the Directorate for Children, Young People and Families reviews recent quality assurance reports in respect of initial assessments or, if necessary, undertake up-dated audits to satisfy itself that overall practice in this area meets Directorate expectations and standards.

Recommendation 4:

That the Primary Care Trust and relevant agencies review their protocols in respect of prescribing and safe storage of methadone in the light of events described in this Review to address in particular:

- risk assessments undertaken by prescribing GP's;**
- information sharing between statutory agencies to inform such assessments;**
- robust and consistent advice by prescribing GP's on the risk posed by methadone to children;**
- specific discussions between the prescribing GP and the patient in which the GP gains a clear understanding of storage arrangements in the family home;**
- regular and systematic review of patients' intake of methadone assessed against their prescribed dosage and;**
- clear record keeping that confirms that all elements of the revised protocol have been addressed with the patient.**

Recommendation 5:

That the revision of the 'Hidden Harm' guidance becomes a strategic priority for the LSCB and encompasses not only awareness raising and training among professionals, but considers the commissioning of educational material to inform the general public.

Recommendation 6:

That Staffordshire Safeguarding Children Board commission or undertake the development of a multi-agency strategy to reduce suicides and self-harming in adolescents over the next five years.

Recommendation 7:

Staffordshire Safeguarding Children Board should urgently commission or undertake work to develop a local protocol whereby professional differences between partner agencies in relation to a child's safety can be formally escalated and quickly resolved.

- 5.2. The Action Plan to address these recommendations, developed by the Serious Case Review Panel, is appended to this report. Staffordshire Safeguarding Children Board has accepted all the recommendations within this report and those in the supporting reports from partner agencies. They have also agreed to monitor their implementation until all are fully actioned and their impact assessed.
- 5.3. The Overview Report, the Executive Summary, the Individual Management Reviews and the Action Plan have all been submitted to Ofsted for evaluation and they have graded the overall process as good.

Alan Ferguson

Independent Author