



Case Review executive summary

April 2007

INTRODUCTION

This is a summary of a serious case review conducted by SSCB in accord with Part 8 of 'Working Together to Safeguard Children' (2006). It was undertaken following the death, as a result of substance misuse, of a 15 year old looked after child. The purpose of the review is to examine ways that child welfare agencies worked together in their discharge of their corporate parenting responsibilities, and to identify lessons that might be learned in improving inter-agency arrangements locally for safeguarding children's welfare.

REVIEW

Whilst the strict criteria for conducting a serious case review were not met, as the tragic death of this young person was not as a result of abuse or neglect, involved agencies and the Inspectorate agree that; this case has implications for a range of professional agencies with regard to how corporate parenting responsibilities are discharged, and that the process of a serious case review will facilitate the most robust mechanism for identifying both lessons to be learnt and any actions to be taken.

CASE SUMMARY

Notwithstanding parental separation in early primary school years and a significant physical injury a few years later, this young person appears to have been afforded a relatively stable early childhood, not requiring of professional interest. However their pre and early teenage years were characterised by

rapidly deteriorating behaviour which included running away from home, substance misuse and anti-social behaviour. Despite carer's best attempts to seek help, inter-familial relationships deteriorated to a position where this young person lived briefly and unsuccessfully with extended family. Voluntary accommodation followed a significant missing episode upon which no family member felt able to care for this troubled 13 year old.

Despite an expressed wish for foster care and robust efforts on the part of front line staff to achieve a suitable foster placement, one was never found. Additionally, a stable school placement could not be achieved.

This young person experienced a total of 6 residential placements over a 22 month period in addition to a short period of incarceration at a secure Training Centre. Their history as a LAC was characterised by rapidly escalating offending behaviour, repeated missing episodes, continued experimentation with substances, deteriorating emotional and psychological well being and often difficult contact arrangements with family members.

LESSONS LEARNED

- The potential for robust front line practice to improve outcomes for young people is seriously eroded by systems failures which result in placement instability and lack of secure educational provision.
- The traditional routes by which professional intervention for emotional and psychological support are received lack the flexibility required by some of our most vulnerable and chaotic looked after children.
- More robust efforts are required to ensure that information which is shared is acted upon. To be effective, different agencies plans made to meet a young persons needs, need to come together, be part of and guided by the care planning process. Work undertaken by different agencies needs not only to be known to others but to be carefully co-ordinated.
- Robust assessment of, and plans to address a young persons attachment needs, should be at the core of the care planning process.
- Repeated "missing" episodes for looked after children must be reviewed as exceptionally high risk behaviour and efforts to address such behaviour achieve a high priority in the care planning process.

RECOMMENDATIONS

- South Staffs NHS Healthcare Trust to review information systems and staffing for LAC.
- 90% of LAC Health Reviews to be completed within timescales.
- The LAC Service (C&LL) is currently reviewing the position regarding placement choice/availability for Staffordshire LAC. The outcomes of this work should be reported to SSCB.
- Resources are employed, or redeployed, to ensure an effective return interview service can be provided to LAC who frequently absent themselves without permission from their placement.
- Staffordshire Police identify a clear strategic lead for missing children.
- The current review of the CAMHS Service Level Agreement specifically prescribes a Care Pathway for LAC, including those placed with independent providers, both within and outside of Staffordshire's geographical boundaries.
- The use of administrative detections should be reviewed to ensure all relevant cases are referred to YOS.
- Agree and implement the current draft "Multi-agency protocol for preventing the offending behaviour of LAC".
- The Placement Unit of C&LL to ensure that all contracted residential services comply with National Standards.
- NSPCC to review its procedures for closing cases.
- Headteachers to be directed in writing by the Director of C&LL to put in place procedures to update school records every academic year and to record and file any attendance/behaviour issues/referrals.
- School records should be transferred swiftly when a young person changes school and issues of concern highlighted.
- Improve the policy/practice for prioritising integration/support for LAC to access timely and appropriate educational provision.
- Ensure that documentation (SENS "Meeting Outcomes Form") clearly states who is responsible for actions following placement decisions.
- All LAC Health Professionals obtain agreement from PCT's to obtain printouts from GP records of children's past health care.

- LAC Nurse to be informed of placement moves within 3 working days of the move occurring.
- Reaffirm practice expectation that all new placements receive a copy of existing LAC Health Plans and that health plans are discussed at LAC Reviews.
- Re-emphasise the Police Force Policy in relation to missing persons.
- The lessons learnt from this SCR to be disseminated to the local children's workforce.
- Target residential staff, (Council and Independent sector), LAC social workers, police YOS staff and LAC Health staff to attend 2007/08 Missing Children Training, as provided by SSCB.

Staffordshire Safeguarding Children Board will be undertaking some Training around Safeguarding Missing Looked After Children during 2007.

Dates will be made available on the Website:

www.staffsscb.org.uk

Alternatively contact Laura Nield – SSCB Training Co-ordinator on 01785 355794

Please pass this bulletin on to other professional colleagues in your workplace

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