Case Review Executive Summary

September 2007

INTRODUCTION

Staffordshire Safeguarding Children Board have conducted a Serious Case Review in accord with Chapter 8 of Working Together to Safeguard Children (2006). The background is the death of a young person aged 15½ by hanging. His family had only recently moved into Staffordshire from the Midlands and in fact they had moved many times within the Midlands authorities. The subject young person had moved from his family home to live with a relative less than a month before his tragic death; and he had only attended the local school for 3 days. At the inquest in June 2007 an Open Verdict was recorded as no suicide note was left.

PROCESS

The purpose of Serious Case Reviews is to establish whether there are lessons to be learned the way in which local professionals and agencies work together to safeguard and promote the welfare of children; to identify those lessons and establish how they will be acted upon.

An independent Safeguarding Advisor has chaired the Overview Panel and written the Overview Report. The Panel met on three occasions to study the Individual Management Reviews and to debate early drafts of the Overview Report which was presented to the Staffordshire Safeguarding Children Board on 20.9.07. In addition, the Chair and the Safeguarding Board Manager made a home visit to the young person's parents who gave their views on the family circumstances and on their perception of the agency involvement. This has been seen as a valuable contribution to the Overview Report.

Relatively little information has emerged from the authorities where the family previously lived, and indeed one of the issues to arise from this Review is that of the poor quality of transfer information in both Child Health and Education records.

Much more information has been elicited for this Review than was sought at the time in question. Specifically there was significant information about the family in general and one of the parents in particular which would - and indeed should - have contributed to assessments and led to further enquiries.

There was only one notable intervention by the Police and the Vulnerable Children's Division. The subject young person sustained a non-accidental injury at the hands of his stepfather and this was investigated by both agencies in a strategically planned Section 47 investigation. The young person did not want the criminal investigation to go any further by not being willing to provide a statement. However, the Vulnerable Children's Division did pursue and complete a Core Assessment which did not recommend any further services or involvement. The case was closed 7 days before the death.

LESSONS LEARNED

- The Vulnerable Children's Division client index system was not checked in relation to the young person's siblings or in relation to where the young person was currently residing.

- Lateral checks were not comprehensively carried out and, so, the significant history of one of the parents was not utilised in the assessment. Therefore the decisions to close down the Child Protection investigation by both Police and Vulnerable Children's Division was taken without a comprehensive/holistic perspective on the family situation.

- The Vulnerable Witness procedures were not adhered to at various stages of the investigation; however the process and timing of the medical examination was in line with procedures and demonstrated good practice.

- The parents were visited by a social worker prior to the joint interview of the subject child and the Overview Panel considers that this was inappropriate as it could have undermined any further action.

- There were lost opportunities to speak to the young person about his perceptions and feelings; therefore there is little understanding of the “child’s world”; insufficient attention was paid to his views within the Core Assessment which was not shared or discussed with him.

- There is no evidence of a considered and ratified decision not to open a referral on the siblings in the light of a confirmed non-accidental injury to the subject child.

CONCLUSIONS

Despite some flaws in the investigation of the non-accidental injury, this review has not indicated that these shortcomings had any bearing on the tragic outcome. There was no information to suggest that the young person might be suicidal or that he might harm himself. The death would appear to be a tragic event which could not have been foreseen or prevented by an action or intervention from any of the agencies.

RECOMMENDATIONS

- Compliance with Assessment Framework and Achieving Best Evidence via training and audit;

- A particular focus of such audit and training should be made on the lessons from this Review; notably:

    - direct communication with young people
    - the use of the Interview Suite
    - checking background histories
    - lateral agency checks
    - critically evaluating information
    - sharing a Core Assessment with a young person of sufficient age and understanding
    - need-focused not just incident-focused

  (VCD and Police)

- Ensure that whenever a Section 47 investigation is opened on one child in a family, any siblings are also considered.

  (VCD)

- Ensure that communicating with young people and understanding “the child’s world” are integrated into all training strategies.

- Ensure that the Client Index is always checked in relation to siblings of the subject child/young person and also in relation to where a child is residing.

  (VCD)

- Upon the admission of a pupil, initiate contact with the previous school and request a Pupil Record transfer; follow this up if there are any delays; and involve the local Education Welfare Service if the delays become significantly out of timescale.

  (Education)

- For all Initial Assessments and Core Assessments, checks to be made by Vulnerable Children’s Division with all relevant agencies who are required to cooperate by providing timely information.

  (All Agencies/LSCB)

- All safeguarding training must contain an element of communicating with children and understanding the ‘child’s world’.

  (All Agencies/LSCB)

NB: In their interview, the parents raised some very poignant and relevant issues relating to the period immediately following the death. The practice implications arising from these issues will be considered by the Serious Case Review Subgroup.

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