

Stockport Local Safeguarding Children Board

Serious Case Review Executive Summary

Child J
Born on 10.12.1990 and died on 10.05.2007

21 July 2008

THE PURPOSE OF THE SERIOUS CASE REVIEW

Stockport Safeguarding Children Board (SSCB) decided to conduct a Serious Case Review following the death of J, a 16 year old, White British, female child who died as a result of an alcohol and drugs overdose while she was a looked after child and resident in a Children's Home.

The purpose of the serious case review was to consider the provision of services to J and her family in order to:

1. establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
2. identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
3. as a consequence, improve inter-agency working and better safeguard and promote the welfare of children

The specific terms of reference were to review events from the decision to instigate Care Proceedings to the date of J's death and to consider;

- The management of the incident
- Management of support to J while she was in care
- Appropriateness of the response to J's needs
- Ascertain best practice in the approach given to children / young people who live this lifestyle
- Management of children / young people's contact with their family and the impact on the children / young people

Management Reviews were requested from all of the agencies involved with J and these were all received. Parents were invited to contribute. An independent chair was commissioned by the SSCB to chair the Serious Case Review Group and write an overview report. The SCRG met 8 times and presented its overview report to the SSCB on 12.05.2008.

CASE SUMMARY

J was removed from the care of her parents when she was 10 years old because of concerns about the harm she was suffering as a result of domestic violence and parental drug misuse. Initially she was cared for by her aunt but was then made the subject of a Care Order and placed in foster care. J had one lengthy foster placement followed by two shorter placements all 3 of which broke down. She was then placed in a residential unit which contained a number of young people with similarly challenging behaviours. Following the breakdown of the first foster placement J had increasing and increasingly unsupervised contact with members of her birth family.

At the time of her death at the age of 16 J was having unlimited contact with her birth family which, as a result of serious issues of its own, was never in a

position to resume her care. J was involved in escalating offending and in chaotic drug and alcohol use. She was largely beyond the control of the residential staff at the home in which she resided. She had been offered and continued to be offered a wide range of services from staff who were committed and enthusiastic but J proved to be extremely difficult to engage.

KEY THEMES AND LESSONS TO BE LEARNT

J remained a looked after child for 6 years having been removed from her family because she had suffered significant harm. Her first foster placement at the age of 10 was planned to be a long term placement. Unfortunately the placement disrupted after 4 years and subsequent placements in foster and residential care were not able to provide J with the sense of permanence she needed. Relationship difficulties were assessed as having been the major cause of the placement disruption rather than lack of support so there may have been nothing that could have been done to “save” the placement. The loss of it, however, appears to have been significant and marked a great deterioration for J in terms of her loss of attachment figures and a sense of permanence. The Review was not asked to consider whether J should have been removed at an earlier age.

J’s contact with her birth family, often described as acrimonious, increased and was largely unsupervised as she moved through her next two placements and got older. The damaging and distressing impact on J of what became unlimited ongoing contact with a family which had severe difficulties of its own and which could never resume her care was underestimated. J turned to her family in the absence of any other significant attachments and no work was able to be undertaken with her to address her ongoing feelings of rejection and loss.

J received a range of universal services appropriate to her age and was offered a further range of specialist services both as a looked after child and in relation to her inability to function in the school setting, her drug and alcohol use, her aggressive behaviour and her escalating offending. J was difficult to engage and repeatedly refused some services in spite of strenuous and imaginative staff efforts to reach out to her. Because of the complexity of J’s needs at times she had many individuals all seeking to make and maintain relationships with her and there was a risk of both duplication of effort and of the aim of different interventions conflicting with each other. Better joined up working, greater coordination and overall management of effort was indicated. The whole picture, in particular the cumulative effect on her of her experiences, needed to be better seen and then used to inform the plan for her care.

J’s placement in the residential unit was felt by some not to be meeting her needs and alternative placements were considered though no appropriate move was identified for her. There were clearly enormous challenges on a day by day basis for staff in caring for J in a residential environment to which she had made no commitment. In spite of their efforts staff were unable to

exert any real control over J and she remained at risk of harm because of her behaviour. Her care plan should have incorporated her need for protection and if necessary how that would be achieved. Had this element in her plan been appropriately extended, by means of a core group if necessary, it might have enabled those working with her to focus better on the risk and how best to manage it.

J had identified learning difficulties but presented as “street wise” and assertive probably masking not only her learning difficulties but also her great sense of loss and distress at her lack of a nurturing birth family. More was expected of J in terms of understanding the consequences of her actions than was probably reasonable and the fact of her learning difficulties was not raised as a factor in determining how best to engage with her or assist her.

J was, at the time of her death, a hard to help young person. However residential staff and staff in various other agencies continued to try to engage her and to work with her.

During the course of various agencies involvement with her J received some excellent and committed input though the use she could make of it was limited.

The damage to J was long term throughout her childhood and adolescence. It might have been minimised had a permanence placement been achieved for her on removal from her family. When this did not happen J became highly vulnerable turning increasingly to her birth family. The contact with birth family which is usually promoted for looked after children was not in J's best interest but it was nevertheless allowed to continue, inadequately managed at times, until it became impossible to control.

The SCRP concluded that while there was a known risk of overdosing in that J engaged in highly dangerous behaviours involving potentially fatal combinations of drugs and alcohol her death could not have been predicted. In addition it was the SCRP view that J's death could only have been prevented by her removal from the environment in which she could access alcohol and drugs and success in engaging her in altering her behaviour.

KEY RECOMMENDATIONS

The following single agency recommendations were made by individual agencies.

Children and Young People's Directorate

1. The Children and Young People's Social Care should increase the clarity of case transfer requirements in order to ensure that plans are maintained effectively.

2. The Children and Young People's Social Care should define contact arrangements clearly and ensure that they are easily accessible to new workers so that agreed arrangements can be better monitored.
3. The Children and Young People's Directorate should ensure that staff and foster carer training in relation to drug use includes the handling of medical emergencies and the issue of capacity to consent to treatment.

North West Ambulance Service NHS Trust

1. The Trust should review the Capacity to Consent Policy to ensure it is in line with all recent legislation and best practice guidance. This has been done and the Policy amended.

Greater Manchester Police

1. All incidents of alleged assault against children should be thoroughly investigated, led by the Police and a crime report submitted. A child's wish not to complain should not be taken at face value. This is Force policy and as such is covered by an expectation that policy is implemented.
2. During the investigation while the cause of death was ascertained it was not possible to identify the precise drugs taken as blood samples taken before treatment had been destroyed. The retention of pre-blood transfusion samples should be requested by the Police within the 7 day period of their retention by the hospital laboratory or, where fatalities are concerned, pre-blood transfusion samples should be retained by the hospital until no longer required by the Police.

The University Hospital of South Manchester

1. Training is being developed to ensure that all Trust staff have a good understanding of the appropriate safeguarding children policy and an understanding that it applies to children up to the age of 18 years. The issue will be raised at the Trust Child Protection Governance Group and work planned with the adult care department about safeguarding in respect of the 16 and 17 year olds.

MOSAIC

1. Screening and assessment for drug and alcohol use needs to be embedded in all services involved with vulnerable young people in Stockport. Staff in Children's Services should all be aware of the referral pathway into MOSAIC
2. Any agency involved with a young person, where there is knowledge of refusal to engage but where there is a clear risk assessment outlining vulnerability in respect of drug or alcohol misuse, should ensure that a referral is made to MOSAIC for support and advice for the carers.

Substance Misuse Services

1. The SMS and MOSAIC are already considering ways in which collaborative working can be improved. This case suggests that added emphasis should be placed on achieving interlinked assessments and interventions where parents and children are in treatment with respective services.

The SCRCP made the following multi agency recommendations.

1. The LSCB should develop a coordinated policy for dealing with high risk cases involving looked after young people. The policy must make clear that where a number of agencies are involved with a young person with complex needs, there is a core group set up to implement the care plan and a clear identification of the lead professional and appropriate core group chair.
2. The LSCB policy and procedure should reinforce the expectation that, whenever risk factors and the need for early intervention is identified by any agency, an appropriate specialist assessment takes place leading to an action plan to support carers linked to any necessary updates to the care plan and intervention for the young person.
3. The LSCB should introduce an explicit and more robust multi agency protection planning system within LAC care plans, implemented by means of a core group if necessary, and that the plan is comprehensively reviewed so that protection planning for children looked after is as rigorous and focussed as for those living in their birth families. Children with safeguarding needs which remain unmet in their placement should be identified by IROs and challenges raised.
4. The LSCB should amend its procedures for children who go missing from home/care to ensure that frequency of short episodes of looked after children who go missing from home merit a planning meeting as well as a long single period. This work has already started.
5. The LSCB should reinforce the expectation that all agencies participate in the Stockport substance misuse screening and assessment programme and monitor compliance. Staff should be trained and feel confident to deal with substance misuse by providing early intervention or referring it on to MOSAIC.
6. The LSCB should require a report to be compiled summarising best practice in respect of Looked After young people exhibiting challenging and disruptive behaviours and that it is used to inform future policy and the future training of workers involved with such young people.

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