BRIGHTON & HOVE

SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

'A'

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1 INTRODUCTION

1.1 EVENT TRIGGERING A SERIOUS CASE REVIEW & FAMILY BACKGROUND

1.1.1 On New Year's Day 2016 a 999 call was made and an ambulance was called to attend an unknown person lying on a railway track in West Sussex. The individual who was pronounced deceased at the scene, was later identified as 'A' (a White British male aged 17) who had been in the care of Brighton & Hove Children's Social Care since 2004 and who was a part-time student at a College of Further Education.

1.1.2 In A's early childhood, he had been exposed to significant levels of physical and emotional abuse and neglect in the context of chronic domestic violence. In more recent years, 'A' had made allegations of historical sexual abuse by a named family member.

1.1.3 Following his entry to care, several foster homes had been unable to manage his behaviours and 'A' (aged 8) had been placed in a therapeutic Unit in Kent. After further unsuccessful attempts to find a foster family that could manage his behaviour, he was (aged 12) placed in a therapeutic Unit in West Sussex and remained resident there until his death. There had been ongoing concerns about 'A's sometimes aggressive and denigrating behaviour, his fears and fantasies about a potential for committing sexual offences and (largely historical) concerns about self-harming.

1.1.4 Plans had been formulated during 2015 to transfer 'A' to a foster home. In November of that year, introductions had begun and what was intended to be a permanent transfer had been scheduled for a date in early January 2016.

CONSIDERATION OF A SERIOUS CASE REVIEW

1.1.5 In accordance with the Local Safeguarding Children Board Regulations 2006 and local agreed procedures, 'A's death was reviewed at a 'serious case review sub-group'. It was concluded that the primary criterion for initiating a 'serious case review' (reproduced in paragraph 1.2.1) was satisfied and a recommendation made to the independent chairperson of Brighton & Hove Safeguarding Children Board (Mr Graham Bartlett) that a serious case review be commissioned. Following further consideration and consultation, the chairperson ratified that recommendation and the Department for Education. Regulatory body Ofsted and the 'National Panel of Independent Experts' (NPIE) were then informed.

1.1.6 This serious case review was undertaken between July 2016 and January 2017. A Coroner's Inquest has been initiated and is currently adjourned awaiting further evidence.

1.2 PURPOSE & CONDUCT OF THE SERIOUS CASE REVIEW

PURPOSE

1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with *Working Together to Safeguard Children* HM Government 2015. A 'serious case' is one in which abuse or neglect is known or suspected and the child has died [as in this case] *or* been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

1.2.2 In this case, the original abuse and neglect occurred in 'A's earlier childhood but there were also more recent allegations of abuse and/or some indications of sexual exploitation.

1.2.3 The purpose of this review is to inform and facilitate learning and to identify required improvements in service design, policy, systems or practice amongst local or national services. Establishing the cause of death remains the responsibility of the Coroner.

CONDUCT OF REVIEW

1.2.4 The primary focus of the review was determined to be from the date in June 2010 when 'A' was transferred to his therapeutic community until his death. A summary of the period in which he had been resident there, was also sought from the former therapeutic unit. An independent report was commissioned from www.caeuk.org and it was agreed that the lead reviewer Fergus Smith would:

- Collate and evaluate material submitted
- Conduct any required supplementary enquiries
- Develop for consideration by the review 'steering group' a narrative of agencies' involvement, an evaluation of its quality and conclusions and recommendations for action by Brighton & Hove Safeguarding Children Board

1.2.5 The review steering group consisted of the:

- Lead Reviewer (chairperson)
- Head of Performance & Safeguarding Brighton & Hove Children's Social Care
- Interim Head of Safeguarding Children West Sussex County Council
- Representative of Sussex Police
- Therapeutic Unit Operational & Developmental Adviser
- Clinical Lead for Child & Adolescent Mental Health Services (CAMHS) & Safeguarding Representative Sussex Partnership NHS Foundation Trust
- Business Manager Brighton & Hove Safeguarding Children Board

1.2.6 The following agencies submitted material:

- Brighton & Hove Children's Social Care
- West Sussex County Council Children's Social Care
- Sussex Police Service
- 'A's Previous Therapeutic Community
- 'A's Current Therapeutic Community

1.2.7 Though the modest size of the second therapeutic community rendered it impossible to identify an author without some contact with 'A' in his 5 years of residence, the report submitted was developed by a sufficiently independent experienced professional and was comprehensive, sensitive and enquiring. Remaining reports were written by highly experienced individuals who had had no direct involvement with A or with the supervision or management of his case.

INVOLVEMENT OF RELEVANT PROFESSIONALS

1.2.8 So as to better understand judgements formed and actions taken by those with responsibility for 'A', an initial consultation event / briefing was undertaken. The purpose and approach to the serious case review was explained. Individual interview/s were subsequently completed with the following individuals:

Brighton & Hove Children's Social Care

- 'A's first allocated 'social work resource officer' (SWRO) who had worked with 'A' and his family from 2010 to 2014
- 'A's allocated social worker who was case-accountable from May 2014 onwards
- The supervisor and manager of 'A's social worker
- The independent reviewing officer (IRO) with case-planning oversight responsibilities since 'A's placement
- Service manager for agency placements
- Assistant director (responsibility for looked after children)

Therapeutic Community

- 'A's link-worker
- An ex head-teacher
- Psychotherapist
- Service manager
- Director

1.2.9 It later proved possible to complete a discussion by phone with the 'supervising social worker' of 'A's potential foster carers and a face to face meeting with the current manager of the relevant independent fostering agency (IFA). All those individuals, in spite of their personal feelings, were open and willing to consider lessons that might be learned from 'A's death so as to improve services for such extremely vulnerable young people. Sincere thanks are owed them all.

INVOLVEMENT OF BIRTH & POTENTIAL FOSTER FAMILY MEMBERS

Birth mother / grandmother

1.2.10 'A's mother was informed that her son's death required a serious case review and she responded promptly to an invitation to contribute. A meeting with her (supported by her own mother) was held. They provided a great many valuable memories of a young man to whom they remained committed in spite of extremely adverse circumstances.

1.2.11 At the family's request, consideration was given to the extent and quality of 'A's early developmental and educational assessments, the challenge of meeting the needs of a mother with significant mental health difficulties who had experienced extensive domestic abuse and the events that resulted over 12 years in 20 placements (representing 31 moves, many prompted by respective carers' need for respite).

1.2.12 The more historical issues identified by the family were explored by means of sourcing and considering records that described why and how 'A' and siblings were committed to care by the Family Court. Those documents also described the attempts made at that time to address mother's ongoing mental health difficulties. The lead reviewer and review steering group are satisfied that the issues referred to above had been adequately addressed already and that the focus on the period since 'A's placement at the Unit in which he spent the last 5 years of this life was appropriate. The lead reviewer also met 'A's mother and grandmother to share with them ahead of the Inquest, the results of this serious case review.

Potential foster carers

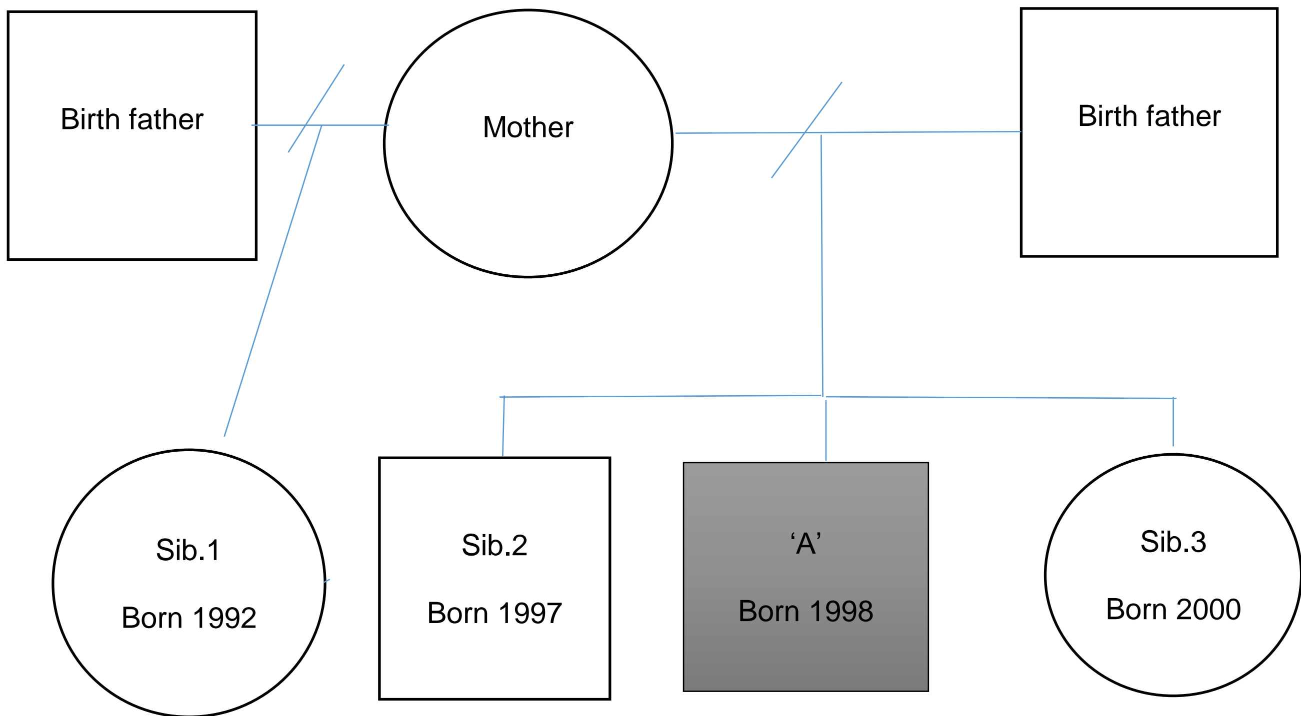
1.2.13 The female carer with whom (together with her husband) it had been hoped 'A' would live also contributed to the review. The author explored what background information had been provided prior to the placement decision being made, how introductions were being managed and how the carers were made aware of 'A's death.

1.2.14 The detail of the experiences and views of birth family and the selected foster carers is provided in the following report and the learning emerging from these contributions summarised in section 5.

PEN PICTURE OF 'A'

1.2.15 As well as his mother and grandmother who clearly loved and remained committed to 'A', and in spite of his troubled and troublesome behaviours, 'A' was very popular with those who worked with him. His charm, good looks, sporting prowess and dry sense of humour was commented upon by several of those who contributed to this review. 'A' himself appears to have been making great efforts *not* to become the sort of person whose sexually abusive behaviours had caused him lifelong distress.

FAMILY STRUCTURE



2 FAMILY HISTORY: EARLY EXPERIENCES OF 'A' IN FOSTER CARE & FIRST THERAPEUTIC UNIT

2.1 INTRODUCTION

2.1.1 Though the focus of this review is from 2010 to 'A's death, section 2 offers some explanation about when and why he first entered care and how his complex and extensive needs required specialist responses.

2.2 ORIGINAL ENTRY TO CARE & EARLY FOSTER PLACEMENTS

2.2.1 As a result of his mother's inability to provide safe, stable and suitable care (itself a consequence of long-term mental health difficulties and an associated susceptibility to violent partners) 'A' was voluntarily accommodated twice in 2004 under s.20 Children Act 1989. Care Proceedings were initiated in August 2005 and a final Care Order made in May 2006 by which time 'A' was 8 years of age.

2.2.2 Between 2002-05 there had been 3 referrals to Child and Adolescent Mental Health Services (CAMHS) (by health visitor, GP and social worker respectively). Mother failed to follow up offers of help in the first 2 instances and the subsequent conduct of Care Proceedings meant that no direct work was undertaken nor a definitive diagnosis determined, prior to 'A's placement described below.

PLACEMENT IN FIRST THERAPEUTIC UNIT

2.2.3 After over a dozen disrupted foster placements, it was determined on psychiatric advice that a 'non-familial' setting was required. 'A' was placed in a junior 'therapeutic community' in Kent and received education on-site until February 2008 when he began to attend a local mainstream Primary School. Planned contact with mother and siblings was maintained and, in spite of the anxiety and challenging behaviours associated with it, was seen by all to be of benefit to 'A'.

2.2.4 An investigation of 'A's disclosure in 2006 of historical sexual abuse whilst at home, could not be progressed because he was unwilling or unable to complete an 'Achieving Best Evidence (ABE) interview. The Unit reported 'A's frequent expressions of low self-esteem e.g. 'I am ugly; I am stupid; nobody wants me'. 'A' could though be comforted and reassured by those staff to whom he related well and his confidence level was regarded as having risen during his time at this Unit. Incidents of self-harm were minor and required no medical response e.g. hitting his head on the wall, scratching himself with his nails or (more rarely) with a broken cup or clothes hanger.

2.2.5 'A' also manifested aggression and violence which because of his age and size could be managed. They were usually in response to the imposition of boundaries and had all but disappeared by the end of his placement (with some re-emergence attributed to anxiety about a planned move to a foster home in early 2009).

FURTHER FAMILY PLACEMENTS

2.2.6 Fostering was raised as a possibility in September 2008, a suitable family identified by December and a transition plan developed and agreed by the Unit and Brighton & Hove Children's Social Care. 'A' met the selected family in January and, after several more visits moved to them in February 2009. This placement has been calculated to be his 17th (though there had been many more 'respite' placements required in order to offer carers a break, and inevitably meant for 'A', further discontinuity of care).

2.2.7 The 17th placement endured 13 months and was followed by an 18th in Kent lasting 3 months and a more local 19th emergency placement, after which residential care was again used as described below.

DECISION TO PLACE 'A' AT A SECOND THERAPEUTIC UNIT

2.2.8 In November 2009 a social worker referral had been made to the then provider of the local Child & Adolescent Mental Health Service – CAMHS (currently provided by the Sussex Partnership Foundation NHS Trust - SPFT). This sought therapy of a directive nature as recommended by 'A's first therapeutic community.

2.2.9 The plan being formulated was for some direct work with 'A' following consultation meetings with the carer. The clinical recording is poor and not of the standard expected by the Trust. The plan was not progressed as a result of the placement disrupting and 'A' being moved on as described below. No evidence with respect to the standards discharge process has been found.

Comment: *thus the need for CAMHS expertise had been discerned since 'A' was under 4 years of age. No diagnostic or therapeutic work had proved possible (though CAMHS* had *accepted and allocated referrals made and offered therapeutic intervention).*

2.2.10 The events that followed the wholly understandable and justifiable decision to identify a further appropriate therapeutic Unit, the issues arising from its use and plans for 'A's transition to greater independence are described and commented upon in section 3 below.

3 KEY EVENTS AFTER PLACEMENT AT SECOND THERAPEUTIC UNIT

3.1 INTRODUCTION

3.1.1 From amongst a *very* large volume of records generated across the review period, key events or milestones are considered below, year by year. Italicised comments about professional practice within and between involved agencies are included.

3.2 2010

3.2.1 There were no pre-placement enquiries made by the 'responsible local authority' (Brighton & Hove) of the 'area authority' (West Sussex County Council) in terms of the latter agency's ability and willingness to be commissioned to offer services such as reviews of special educational needs or child and adolescent mental health services (CAMHS). Interviews have confirmed that there was an assumption that the new placement could provide for *all* 'A's care, educational and therapeutic needs.

3.2.2 In June 2010 'A' was placed at his new 'Therapeutic Community Unit'. His allocated worker completed an initial visit to him (as required by regulation) within a week.

Comment: 'A*'s complex case was allocated to a 'social work resource officer' (SWRO) rather than a registered social worker as best practice (and by 2011, regulations) required.*

UN-AUTHORISED ABSENCES

3.2.3 On 02.08.10 the Unit notified the placing authority of an un-authorised 3 hour absence over the weekend. Records indicate that there were several other such occasions in 2010 though on all of them, 'A' returned without incident when found by staff or police officers. The report submitted by Police provides clear confirmation that the first episode in late July and all others were responded to efficiently and took full account of 'A's reported vulnerabilities.

BEHAVIOURS & FAMILY CONTACT

3.2.4 Though 'A' appeared to be relatively settled, there were incidents that illustrated his ongoing levels of distress e.g. on 09.08.10 staff were obliged to restrain him for about 10 minutes when he had lost control and was throwing objects and hitting out.

3.2.5 Contact with mother and siblings had been agreed at the point of placement and was further debated at the initial review. At a planned contact on 24.08.10 'A' proved unable to sustain a full 2 hours with mother and other family members and his allocated worker later discussed the implications of this with mother and staff.

STATUTORY REVIEW 1: AUGUST 2010

3.2.6 A sensitive and comprehensive report was provided and debated at S's first s.26 statutory review[1] on 12.08.10. Mother though invited, reportedly felt unable to be present. She was later offered an opportunity to be taken through the discussion held at the meeting. It has been confirmed that mother was always invited to reviews.

A SIGNIFICANT 'MISSING' EPISODE

3.2.7 On 10.09.10 'A' again ran away. On this occasion, the event seems to carry more meaning than the more simple and frequent 'absent without authority' episodes. 'A' had climbed out of a first floor window and was missing for about an hour. He later reported that he was trying to undermine his placement so that he would have to move on.

3.2.8 Because the independent therapeutic Unit is situated in West Sussex, the response to the report of 'A' being missing had been handled by Children's Social Care and Police in that County. Records of responses included some concern that staff had failed to notice the boy's departure, that the Home was 'untidy' and that 'A' was sleeping on the floor of his bedroom.

Comment: *these reports do not make it clear whether 'A' actually had a bed which he could have used (Unit staff have confirmed that he did*).

3.2.9 The allocated worker's response was prompt. She discussed the incident with the Unit and her own supervisor and visited 2 days later.

STATUTORY REVIEW 2: NOVEMBER 2010

3.2.10 In accordance with the relevant regulations, a second independently chaired review was held within 3 months on 25.11.10. 'A's mother was not present on this occasion though 'A' was and contributed. The allocated worker noted that 'A' struggled to accept that his difficult behaviours made it hard for others, especially foster carers to manage him – hence necessitating a residential placement.

3.2.11 Contact arrangements with 'A's mother and other relevant family members were discussed and clear plans agreed. 'A' confirmed that he had a copy of his 'Care Plan'[2] and understood it. His allocated worker had visited him on 7 occasions since his placement in late June.

Comment: *the frequency of visits was well over the regulatory minimum.*

[1] S.26 Children Act 1989 and associated regulations / guidance requires independently chaired reviews of those entering the care system to be completed after 20 working days, within 3 months of that date and thereafter at intervals not exceeding 6 months.

[2] Regulations require that normally before a child is placed and anyway within 10 working days, a 'Care Plan' must be developed; this plan reflects the intentions of the placing authority and the sort of information it must contain is also described in regulations.

3.2.12 Amongst the sensitive issues of concern during this period was that of 'A's birth father with whom there had been no contact since his very early years. It was unclear whether it would be safe to allow contact and that possibility was not pursued.

3.2.13 Before and for days after each planned contact with his mother, 'A' became very agitated and his behaviour more challenging. The allocated worker continued to make frequent visits to 'A'. Contact with (and in 'A's mind, the possibility of a return to), his last pair of foster carers was being considered. The carers were of the view though that resumed contact would offer false hope of a return to them.

Comment: *though not apparent from the review paperwork, supervision notes at this period refer to an intention to find 'A' a further foster home.*

3.3 2011

MANIFESTATIONS OF ANXIETY

3.3.1 On 04.02.11 an outburst by 'A' prompted a physical restraint by 2 female staff. Staff concluded that 'A' had been feeling 'uncontained' and was testing the extent to which females would be able to overpower him.

Comment: 'A*'s apparent need to assert control rather than be a victim of it characterised and explained many of his behaviours at this stage and as he moved into adolescence.*

3.3.2 During this time, 'A', though embarrassed by having to acknowledge it, was referring to some sensitive medical symptoms about which he did not want his family to be made aware.

FURTHER EPISODE OF RESTRAINT

3.3.3 On 22.02.11 the Unit reported an attack by 'A' on his then link-worker. The view was that he had been serious in his attempt to hurt him. Staff had restrained 'A' who was by then speaking more openly of his confused feelings toward his mother.

DISCLOSURE OF HISTORICAL SEXUAL ABUSE

3.3.4 'A' was interviewed on 10.03.11 about allegations made about a month earlier to a member of staff. The allegations centred on the sexual abuse of 'A' and others, by a man described by 'A' as his 'father'.

Comment: *the allegations had been shared immediately with the placing authority and appropriately triggered a strategy discussion with Police.*

3.3.5 During March 2011 there was further liaison between 'A's allocated SWRO and Police. 'A's maternal grandmother (MGM) and mother were made aware of the allegations. MGM stated that she had no knowledge of such events.

Comment: *it is clear that in spite of her inability to cope with 'A's high level of need, mother was consistently supportive of the care provided to her son by the Therapeutic Unit and has also acknowledged the support it extended to her*.

3.3.6 Mother and MGM provided names of 2 men who had had opportunities to abuse 'A' and others. Mother thought that one was more likely to be the perpetrator. In the event, and in spite of efforts by all concerned, 'A' felt unable to attempt an ABE interview until about a year later and Police investigations were delayed until then.

FURTHER EPISODE OF RESTRAINT / MINOR SELF-HARM & COMPLEXITIES OF FAMILY CONTACT

3.3.7 Reportedly because of his anxiety about a scheduled Police visit, 'A's behaviours on 08.03.11 prompted physical restraint lasting 2 hours. He had been very destructive and had cut his arm with a broken lightbulb.

3.3.8 MGM was unwell during March 2011 and there was considerable debate about the need and benefit of 'A' meeting older half-sister (sib.1) without his grandmother being present. 'A's feelings of anger coupled with protectiveness toward his mother made contacts with her challenging.

3.3.9 Reports from the Unit were of increasing levels of violence, an obsessional need for his link-worker to spend time with him rather than other residents and his growing awareness and jealousy of the more harmonious family relationships enjoyed by many others.

3.3.10 By April 2011 planned contact arrangements were rendered uncertain because of tensions between siblings and were finally postponed by staff and sib. 2's carers. 'A' was reported to be pre-occupied with medical difficulties for which he was awaiting surgery.

3.3.11 A Brighton & Hove social worker SW1 completed some direct work with mother at this time and established that she had herself experienced some early childhood trauma.

STATUTORY REVIEW 3: MAY 2011 & THREATS OF SELF-HARM / VIOLENCE

3.3.12 On 09.05.11 a 3rd review was completed. 'A' attended and contributed his views. Records indicate a consensus amongst those present that his placement remained the best option for the foreseeable future. 'A'. expressed a preference to remain rather than be found a foster family, though that *possibility* was recognised by the professionals at the meeting.

3.3.13 'A' appeared unsettled after the May review e.g. he punched his female link-worker in the face. The report supplied by the Unit refers to other serious assaults during the year including spraying boiling water at a female staff member and several occasions on which he kicked and punched staff. The Unit also reported threats of self-harm. At this time 'A' was also exposing himself to other young people.

3.3.14 On 19.05.11 a one-off consultation with an independent psychotherapist, focused on 'A's anxiety about his medical problem (a need for minor surgery was later confirmed).

3.3.15 The allocated worker continued her high level of visits to 'A' who was still considering whether to complete an 'Achieving Best Evidence' (ABE) interview with Police. A detective constable (DC1) made an arrangement to familiarise 'A' with the interview suite in advance of a formal interview and a joint visit at which the formal interview process was explained was completed by DC1 and 'A's allocated worker.

3.3.16 The Unit was considered to be managing 'A's anxieties and challenging behaviours and the focus of the allocated worker was making contacts with significant family members as constructive as possible. Staff were at this time seeking to assist 'A' to distinguish sexually exploitative relationships from those based on love and commitment. At about his time, his first link-worker informed 'A' that she would be leaving.

ANNUAL HEALTH ASSESSMENT

3.3.17 On 24.08.11 'A's first annual health assessment (a regulatory requirement) was completed. It noted (not wholly accurately) that he was in receipt of 'various forms of therapy'. 'A' had declined to discuss the 'growing up' section of the pro-forma used for these annual assessments (which would have offered an opportunity to explore issues of puberty / understanding of sex / sexuality).

MISSING EPISODE 3

3.3.18 On 24.09.11 'A' was reported as missing with £400 taken from the Unit's petty cash. He was found next day by Police and returned, when he assaulted head-teacher HT1 causing a 'black eye'. This was the only episode of 'A' being missing during 2011.

3.3.19 In September 2011 the needs for 'A' to have 1:1 therapy from an external source was recognised and (according to records) agreed.

Comment: *this 'agreement' is the first of several that illustrate a difference between practical time-focused expectations of Brighton & Hove (the responsible authority which commissioned the placement) and the therapeutically-minded provider Unit where implementation of any plan critically depended upon there being a consensus that the timing was optimal. Both perspectives were legitimate but the continuing failure to wholly resolve differing expectations represented a joint weakness of service delivery.*

PERSONAL EDUCATION PLAN (PEP) REVIEW

3.3.20 On 31.10.11, 'A's PEP was reviewed again. 2 previous such reviews had been completed (October 2010 and May 2011and had included the hope that 'A' might return to mainstream education, perhaps in 2 years). The records of this review noted that 'A's special educational needs (SEN) statement had been reviewed in July 2011 by the 'area authority' (West Sussex) and remained unchanged. The content of this latter PEP review focused (as had earlier such reviews) on behaviour and contained little educational material.

COMPLETION OF ELECTIVE SURGERY / SELF-HARM EPISODE

3.3.21 'A' underwent a successful minor operation, the nature of which though, evoked memories of previous traumas. 'A' claimed at this time to have self-harmed by drinking some fish tank cleaning fluid and went on a few days later to cut his forehead, arms and legs, also it was thought in reaction to the experience of the medical intervention.

3.3.22 Reports of 'A's behaviour at this time note his difficulties if anyone got too emotionally close to him. He appeared to be especially threatening and abusive to female staff. 'A' was also expressing anxiety about the heritability of his mother's mental health difficulties.

Comment: *it would have been helpful for 'A' to have been offered an informed view by a psychiatrist or clinical psychologist on the probability of him or his siblings experiencing mental ill-health.*

STATUTORY REVIEW 4: NOVEMBER 2011

3.3.23 At his 4th review which was attended by 'A' though not his mother, an improved ability to manage his own routines was acknowledged. 'A' confirmed at this meeting that he felt unready to undertake the required ABE interview. Efforts by Police to gather basic information e.g. when either of the 2 potential suspects were in contact with 'A' and his siblings continued but the investigation inevitably remained incomplete awaiting 'A's development of sufficient confidence to participate.

3.3.24 'A's mother was supportive of the Police investigation and of the arrangements being formulated by her son's allocated worker for ongoing contact with family members (mother, siblings, grandmother and maternal great-grandmother).

3.3.25 The allocated worker continued to maintain a high level of contact and her notes reflect a sensitive understanding of 'A's aggression.

3.4 2012

ASSAULTS BY 'A'

3.4.1 What had been physically destructive behaviour before Christmas 2011 escalated to significant violence in January of the New Year. On 09.01.12 'A' assaulted 2 female staff members punching both in the head and face. 'A' ceased his attack when male staff arrived. The incident was attributed to anxiety over the loss of his valued first link-worker. The SWRO disagreed with the decision made by the victims *not* to press charges (the Unit policy was to allow staff discretion with respect to their response and to support the decision made). The search for suitable off-site psychotherapy had not at this point produced a suitable provider

Comment: 'A's *conduct represented a significant risk of harm to staff and would have been (in many other contexts) considered criminal. The contrasting attitudes toward the behaviour offers a further example of a philosophical difference of approach which would later underpin and complicate the transition to greater independence*.

STATUTORY REVIEW 5: APRIL 2012 & SUBSEQUENT TRANSFER TO UNIT FOR OLDER BOYS

3.4.2 By April 2012 'A' was reportedly keen to transfer to a linked Unit for older boys. He was also pressing for more unsupervised family contact. Records of contact by his allocated worker and by Unit staff for the following few months seem largely focused on the intended transfer which was completed in September 2012.

STATUTORY REVIEW 6: OCTOBER 2012

3.4.3 On 12.10.12 'A's 6th review was completed, again chaired by the same reviewing officer (IRO1). 'A' attended as did his allocated worker and care and educational staff from the Unit (director, HT1 & virtual school representative VS1).

3.4.4 The meeting learned that there had been no recent outburst of violence and that 'A' was improving his ability to relate to others. Though the agreed plan was for ongoing residential placement with some possibility of a foster home, a later exchange between his allocated worker and the director noted 'A's wish to resume living with his mother when he became 16 years of age and his stated belief that she could look after him adequately.

3.4.5 Subsequent conversations failed to entirely shift mother from a well-meaning and certainly mistaken view that she *might* be able to cope with her son's return. Meantime an annual plan for contact during the following year with each family member was drawn up.

Comment: *contact arrangements, though complex, were typically clear and always rooted in 'A's best interests*.

MISSING EPISODE

3.4.6 'A' was reported missing only once during 2012 (in November). He had left accompanied by another resident and returned just after midnight having he reported, given up an attempt to walk along the beach to a nearby town. The number of times 'A' went missing increased sharply in the following year and the most significant episodes are described below.

3.4.7 Individual therapy had still not begun. Enquiries during the course of this serious case review suggests that the elapsed time was in part due to the challenge of identifying the best provider and in part a measure of 'A's perceived readiness (within the Unit) in the view of staff. The psychotherapist herself expressed her opinion to the author that 'A' would *not* have been ready sooner for what had been envisioned as twice-weekly, but instead became weekly therapy.

3.5 2013

3.5.1 Early in the New Year a social worker from East Sussex reported that 'A' had left a message on the phone of a former foster carer. The message appeared innocuous though the female carer had been upset because of 'A's previous (unspecified) behaviours. Days later after an unauthorised absence, 'A' phoned his mother and shared with her a list of concerns and anxieties about schooling, his placement and of a girl with whom he was 'in love'.

REVIEW HEALTH ASSESSMENT & INCIDENT OF SEXUAL EXPLOITATION

3.5.2 On 09.01.13 'A' was seen by a different nurse. A 'strengths and difficulties' (SDQ) questionnaire (a standardised instrument for recording needs) was given to his link-worker for completion 'if deemed appropriate at this present time'. It remains unknown whether this SDQ was completed. The nurse anyway recorded that 'A's emotional needs were being met within his residential Unit.

3.5.3 On the same day (it is presumed *after* completion of the health assessment, since its report makes no mention of the event) 'A' admitted that he had planned to meet a man whose number he had seen on a toilet wall alongside the message 'call for sex'. All relevant agencies were informed, a strategy meeting convened and a criminal investigation initiated with respect to a man whom 'A' indicated was middle-aged (the basis 'A' on which believed that, is uncertain). In spite of extensive enquiries, this man was not traced.

INCREASED FREQUENCY OF MISSING EPISODES

3.5.4 In response to the events of 09.01.13 the Unit recognised the heightened risk and required staff to immediately inform Police if 'A' ran away or was absent without authority.

3.5.5 At her supervision toward the end of January 2013, the allocated worker noted that 'A' was continuing to run away, mostly for short periods during which he met a variety of individuals. 'A's further response to his contact with the potential abuser was a mixture of fear and excitement which at times required staff to physically prevent him from leaving the Unit.

3.5.6 The agreed safety plan was that 'A' should not be out alone, though it was acknowledged that he was not complying with that expectation.

3.5.7 The report provided by the Unit refers to a decision made by 'A's allocated worker to allow unsupervised family contact from this point on. This is *not* confirmed in the records maintained by Brighton & Hove nor included in its report to this serious case review. Any such change should be the subject of planned multi-agency debate that includes child and parent.

3.5.8 A 'care planning meeting' was convened on 20.02.13 and 'A' and his mother attended. 'A' was reported to be in a pleasant and positive mood contributing well and showing 'great self-awareness'. He expressed a wish to return home but his mother was able to say that she thought he ought to remain at the Unit until he was 18.

3.5.9 Less than a month later the allocated worker learned at a visit that there had been a decline in 'A's engagement with school and that he was manifesting a misplaced confidence in his ability to manage (though there remained amongst those who knew him well, a belief that he knew really, that he was not ready for more independence).

3.5.10 In mid-March 2013 'A' learned from his birth mother that he had been the product of her rape. At this time he was saying to his family that he was bi-sexual, later gay. 'A' was said by his mother to have 'found his 'brother' via FaceBook' [the person in question was actually the son of sib.1's father]. Apparently as a further consequence of tracing this individual, 'A's birth father contacted his mother. She asked and he agreed, that he would initiate no further contact.

STATUTORY REVIEW 7: APRIL 2013

3.5.11 The 7th review which was attended by mother and 'A' generated no new issues. Discussions in Spring 2013 included thoughts of sourcing a family which might provide 'A' with a short-break from his residential care and offer some experience of a more age-appropriate level of independence. 'A' supported the idea but after further debate within the Unit, he was deemed unready for such an arrangement.

Comment: *contact with family members continued to be highly prescribed though increasingly and age-appropriately, less restrictive*.

MISSING FROM PLACEMENT EPISODES & FAMILY CONTACT

3.5.12 During May 2013 'A' was recorded as missing on 3 occasions (for over 4 hours, 3 hours and 40 minutes respectively). Contact with his family continued to be of importance. Some sessions remained supervised and others e.g. with his grandmother (MGM) were unsupervised. A proposal from mother's Adults' Services support worker that 'A' could visit his mother in her flat was considered and rejected though the reasons for that decision were not located in records.

3.5.13 'A' was anyway spending time after school with a friend who (*apparently* by chance) lived next door to his mother. Inevitably, levels of contact with her well exceeded the formally agreed arrangement. 'A's last episode of being missing during 2013 was in June. There had been 16 to that date, most associated with him meeting friends locally and all resolved by him returning to the Unit of his own accord.

REVIEW OF PERSONAL EDUCATION PLAN (PEP); DELAYED PSYCHOTHERAPY

3.5.14 At a further annual review of his PEP on 12.06.13 'A' expressed anxiety when the possibility of a college placement was discussed. He did though agree to visit a college when a suitable one was identified.

3.5.15 By September 2013 an external psychotherapist had been identified though sessions had still not started. Discussions between Unit director and allocated worker referred to a hope that 'A' would be ready to be fostered by the time he was 16 or 17.

Comment: *this option had been mentioned but not yet explored at a care planning or statutory review meeting involving 'A' or his mother.*

STATUTORY REVIEW 8: SEPTEMBER 2013

3.5.16 'A' attended his 8th review and had submitted his written comments to the independent chairperson (IRO1). Mother was also present and contributed. The worker's report contained the following entry….'It is felt this foster placement within a therapeutic residential home continues to be the most appropriate placement for 'A' at this time, the department shall be exploring the possibility of a foster placement as respite initially over the next review period'.

Comment: *the meaning of the first part of the sentence is very unclear; no respite family was anyway, ever identified*.

3.5.17 Records of 31.10.13 refer to concerns expressed by sib.1 about 'A's interest in the recent drowning of a young man of similar age. 'A', who had not known the victim visited the site and laid a rose there.

Comment: *this incident offers the first and arguably only example of any 'morbid preoccupation'*.

3.5.18 The allocated worker's supervision record for this period reflect a growing sense of frustration that the planned psychotherapy had not begun, a recognition that actual contact with his mother was nearer daily than the formally agreed once per month, and that a foster placement might be an overly ambitious plan given 'A's ambivalence.

SELF-HARM EPISODE

3.5.19 On 13.12.13 A required the insertion of stiches at a hospital A&E Department having (staff believed) deliberately cut his forearm. A room search revealed other blades hidden his room, as well as a mutilated baby doll that 'A' had been using for the purpose of sexual gratification. In a conversation between the director and the allocated worker, the former expressed concern that some of 'A's conduct was 'becoming dangerous' (a reference to these events and 'A's previously shared fears and fantasies).

Comment: *this was an early illustration of the greater level of concern felt by those within the Unit when compared with Brighton & Hove staff; at interview the director recalled feeling that 'A's profound disturbance was only being 'contained'. SWRO and to a greater extent successor SW2, focused on what 'A' could and (given his age) would increasingly be expected by society to be able to do.*

3.5.20 'A' was allowed an overnight stay with his mother at Christmas which was carefully planned and incident-free. The allocated worker visited 'A' on 24.01.14 and met with staff. Her account does not refer to any more behaviours that might reasonably be considered 'dangerous'.

3.6 2014

MISSING EPISODES & VIOLENCE REQUIRING RESTRAINT

3.6.1 ‘A’ was absent without authority on 6 brief periods in January 2014 (and once thereafter that year). On the first and most significant occasion his violence required 3 staff to hold him. Later, having been abusive and threatening ‘A’ and a fellow resident left the Unit. After several further disruptive returns to the outside of the Unit during the night, ‘A’ reported he had been assaulted by a peer and was collected. The incident was reported to local Police and Children’s Social Care.

3.6.2 Of the other 5 occasions of unauthorised absences in January 2014 records confirm that 3 were reported to Police. His link-worker in a subsequent conversation with the allocated worker referred to ‘A’s loneliness. In February mother reported that she had traced the children of her ex-partner and had to be dissuaded from pursuing revenge for what she regarded as him having ruined all their lives. The risk of ‘A’ getting embroiled with his mother’s grievances was recognised.

REVIEW HEALTH ASSESSMENT

3.6.3 On 30.01.14 the same nurse as in 2013 completed the routine health assessment. She noted that a ‘strengths and difficulties questionnaire’ (SDQ) had been completed and her completed form referred to stress, getting on with peers and behavioural difficulties. On this occasion sexual health was discussed though there is no indication that ‘A’ shared any fears about his developing sexual preferences.

FURTHER EXAMPLE OF SEXUAL EXPLOITATION

3.6.4 On 08.02.14 ‘A’ revealed he had been speaking to a man and exchanging intimate self-images via Facebook / Snapchat. The man claimed to have raped a child, sent some apparently sadistic images and made threats to ‘A’. Police responded and because the man lived abroad, involved Interpol. Exchanges between Police and link-worker acknowledged their concern about the possibility of ‘A’ becoming a perpetrator.

FURTHER ALLEGATION OF HISTORIC SEXUAL ABUSE & A REFERENCE TO SUICIDE

3.6.5 On 11.02.14 ‘A’ wrote extensively about memories of childhood sexual abuse. His mother later acknowledged the fact of his abuse, though named an alternative perpetrator to the one identified by her son. A strategy meeting was held. Tensions within the family were heightened during February when ‘A’ alleged that his siblings had been selling drugs during one of the unsupervised contacts. His mother acknowledged needing supervised contact. ‘A’ apparently spoke to her about suicide at around the time of a successful supervised ‘Mother’s Day’ contact, claiming he knew someone who had jumped to their death whilst Police were present.

STATUTORY REVIEW 9: MARCH 2014

3.6.6 On 13.04.14 'A's 9th review was held. 'A' attended and contributed. Mother was not present. The record again includes the mis-leading response (possibly 'copied and pasted') to the question 'what is the chosen care plan for this child?'- 'long term foster placement until independence - It is felt this foster placement within a therapeutic residential home continues to be the most appropriate placement for 'A' at this time and his mother'.

3.6.7 By April 'A's claims that he was bi-sexual[3] had become more assertive and he included this contention on FaceBook. The outstanding ABE interview was scheduled for a date in April but cancelled when 'A' (actually en-route to the event) felt unable to manage it.

ALLOCATION OF A SOCIAL WORKER

3.6.8 With effect from 13.05.14 a social worker SW2 from the 'Looked After Children LAC Team' was allocated. SWRO had made her farewell visit in mid-April and provided a useful summary of relevant issues. Aside from the still outstanding psychotherapy (according to Brighton & Hove, to be twice weekly) her summary offered no hint of the differing perspectives described below.

3.6.9 What emerged from interviews during the course of the review is that when SW2 subsequently obtained a post in the newly-formed 'Adolescent Pod', it was agreed that she should (for the sake of continuity) retain 'A's case. Similarly as later described, an element in the planning for a transfer to a foster home *prior* to 'A' being 18 was that it would ensure ongoing involvement by SW2 and IRO1 with whom 'A' was very familiar.

Comment: *the wish to minimise change for a young man who had already endured so much of it, was commendable*.

3.6.10 The first supervision record of 22.05.14 of SW2 notes that the Care Plan was for 'residential placement'. Records of reviews and supervision notes of both allocated workers are not wholly consistent in how they describe desired and anticipated future placements.

3.6.11 The analysis section of SW2's supervision record of 22.05.14 recorded …'current concerns about lack of education at current placement for 'A'. This is historical and Unit has not responded to decisions made at last PEP (Personal Education Plan). Provision by the school is inappropriate, school reports required. SW2 to follow up with the Unit to send school reports and evidence of work done with 'A'. BTEC application requested in October, still not done by school. SW2 to discuss with school for completion and submission of application. SW2 will visit 'A' on return from leave'.

[3] According to the Office for National Statistics (ONS) 1 in 30 young people (aged 16-24) in Britain identify themselves as lesbian, gay or bisexual. This is an increase from 1 in 38 4 years previously. The national average for all ages is 1 in 60 Release: Sexual Identity by Age Group www.socialsurveys@ons.gsi.gov.uk

Comment: *interviews have confirmed a fundamental difference of expectations; Brighton & Hove's Virtual School*[4] *(in particular newly appointed VS2) expecting clear educational targets and measured progress whilst the Unit's priorities were mood or behaviour-related ones, on the basis that only when self-esteem or motivation were sufficient could a pupil make educational progress*.

RE-CONVENED PEP REVIEW

3.6.12 What had apparently been a contentious PEP review in early May promoted a re-convened meeting on 30.06.14. The psychotherapy that had been agreed in September 2011 to be necessary had begun (nearly 3 years later). Recognition of the need for or availability of, other psychological or psychiatric perspectives does not appear in records at this time or subsequently.

3.6.13 'A' declined a planned contact with an unidentified family member in mid-July and was noted to have a lowered mood state. He was reported missing (for the final time that year) on an occasion in August when he chose to stay out at a friend's party. 'A' remained in constant contact throughout his absence and a return interview was completed by a duty officer from SW2's team and no concerns were identified.

Comment: *this episode and others like it also highlighted a difference of perspective and priority; SW2 regarding such conduct as typically adolescent and not of itself, necessarily indicative of the high level of emotional disturbance 'A' was enduring*.

STATUTORY REVIEW 10: SEPTEMBER 2014

3.6.14 'A' and his mother were present at his 10th review, the records of which added little to previous accounts of events and proposed responses. SW2's records dated 01.10.14 implied a more rigorous evaluation of progress. They referred to a 'lack of a coherent plan for 'A' to move on into less support' and the option of a further foster home was specified. At a supervision session with supervisor 2, there is increased emphasis on the need for 'A' to develop the ability to be more independent and upon his educational deficits.

3.6.15 As part of a corporate review in November of high cost placements IRO1 contributed his clear view that 'A' should remain at his Unit until he was 18 when a planned move to more independent setting would be justified. The case was debated at a 'Care Planning Panel' on 02.12.14 and a target date of 2015 was set for there to be further discussions with the Unit about 'A' moving to an alternative placement.

Comment: *panel records and reported experiences of operational staff provide sufficient reassurance that case planning was not being 'cost-led'*.

[4] Each local authority is obliged to maintain a 'virtual school' for its looked after children and the teacher/s who fulfil that function will support, promote and monitor educational progress for pupils who may be placed in a wide variety of educational settings within and outside of the responsible local authority.

3.7 2015 / 16

3.7.1 In early 2015 the Unit described 'A's behaviours as 'pretty horrid at the moment'. 'A' was still attending a local college 2 days per week. Staff referred to him feeling very sad and experiencing lots of loss. As a result of an incident around Christmas at his mother's home 'A' was feeling hostile toward her and there was very limited contact for 3 months. HT1 had met with a 'youth employability adviser' and options for educational and training needs were addressed.

A SIGNIFICANT CASE DISCUSSION: JANUARY 2015

3.7.2 On 30.01.15 a meeting was held involving SW2, IRO1 and supervisor 2. A meeting with the Unit was planned and a 'pathway to independence' contemplated. This was thought likely to involve increasing time without Unit staff support at the college for some 6 months, unaccompanied trips to meet his mother, joining groups / clubs and being referred to a local youth organisation for lesbian, gay, bisexual and transgender (LGBT) young people.

3.7.3 The planned meeting was held on 09.02.15 and involved HT1 and the service co-ordinator (and author of the report to the SCR). Its record cited the possibility of a planned move to a foster home by the time 'A' was 17 and a move to supported lodgings by his 18th birthday. It was agreed that 'A' would need a resilient, enquiring carer because some of his 'denigrating' behaviours could leave carers feeling wretched.

3.7.4 Records also captured a consensus that 'A' doesn't need another family, he is quite clear he already has a family'. The notes reflect a collective concern that ...' if we leave it much longer, he will be too old & would instead be referred to "supported accommodation" which is less likely to meet his needs'.

3.7.5 Interviews completed during this review clarified the intentions of the case planners viz: if 'A' was in a family ahead of his 18th birthday he would eligible for 'staying put' (post 18 support). A further and helpful element of planning was that his former allocated worker (SWRO) would be re-allocated to become his 'personal adviser' (PA) (a role required by the Leaving Care Act 2000 and associated Regulations).

CONTENTIOUS REVIEW HEALTH ASSESSMENT

3.7.6 At a consultation on 12.02.15 with a third nurse, 'A' raised a concern he might be dyslexic. According to Unit records, 'A' also reportedly discussed having had unprotected sex and (as well as taking a sample for Chlamydia testing) the nurse provided him with 3 condoms. Unit staff who dealt afterwards with a very confused and anxious 'A' thought the nurse had insufficient awareness of the young man's special circumstances or needs. The records made by the nurse refer *only* to a 'discussion on sexual health', did not capture with whom 'A' had had intercourse (e.g. age / age differential or gender) and there is no indication that she had been briefed in advance about his specific anxieties or needs.

3.7.7 HT1 believed that the risk of unacceptable behaviour had been increased by the way the health appointment had been handled.

Comment: *there was clearly scope for more effective liaison between health and care professionals so as to offer relevant health care / advice without adding to 'A's already high anxiety levels. Of the several Unit staff interviewed by the author, HT1 expressed the greatest level of fear about 'A's potential for harming more vulnerable individuals (and for his sexual exploitation).*

3.7.8 'A' was maintaining a consistently high level of college attendance though was challenging within the Unit. Staff described him as talking about the future a lot. Whilst still in phone contact with his mother, there had been only 1 face to face meeting since Christmas.

DIFFERING VIEWS ABOUT 'A's LONGER-TERM NEEDS

3.7.9 During a conversation between SW2 and service & operations co-ordinator about 'A's Pathway Plan, the latter indicated that the Unit did *not* support the idea of a move to foster care. Staff had *not* (as had been agreed at the February meeting) discussed the plan with 'A'. This was followed up by an email on 09.02.15 in which it was argued that 'A' was 'too intense for 1 person to manage; there was an ever-present threat of violence and that the proposed timescales left insufficient time to prepare him for such a radical move.

Comment: *the Unit had been represented at the February meeting and received notes of it; their response indicates that their objections had not been convincingly argued or anyway completely resolved on 09.02.15; interviews during the course of this review indicate that the Unit was a reluctant (though in the final analysis, willing) partner in the plan for a foster placement.*

STATUTORY REVIEW 11: MARCH 2015

3.7.10 A 'Pathway Plan Review' meeting (a formal review of those of 16+) was held and included SW2, IRO1 (chairperson and note-taker) and 2 Unit directors. Differences of opinion about 'A's readiness for greater independence / placement in a non-residential environment were debated. The record of SW2's supervision a week later by supervisor 2 acknowledged doubts amongst residential staff but reflected an even more explicit and determined stance viz: that 'A' *would* move by his 17th birthday to a suitably matched foster home. On 23.03.15 a report was submitted to Brighton & Hove's Placement Panel which acknowledged remaining differences of opinion but approved the plan to which Brighton & Hove Children's Social Care was still committed.

3.7.11 'A's reported understanding of a meeting with SW2 on 25.03.15 was that the advantage of being fostered before he was 18 was that he might remain there until he was 24. If he stayed at the Unit, he would need to leave when 18 and subsequent options would be less clear.

Comment: *the debate between commissioner and provider seems to have resulted in more polarised positions rather than a negotiated consensus; 'A' himself appeared unhelpfully confused by the apparent choices.*

3.7.12 On 13.04.15 IRO1 (who chaired *all* ‘A’s reviews and knew him well) emailed SW2 to state that the Unit would need to retain and offer a level of continuity after a transfer to alternative care. At interview, he confirmed (as did others) that such continuity was contemplated by means of continuing his college attendance, post-discharge weekly psychotherapy and regular contacts with ‘A’s link-worker.

FURTHER REVIEW OF PEP / EDUCATION & HEALTH CARE PLAN

3.7.13 The annual review of ‘A’s special educational needs (SEN) statement (now called Education & Health Care Plan (EHCP) suggested the Unit was perhaps still confused and not wholly behind the authority’s plan. A further ‘professionals’ meeting’ sought to address remaining differences. It was attended by all relevant parties (in February the Unit has been represented by HT1 and service manager only) including a representative of Brighton & Hove’s ‘Children’s Placement Team’ CPT1. Notes (written by supervisor 2) indicate that:

- …’it was clear throughout the meeting there are still concerns about the proposed move for ‘A’ when he is 17. Clearly his behaviours can be difficult to manage once he has moved out of his comfort zone and this would be difficult for one foster carer to manage alone. Agreed the placement would need a lot of additional support. ‘A’ has engaged well at the Unit and it was agreed it would be ideal if he could continue with the same therapist when he moves. CPT1 advised that the right match needs to be found and they would recommend a referral be put forward for a foster placement in August to start a search. The move would be done in a planned way around his 17th birthday, with Unit remaining involved and supportive

Comment: *fostering has been spoken of as a possibility in late 2014 and records of February and March joint agency meetings in 2015 include references to that aspiration, albeit without precise timescales*.

3.7.14 A director offered a succinct and challenging view stating that… ’the fact is that ‘A’s deep disturbances around ordinary family life cannot be worked out within it’. In response to a request for her views, ‘A’s psychotherapist wrote:

- ‘My clinical opinion is that ‘A’ is still greatly in need of the containing function the work of the Unit provides through daily, ongoing and intensive therapeutic care. ‘A’ is at risk of regressing to his highly disturbed past behaviours. He needs a very well thought out plan and preparation for his introduction and integration to specialist foster care. Even with this, I believe that the intensity of his needs and ways of relating, which can be extremely denigrating and threatening, will remain a challenge to meet in a foster placement. This is more likely to succeed with careful preparation and with Unit staff providing support, continuity and outreach services….’

3.7.15 At interview, the psychotherapist expressed surprise that what was determined to be a suitable foster home had been identified so soon. She highlighted the not unusual contrast between ‘A’s assurances to his social worker that he did wish to be fostered, with comments to trusted staff that he did not.

Comment: *the psychotherapist’s surprise is shared by the author; for ‘A’ to be safely contained within a family was a very substantial challenge*; *that said the options for a young man such as ‘A’ who would inevitably require ongoing support but had no diagnosed condition, were extremely few in number.*

3.7.16 The psychotherapist had expected a longer introductory period. ‘A’ had been aware of the plan for some months and had been introduced to and visited the family on 2 subsequent occasions, but (as described below) he was told only a week before Christmas of the final move scheduled for the New Year.

3.7.17 The psychotherapist’s weekly sessions with ‘A’ had not identified any grounds to fear intentional self-harm or suicide. Her anxiety had been about an ongoing risk of sexual exploitation and of the young man being unable to resist acting out some of his violent sexual fantasies.

ALLEGATION OF SEXUAL ABUSE BY MEMBER OF STAFF

3.7.18 On 15.07.15 the Unit reported an allegation from a resident that a member of staff was having a sexual relationship with ‘A’. The staff member had been suspended and an appropriate referral made to the relevant West Sussex ‘local authority designated officer’ (LADO).

3.7.19 A discussion between director and SW2 indicated that ‘A’ had made no allegations but spoken of ‘fancying’ the member of staff concerned. A strategy meeting was convened and subsequent joint investigations involving ‘A’ revealed no allegations of abuse and confirmation of some ‘flirting’ on his part. The end result of this investigation was that the member of staff was wholly exonerated and reinstated.

3.7.20 On 14.08.15 ‘A’ went missing briefly whilst on a holiday caravan site. Staff were concerned that he was with younger children whom he had met. Police were notified but ‘A’ returned of his own accord just after midnight and no offences were alleged or disclosed.

3.7.21 At this period, ‘A’ reported in a phone conversation with his previously allocated Brighton & Hove worker (with whom for unknown reasons he was speaking) a preference to move into foster care as soon as possible. In early September SW2 was told by a Unit manager of the still fragile mother-son relationship.

Comment: *though it varied across time, the underlying quality (attachment / confidence) of ‘A’s relationship with mother / sibs. appeared little changed.*

REFERRAL FOR A LONG-TERM FOSTER HOME

3.7.22 In early October 2015 SW2 had completed a referral form (which was approved by her manager) and submitted it to the local authority's 'Children's Placement Team' (CPT). The referral included a reference to, though offered little detail about, the anxiety felt by 'A' concerning thoughts of harming females and a possible sexual interest in children.

3.7.23 References within the referral to self-harming were only to scratching / cutting of his arms and (understandably in view of the history of more recent years) no ongoing risk of such behaviour or anything more serious was identified.

3.7.24 The referral form indicated that sexualised conduct had not been an issue since 2007 and that physical violence toward carers was not an acknowledged risk. These assertions were at odds with sexually concerning behaviours and overt violence (inflicting actual bodily harm) toward female staff during 2011 as well as the risks articulated by Unit staff in meetings during early 2015.

Comment: *for a referral of an individual with such complex needs, the request to identify a suitable placement by November was very ambitious; the extent to which, in seeking a suitable match, an in-house team or (as in this case) an independent fostering agency (IFA) provider ensure that they share* all *available information with the selected carers is of vital importance in terms of the prospects of the placement sustaining across time*.

3.7.25 The referral by SW2 recognised and spelled out the agreed need to sustain the therapeutic weekly input to which child 'A' was said to be committed. On 29.10.15 IRO1 completed a visit to 'A' who spoke of the proposed move and his wish that it *not* be rushed. 'A' had not seen his mother for a few weeks and was having no contact with siblings at this time.

STATUTORY REVIEW 12: NOVEMBER 2015

3.7.26 On 02.11.15 'A's last formal review was convened. Mother and 'A' were present (the latter for only the second half) and contributed fully. Both expressed some uncertainty about the planned transfer to a foster home which was contemplated 'in the New Year'. Neither gave any indication that it represented sufficient threat to trigger self-harm.

3.7.27 A query from the Unit director of what would happen if a suitable placement was not located was left unresolved i.e. records do not describe a contingency position (a plan B) understood and agreed by all parties.

INTRODUCTIONS TO POTENTIAL FOSTER CARERS

3.7.28 The Independent Fostering Agency (IFA) that identified a foster home submitted a description of the recommended carers (a mature married couple) to Placement Team staff CPT1 and CPT2. They used an established matching system and evaluated the placement as ‘suitable’ on 02.11.15.

Comment: *information provided about the carers included reassurances about experience and ability to deal with those at risk of sexual exploitation; it did not refer to their knowledge of or likely ability to withstand, still-evident denigratory conduct nor (even more critically in the context of possibly frequent physical contacts by grandchildren) ‘A’s fears and fantasies about sexual abuse of children.*

3.7.29 The couple having been made known to SW2 on 02.11.15, she visited on 17.11.15. SW2 was initially uncertain of their suitability but an opportunity for ‘A’ to meet them was arranged for 01.12.15. In response to a request by the carers for relevant information, a list of examples of ‘A’s denigrating comments / conduct had (after a delay) been emailed on 23.11.15 by the Unit to SW2.

3.7.30 The author has seen an email thread indicating that 2 days later SW2 forwarded the above list to the IFA’s supervising social worker SSW1. She in turn confirmed to SW2 that she had forwarded it to the carers, and has provided evidence of so doing. The safe receipt of that email by the carers remains unconfirmed (the carer has no memory of seeing it). It is though accepted by all parties that the issue of ‘A’s capacity to be denigrating *had been* discussed with the carers.

Comment: *though useful in their own right, the examples of ‘denigrating conduct’ represented only a proportion of the information that should have been provided in advance of ‘A’s move.*

3.7.31 The introduction on 01.12.15 is reported to have gone well and further short visits were planned – the next being on 07.12.15. ‘A’s link-worker was present at the initial meetings with the carers and noted that they had been unaware of the large number of previously disrupted placements (‘A’ himself shared that information).

3.7.32 SW2 asked the Unit to formulate and provide dates for further introductory visits and required a final move by 08.01.16. A ‘Transition Plan’ was supplied by the Unit on 11.12.15 or 14.12.15 [reports vary]. It confirmed its commitment to ongoing support after ‘A’ moved on. ‘A’ was at that time making positive comments about his potential carers.

3.7.33 Further visits were planned with a view to transfer on 08.01.16. On 18.12.15 ‘A’ spent a whole day with the intended carers. He was told that evening during the course of a ‘farewell’ meal for HT1 (with whom ‘A’ had been close) of the agreed transfer date (previously agreed by SW2 and link-worker in early December).

Comment: *'A' should preferably have been informed at an earlier and less emotionally-charged period of the previously agreed date of his transfer; Christmas is not generally an auspicious time to effect major changes*.

3.7.34 At the author's meeting with the female carer as well as in a later phone conversation, she could not recall being been told of 'A's attacks on female staff at the residential Unit. She was aware of and untroubled by 'A's thoughts of being gay or bi-sexual. She reported that she remained unaware of the risks of sexual exploitation *or* 'A's fears of becoming a paedophile. The latter issue *had* though been included in the referral form submitted by SW2 to her Children's Placements Team and (as recalled by both social workers) been raised with the carers.

3.7.35 The author undertook investigation of information flow with respect to:

- What (aside from the referral) had been passed by SW2 to her department's Children's Placement Team (CPT)
- How much of the information provided was subsequently shared by that team and/or by SW2 with the selected independent fostering agency (IFA)
- What had been shared by the IFA with its nominated carers in advance of the introductory meeting or later
- Alerting the carers to 'A's persistent anxiety that he might be capable of sexually abusing children
- Formulation of any written risk assessment that recognised and sought to mitigate identified risks

3.7.36 The 'IFA's 'supervising social worker' SSW1 had been unwell during the course of this serious case review and unavailable to confirm or amend the extent of briefing with respect to the planned placement. On her return to work SSW1 was able to:

- Report that the agency's normal practice in response to a potential 'match' is to read out the entire referral form to a carer (in her opinion a colleague would have done so and confirmation that this is now standard *recorded* practice was provided by the registered manager during his meeting with the author)
- Confirm that in a meeting with the carer (SW2 had *not* been present) that she *had* discussed the potential risk with respect to the children of the carer's daughter. So as to reduce risk, contact between grandparents and children was contemplated at the latter's' home rather than at the grandparents' house

3.7.37 SSW1 accepted that a copy of the referral form had not been left with the carers, nor any risk assessment committed to paper. She was un-surprised to learn that Brighton & Hove had not provided written material ahead of the transfer, indicating that this was a frequent experience across local authorities.

3.7.38 In spite of information latterly supplied by SW2 and SSW1 (including a record of the visit made on 17.11.15 by the former), it remains the carers' perception that they remained unaware about 'A's persistent anxiety about sexual predilections. and had been given no written material from either Brighton & Hove or their IFA.

3.7.39 An interview with 'A's link-worker confirmed a discussion also recalled by the carer (and contained in a handwritten 'running record / diary' of introductions, completed and returned following 'A's' death). It had referred to 'A' joining her whole extended family (i.e. including the carer's daughter and her 3 children) at a 'Center Parcs' half-term break.

Comment: *amongst those involved, there were differing levels of understanding and acceptance of the potential risks that 'A' might represent; there was a need to complete a clear risk assessment spelling out precautions needed to minimise the risks that 'A' potentially represented*.

3.7.40 'A' had, after his introduction to the carers expressed anxiety to his link-worker about what he surmised they had *not* been told about him. Quite understandably, he lacked the confidence and had not wished to undermine the possibility of acceptance by sharing *all* his fears and fantasies.

Comment: whilst *SSW1's recollection is that the carers* had *been made aware of the potential risk that A represented; 'A' would not have known that and would inevitably have assumed that his potential carers had been denied this important information. It is important that those being placed are clear about what information has been / is being shared with carers.*

EVENTS ON DAY 'A' DIED

3.7.41 The Police report submitted provided a succinct account of the events immediately preceding 'A's death on New Year's Day 2016 when he and other residents were out with staff at a local fast food restaurant. In the author's view it is unnecessary to provide detail in a document that is to be made public. It does though seem possible that an incident involving 'A' and a younger fellow resident reminded 'A', of his fear of committing sexual offences against younger children.

3.7.42 'A' immediately left the scene and his responses to texts sent by staff implied a clear intent to self-harm. The last such message was at 18.02 and within a further 10 minutes Sussex Police was notified of a person (later identified as 'A') under a train at a level crossing.

3.7.43 Meanwhile, at 18.00 the West Sussex Emergency Duty Team had been alerted to 'A' being 'missing'. 1 hour later the team was informed that Police had attended and reported with 99% certainty that a person killed by a train near a local station was 'A'. Mother and the on-call manager for Brighton & Hove Children's Social Care were informed. Mother and sib.2 confirmed receipt of a text from 'A' at about 17.30 though its content was not shared at that time.

3.7.44 'A' had been due to be taken by his link-worker for his first overnight stay with the carers on Sunday 03.01.16. When he failed to arrive, they were disappointed and assumed he had changed his mind. They did not call the residential Unit (SSW1 believes that they did not have the phone number) and instead awaited clarification of 'next steps'.

Comment: *'A's tragic death occurred on a Public Holiday and SW2 did not learn of the event until Monday 04.01.16; she immediately informed the involved IFA and the potential carers were made aware of 'A's death when SSW1 made an urgent visit later that morning*.

3.7.45 The carers were also disappointed that they were not informed of or invited to, 'A's funeral which they would have wished to attend.

Comment: *the author has subsequently learned that the birth family insisted on nobody outside of the family attending the funeral. That understandable stance should not have prevented the carers being informed about the familial view (which they report they would have respected and accepted).*

4 RESPONDING TO THE TERMS OF REFERENCE

4.1 QUALITY & TIMELINESS OF CARE PLANNING

PREPARATION & PLACEMENT AT ‘A’s THERAPEUTIC UNIT

4.1.1 At the time of ‘A’s placement at his therapeutic Unit, the Care Planning, Placement and Case Review (England) Regulations 2010 had been published, though came into force only in April the following year.

4.1.2 The above regulations reflected established best practice and thus sought to maximise the opportunities for rehabilitation or where that was not possible, a local family-based placement.

4.1.3 The justification for the use of specialist residential care for ‘A’ was overwhelming. ‘A’ was, and arguably remained, incapable of coping with the intensity of emotional demands that prevails in most families.

4.1.4 Though his ‘out-of area’ placement pre-dated the ‘Care Planning Regulations’ requirement for approval of a ‘nominated officer’, the reviewer has no doubts that the decision-making with respect to ‘A’s need and authorisation of expenditure were properly completed.

4.1.5 The fact that the independent placement at the Unit in West Sussex endured for 5 years offers sound evidence that the choice of placement was a well-informed one. The safe consistent care and unconditional commitment shown him by staff enabled him to make (notwithstanding his un-timely death) substantive developmental progress.

4.1.6 Whilst acknowledging the justification for and effectiveness of the placement at his Therapeutic Unit, no evidence has been presented to confirm *any* preparatory enquiries of the ‘area authority’ in terms of educational or psychological / psychiatric support.

SUPPORT & OVERSIGHT OF PLACEMENT

4.1.7 Though the allocated ‘social work resource officer’ SWRO was clearly very committed and competent in meeting the many and varied needs of ‘A’ and his family, such a complex case should have been allocated to a registered social worker. A check of published reports has confirmed that Ofsted in its inspections of Brighton & Hove in 2011 and 2013[5] had also identified and challenged this issue. The author has been assured (and a more recent Ofsted report confirms) that all looked after children are now allocated a registered social worker.

4.1.8 Setting aside the issue of her qualification, the continuity of support from SWRO coupled with the consistency of his independent reviewing officer (IRO) were helpful to ‘A’.

[5] See reports at www.ofsted.gov.uk/

4.1.9 IRO1 developed and maintained a constructive professional relationship with ‘A’ and records confirm that ‘A’ (and to the extent possible by her level of functioning at any one time) his mother were invited to contribute to all statutory reviews.

4.1.10 IRO1 also fulfilled a less obvious and more informal role particularly during the planning of ‘A’s move to a foster home. IRO1 and Unit director met and undertook broader (unrecorded) discussions about the challenge ‘A’s needs and insufficiency of resources posed.

4.1.11 Paradoxically, the reflective and considered approach of these highly experienced professionals may have further reduced the possibility of an explicit challenge by the Unit of Brighton & Hove’s plan.

TRANSITION PLANNING

4.1.12 A retrospective examination of records and the reflections of involved professionals highlights the anxiety felt by ‘A’ himself and a proportion of adults seeking to work in his best interests.

4.1.13 Most residential staff, ‘A’s psychotherapist and to a lesser extent IRO1 and SW2 were initially uncertain about the prospects of ‘A’ being able to make the transition to a semi-independent life outside of the total institution in which he had spent formative years (in consequence becoming dependent and somewhat institutionalised).

4.1.14 Though the doubts of various individuals were articulated in various planning forums, they were never entirely reconciled and shaped into a clear consensus. In the mind of the reviewer, there were 2 distinct and in their own right legitimate narratives being played out in the months prior to planned discharge.

4.1.15 The commissioning local authority initially via its ‘Care Planning Allocation Panel’ addressed the ‘outer world’. It perceived an age-related need for ‘A’ to achieve a degree of independence via a route that maximised continuity of professional input (SW2 and IRO1) and would attract a right to post-18 ‘staying put’ support.

4.1.16 Those whose relationship was a close and more personal one (residential staff and his psychotherapist) developed an alternative perspective. They sought to distinguish what they interpreted with considerable anxiety to be a façade of confidence, from the continuing turmoil in ‘A’s inner world and the risks that would ensue for him (via sexual exploitation) and potentially others (*if* he were to act out his sexual fantasies).

4.1.17 A more robust dialogue perhaps involving formal challenge or complaint *might* have rendered more visible and accessible the experience over 5 years of ‘A’s characteristic responses i.e. that fear of rejection and/or loss of control typically prompted him to appear more confident or competent than he actually was. A challenge *might* also have prompted the commissioning of an independent opinion (see below).

4.1.18 'A's inner world was typically revealed only to those whom he knew extremely well and trusted. Unhelpfully, such trust was often made evident by aggressive or rejecting conduct.

4.1.19 The therapeutic Unit itself is accredited by the Royal College of Psychiatry and staff receive regular supervision and support from appropriately registered sources e.g. Tavistock Clinic & Portman NHS Trust . It appears that the very real professional competence and confidence within the Unit coupled with a presumption amongst Responsible Authority staff (including IRO1) that the Unit had sufficient expertise mean that the possible need to seek additional (including psychiatric) opinion about 'A' and his prognosis was not considered at any of the many meetings such as statutory reviews.

4.2 EFFECTIVENESS OF INTER-AGENCY CO-OPERATION

Unit – Police

4.2.1 The reports from the Unit and Police refer to a total of 27 calls made to report 'A' as absent without authority or missing. Accounts provided offer sufficient confirmation that all episodes were handled in a sensitive and proportionate manner by both agencies. Aside from the responses of uniformed Police to reports of 'A' being absent / missing, the 'Safeguarding Investigations Unit' (SIU) collaborated well with the Therapeutic Unit and made all reasonable efforts to enable 'A' to complete an ABE interview about his alleged historical abuse.

Unit – Responsible Authority

4.2.2 Until early 2015, records and feedback from those interviewed provide reassurance that the level of inter-agency co-operation was across time, very good. As highlighted by Brighton & Hove's report submitted to this review, in spite of numerous dramatic incidents which had the potential to 'split' the adults working to safeguard and promote 'A's welfare, the following few were the only ones that potentially undermined that co-operation:

- The Unit's stance of allowing staff who had been assaulted to determine whether they would make a formal allegation of crime
- An insufficiently explored or challenged delay in initiating the psychotherapy agreed in 2011
- Concerns about the very limited educational offering to 'A'
- (Of greatest relevance) the differing perspectives and level of concern about the risks that 'A' faced and represented as he moved toward a foster placement in late 2015

4.2.3 Of those potential challenges, the first one might usefully have been established by commissioners *prior* to the placement. The dilemma of balancing the interests and rights of children and staff remains in all such placements (according to a House of Commons Committee[6] and Howard League for Penal Reform, the more typical and in their view unhelpful, response to less serious conduct than that displayed by 'A' would be to criminalise it[7]).

4.2.4 The delay from 2011 to 2014 before initiation of psychotherapy (as described earlier in this report) offers an example of a discernible difference in organisational culture. From the Responsible Authority perspective, the service should have begun as soon as possible but in any case by the time of the next review. From the perspective of the residential provider, the delay not only reflected the superficial difficulty of identifying an appropriate psychotherapist but more importantly, a considered judgment about 'A's capacity and willingness to engage with such therapy. In the view of the psychotherapist herself , 'A' would not anyway have been able to make use of the therapy he received any earlier than it began in 2014.

4.3 EXTENT TO WHICH 'A's 'VOICE' WAS HEARD

4.3.1 In his early years, 'A's voice was relatively inaudible because the vast majority of contacts by professionals were with his mother. The psychiatric opinion which reinforced the commissioning of residential therapeutic care *was* a function of his behaviours and had been provided by a skilled and experienced specialist.

4.3.2 It is clear that 'A' was *fully* involved by SWRO, SW2, residential link-workers and teaching staff. This is apparent from records of regulatory visits to the Unit, everyday dialogue with link-workers, daily 'house meetings' and regular LAC reviews (where his wishes and feelings were sought before and during meetings).

4.3.3 The more significant challenge faced by Unit staff and the Responsible Authority was how and to what extent 'A's expressed and variant views should be weighed against his non-verbal wishes / feelings. 'A's feedback to Unit staff of a meeting in March 2015 with SW2 does suggest that 'A' was confused about the apparently stated advantages of a foster home over further residential care viz: a potential home until his 25th birthday versus leaving the Unit at 18 with no certainty.

4.3.4 The planned transfer date of 08.01.16 was arguably arbitrary though the author is satisfied that it was not shaped by financial concerns about the costs of 2 contemporaneous placements. 'A's voice (via feedback after each contact with the carers) should have been more prominent. Such opportunities were diminished by an unfortunate coincidence of Xmas and SW2's annual leave.

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[6] In 2013, the House of Commons Justice Committee concluded that more effort was needed from local authorities, children's homes and prosecutors to prevent the unnecessary criminalisation of vulnerable children in care and care leavers.

[7] More recently (2016) the Howard League for Penal Reform 'Criminal Care: 'Children's Homes and Criminalising Children' has reported that 'looked after' children in children's homes are being criminalised at excessively high rates compared to all other groups, including those in other types of care.

4.4 SELF-HARMING EPISODES

4.4.1 ‘A’s self-harming was more evident in the early days of his placement e.g. 1 such episode in 2010, 6 in 2011 and a further 1 in 2013. The total of 8 episodes occurred in the following order:

- Self-inflicted 3 inch cut to right leg (reported by him to be a self-punishment for being open with his feelings at a ‘Children’s Meeting’ (29.09.10)
- An attempt (prevented by staff) to throw himself downstairs because he reported he wanted to hurt himself (22.02.11)
- Scratching of arm with a broken light bulb, linked by him to anxiety about the imminent interview with Police (05.03.11)
- Further scratching, this time of the back of his hands; on this occasion whilst staff were able to prevent his actions, ‘A’ was unable to offer an explanation of what had triggered the event (19.04.11)
- A threat to jump from a bannister, which action was prevented by staff (21.04.11)
- Reported ingestion of (fish tank and window) cleaning product and orange juice (06.10.11)
- Whilst in a barricaded room, superficially cut hands, arms and forehead and expressed a wish to be hospitalised (07.10.11)
- Used sharp blade to cut right forearm with consequent loss of blood and need for stiches (13.12.13) – thought to be linked to self-harming of a then fellow-resident

4.4.2 The report supplied by the Unit points out that self-harm for ‘A’ was typically *not* a private activity and may have represented a means to illustrate distress when he was unable to finds the words to describe it.

4.4.3 Over time the rate of such incidents decreased and the analysis offered by the Unit’s report suggests that the driving force for self-harm (underlying distress) was managed well and (until the prospect of leaving and re-entering a family arose) sufficiently contained.

4.4.4 Just as ‘A’s affect and conduct varied over time, there were occasional morbid thoughts:

- October 2013 when he laid a rose at the site where an individual unknown to him, had drowned
- December 2013 (the cutting episode described above)
- April 2014 when ‘A’ reported that he had spoken with his mother about knowing someone who had jumped to their death whilst Police were present

4.4.5 A risk assessment dated July 2015 spelled out the anticipated rise in 'A's anxiety levels as his move-on drew closer and the consequent increasing risk of renewed self-harming.

4.4.6 The witness statement provided to British Transport Police by a Unit director identified (with the advantage of hindsight following the death) a number of possible indications that he had been planning to kill himself. She also cited his mother as having alerted an unidentified member of staff in Brighton & Hove to relevant references (which *she* recalled included stepping in front of a train).

4.4.7 The report submitted by Brighton and Hove made no reference to any such alert and a re-examination of records and renewed enquiries of SW2 and records maintained by Children's Social Care and Adult Services (for mother's mental health needs) have not confirmed the accuracy of the claim.

4.4.8 In contrast to the view formed by that director it seems to the author and the review steering group that 'A's death was more likely to be a function of the following 2 factors, of which the former was recognised and being partially managed, and the latter recognised but essentially beyond immediate containment by staff present at the time:

- 'A's generalised anxiety about the imminent transfer to a foster home (and more specifically possible exposure to the carers' grandchildren)
- The impact of what went through 'A's anxious and fearful mind about what he may have wanted or planned to do when he and a younger resident absented themselves from staff supervision less than 1 hour before his death

4.5 ANY ISSUES RELATING TO FAMILY CONTACT

4.5.1 'A's attachment to his mother was a very anxiety-laden one which posed enormous challenges to all involved professionals.

4.5.2 Records indicate and interviews have confirmed that the relevance and importance of familial contact for 'A' was clearly recognised and facilitated well. Arrangement for contact naturally varied over time but always seemed to be flexible according to prevailing conditions and anyway rooted in what was regarded as his best interests.

4.5.3 Though mother was not always in agreement with arrangements made, she was exceptionally well supported by the Unit and in turn had a respect for the considerable efforts that staff there expended on supporting her son's development.

4.6 VIOLENT & AGGRESSIVE OUTBURSTS

4.6.1 'A's numerous episodes of violence (a proportion targeted toward females) seems to have been handled extremely well within the Unit. Whilst his wish to 'test the limits' was recognised, at no point did staff contemplate giving up on the commitment made to 'A' and his family.

4.6.2 As described in section 3, there existed a significant difference of view between that which is more prevalent in society and the more 'understanding / insightful / accepting' perspective of those within the environment in which 'A' spent some 5 years.

4.6.3 SWRO and SW2 (and their employing agency) whilst sympathetic to 'A's underlying distress, were closer to the attitude of wider society in thinking that a physical attack resulting in actual bodily harm justifies Police involvement, potential arrest and criminal charges.

Comment: *A significant proportion of those who enter the criminal justice system re-offend*[8] *- there may be scope for clearer pre-placement elaboration of what being placed in a therapeutic environment may or will actually mean in the event of future conduct that would be regarded as 'criminal' elsewhere - the weight of evidence is though insufficient to justify any recommendation.*

4.7 SEXUALISED BEHAVIOR

4.7.1 As early as November 2010 when 'A' was 12 he was sharing with staff some of his disturbing preoccupations with violent sex and paedophilia. The view within his Unit was that therapeutic work would need to be undertaken lest these confused anxieties become ingrained and a dominant part of his personality.

4.7.2 The following further specific references to concerning or atypical sexual behaviours emerge from the Unit's records:

- 'A's 'very dark, violent sexual fantasies'– perception of sex and sexual relationships remain distorted and scary for him' (report for April 2012 review)
- 'A' referred to his swapping naked pictures with a man whose number he had seen on a toilet door; he admitted that a part of him wanted to meet the man (January 2013)
- A blindfolded baby doll (acknowledged to be a masturbatory toy) was found in 'A's room with a cord around its neck (December 2013)

[8] Latest (2012/13) Ministry of Justice statistics show that of the 49,369 10- to 17-year-olds who were either cautioned, or handed a community or custodial sentence between July 2012 and June 2013, a total of 18,090 went on to reoffend within 12 months – a rate of 36.6 per cent. The re-offending rate for those released from a custodial sentence was even higher at 68.5%.

- ‘A’ contacted a paedophile via the internet; the man’s claim to have raped a 9 year old stirred up anxieties about ‘A’s own victimisation and he admitted some motivation to abuse (February 2014)
- ‘A’ admitted to an attitude toward females that left him fearful for what he might do to harm them (March 2014)
- ‘A’ (by then rising 16 years of age) reported sexual activity with a girl whilst absent without leave (August 2014)
- ‘A’ repeated his concern about what might happen if he made the ‘wrong’ choices in life and said that his deepest worry was being a paedophile (September 2014)
- ‘A’ was still preoccupied his fear of becoming an abuser at the time of his annual review report in March 2015

4.7.3 With respect to those events that required such a response, staff and subsequently his allocated worker took all appropriate safeguarding measures.

4.7.4 The trust that ‘A’ placed in staff in his Unit enabled him to verbalise his dark fears with less fear of rejection than he had experienced in all previous family placements.

4.7.5 The Unit’s report to this serious case review highlighted the importance of his individual psychotherapy that after considerable delay, began in Summer 2014. Though the March 2015 reports noted that there had been no sexualised behaviour toward peer group or adults for some time, the behaviour re-emerged in July 2015 when ‘A’ grabbed the testicles of a younger resident whilst ‘play-fighting’. SW2 was appropriately alerted to that incident.

4.7.6 The same report urged Brighton & Hove representatives to enable ‘A’ to continue to address and explore his disturbed thoughts and feelings around sex and sexuality within a planned and managed environment i.e. the current Unit.

4.7.7 The author of the report supplied to the SCR explains that ‘it was feared that if ‘A’ left the Unit prematurely it could leave him catastrophically exposed, forcing him to return to his older habitual defences as the only means of psychological survival. This would leave him out of touch and therefore out of control and regulation of his deep relational and sexual disturbances. There would invariably be an increased risk of them being dangerously enacted’.

4.7.8 A report from his psychotherapist in March 2015 includes a warning that……’although ‘A’ has made huge progress, a less intensive placement would struggle to contain him safely’.

4.8 SUFFICIENCY & QUALITY OF PSYCHIATRIC / PSYCHOLOGICAL SUPPORT

4.8.1 Without regard to the quality and quantity (regularly monitored via reviews) of direct therapeutic care, psychotherapy and social work, there remained an unmet need for a psychiatric perspective.

4.8.2 The Royal College of Psychiatry Report CR 195 '*When to See a Child and Adolescent Psychiatrist*' suggests a consultant CAMHS psychiatrist 'should be involved in the care of any patient who has… the possibility of a mental disorder and there is a risk to self or others'.

4.8.3 The above report offers a non-exhaustive list of mental health conditions when psychiatric involvement with children may be useful, of which 3 relevant categories refer to those:

- 'With emotional and behavioural problems, particularly when parental mental illness is a significant factor in the child's presentation
- Who have experienced complex trauma (often in the context of child abuse)
- With emerging emotionally unstable personality disorder'

4.8.4 The report was not published until 2014. Thus, the reference to it is made here so as to inform future, rather than criticise past professional practice.

4.9 FORMALLY 'NOTIFIABLE' INCIDENTS & ANY ADDITIONAL ISSUES OF RELEVANCE

4.9.1 So far as can be determined from records supplied, all events that required notification to the area or placing authority or regulatory body Ofsted were duly notified by the therapeutic Unit and no additional issues considered to be of relevance have been identified.

5 FINDINGS & CONCLUSIONS

5.1 GOOD & SUB-OPTIMAL PROFESSIONAL PRACTICE

5.1.1 An exploration of the services provided to 'A' and his family over the period of review has identified effective systems and good professional practice as well as other examples of systemic weaknesses or sub-optimal practice.

STRENGTHS OF SERVICE DELIVERY

5.1.2 The following organisational and/or individual achievements undoubtedly assisted an extremely troubled 'A':

- The care, commitment and skill of staff at his therapeutic placement and the consequent stability those features offered 'A'
- An unusual and welcome continuity with only 2 allocated workers, 2 Unit 'link-workers' and 1 independent reviewing officer (IRO) across 5 years in placement
- Persistence, in spite of its intrinsic complexity, in efforts by Unit & Brighton & Hove staff to involve 'A', his mother and siblings in maintaining contact with one another
- 'A's high level of involvement in an age and stage-appropriate manner in day to day and long-term planning

OPPORTUNITIES FOR LEARNING / IMPROVEMENT

5.1.3 A retrospective evaluation of the multi-agency efforts made to care and plan for 'A' also inevitably identified opportunities for organisational and individual learning. These can usefully be summarised under 3 headings: choice and initiation of placement, issues arising during that placement and transition toward what was hoped would become greater independence.

Choice & initiation of placement

5.1.4 On the basis of then known needs, the choice of an out-borough residential therapeutic community was justified by the evidence of many failed family-based alternatives. The evaluation by Ofsted of this particular Unit as 'outstanding'[9] may have added confidence about its potential use, but no evidence has been located of pre-placement enquiries by the Responsible Authority to determine the existence and potential availability of relevant local facilities e.g. CAMHS or of the likely (and actual) limits to the Unit's educational offering.

[9] www.ofsted.gov.uk/reports URN SC449155 ; the Unit was rated as 'good' at its latest 2016 inspection.

Issues arising during placement

5.1.5 Whilst there was a high degree of compliance with elements of the Care Planning and Review Regulations (initially 2010 and later the 2015 amended equivalent) e.g. frequency of visits, independently chaired reviews, an 'agreed' need for additional therapeutic support was not met for 3 years and at no point was the possibility of seeking a multi-disciplinary assessment of risk to self or others, discussed.

5.1.6 There was a significantly differing perspective between those who knew 'A' very well and their recognition of the potential risk he represented ('A's 'inner world' was one that frightened him and triggered a significant level of concern about his potential to harm others), versus those whose actions were largely influenced by his age and a more pragmatic concern to avoid a sudden 'step-down' from the high level of support of the sort provided since 2010.

Transition toward greater independence

5.1.7 Differences of perspective / philosophy and risk assessments required more rigorous debate and potentially escalation. Had there not (during 2015 especially) emerged mutual frustration between Unit and Responsible Authority and a distraction from shared goals, the potential for achieving the following could have been enhanced:

- A more extended introduction rooted in agreed interpretations (by Unit *and* Responsible Authority) of how 'A' was *actually* coping with incremental steps toward his move (brief visit, overnight stay, weekend, few days etc)
- Formulation of a contingency 'plan B' to anticipate a *likely* (in the reviewer's judgement) disruption of placement

5.1.8 The effectiveness of transition planning was also undermined and a disruption rendered more likely by a failure:

- Primarily of Brighton & Hove but also of the IFA to adequately brief and provide carers with a written summary of 'A's background, Placement and Care Plan and other (risk management) advice (see reg. 9 and Sch.2 Care Planning Regulations 2010); its absence left them insufficiently informed and able to mitigate behaviours posing a risk to 'A' himself or others
- To make it clear to 'A' what personal information had actually been shared with his potential carers

5.1.9 Amongst those who knew 'A' well and cared greatly about him, neither professionals or family had discerned that he was thinking about self-harm. Subject to the Coroner's Judgment, it appears that behind a 'brave face', anxiety about leaving the security of his home of 5 years to face the emotional pressure of normal family life, expectations of age-appropriate education and above all, an immediate panic about what sort of a person he might become, overwhelmed him.

6 RECOMMENDATIONS

6.1 INTRODUCTION

6.1.1 Individuals who had worked with 'A' were prompted / encouraged by his death or this review to reflect upon alternative judgments / actions.

6.1.2 The review has sought to avoid a preoccupation with individual errors and in spite of the tragically premature end to 'A's life, a critical examination of the sometimes extraordinary efforts made by professionals has identified only a few systemic learning opportunities within the agencies specified below.

6.2 ACTION REQUIRED OF AGENCIES

6.2.1 In addition to the potential for internal improvements identified by some agencies (e.g. procedural changes at the therapeutic Unit, further training about the vulnerability of care leavers by Brighton & Hove), the more substantive opportunities for agency-wide improvements are as follows:

BRIGHTON & HOVE CHILDREN'S SOCIAL CARE

6.2.2 Brighton & Hove should assure itself that, with respect to its looked after children:

- *All* relevant available information is being passed over (when possible ahead of placement) in accordance with Care Planning Regulations 2010, to those individuals who are be entrusted with the care of a child
- That the individual being placed is provided with an age-appropriate appreciation of information being passed over
- All Care and Placement Plans (the priority being 'high risk' cases) include a clear contingency position (a 'plan B' as per para. 2.45 Volume 2 *Care Planning, Placement & Case Review Regulations Guidance* 2015)

SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

- In the context of '*Who Pays'* Commissioning guidance, the Trust should continue to progress discussions with the relevant 3 authorities (West Sussex, East Sussex and Brighton & Hove) to facilitate access for 'looked after children' to specialist mental health services for those placed 'out of area' and still remaining within Sussex

THERAPEUTIC UNIT

- Management should review organisational capacity (knowledge and assertiveness) to challenge any Care Plan about which the Unit has insufficient confidence

7 GLOSSARY: ABBREVIATIONS / PROFESSIONALS

Abbreviation	Meaning
ABE	Achieving Best Evidence
A&E	Accident and Emergency Department
CIN	Child in Need
EHCP	Education and Health Care Plan
IRO	Independent Reviewing Officer
LSCB	Local Safeguarding Children Board
NPIE	National Panel of Independent Experts
PA	Personal Adviser
SIU	Safeguarding Investigation Unit (Sussex Police)
SCR	Serious Case Review
SDQ	Strengths & Difficulties Questionnaire
SEN	Special Educational Needs

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