Learning & Improvement Report

Brighton & Hove Local Safeguarding Children Board
Response to Child A Serious Case Review

A Serious Case Review must be carried out for every case where abuse or neglect is known or suspected and either a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

In early 2016 A's body was found on a railway track. A was 17 years of age, was subject to a Care Order to Brighton & Hove City Council and had been in care since 2004. He was placed in a residential therapeutic unit in a neighbouring county in 2010 and remained there until his death. The Serious Case Review I commissioned covers the period since A entered the residential unit.

It is known that A had been exposed to significant levels of physical and emotional abuse and neglect in the context of chronic domestic violence in his early childhood. A had spent time in a number of foster homes. Unfortunately none of these could meet his complex needs. He was then placed in a residential therapeutic unit in another local authority at the age of 8. After further unsuccessful attempts to find a foster family that could manage his troubled and troublesome behaviours, at the age of 12 he was placed in residential therapeutic unit in a neighbouring county and remained there until his death. There had been ongoing concerns about A's sometimes aggressive and denigrating behaviour and (largely historical) concerns about self-harming. A was concerned about 'inheriting' mental health difficulties. A was said to be very popular; his charm, good looks, sporting prowess and dry sense of humour was commented upon by several of those who contributed to this review.

At the point of publication of this report the Coroner's Inquest has been initiated and is currently adjourned awaiting further evidence.

This review highlights a number of differing perspectives between the commissioners and the providers: the local authority and the residential therapeutic unit and the polarised positions that existed between the two (rather than a negotiated consensus). Perhaps the most notable of these differences being around A's readiness for greater independence / placement in a non-residential environment as he approached adulthood.

Working Together 2015 allows LSCBs to use any learning model consistent with the principles in the guidance. This review was conducted using a systems methodology and Fergus Smith, an independent person with experience in conducting reviews arising from safeguarding concerns, was commissioned as the lead reviewer.

To support the process, a review steering group consisting of senior managers from involved agencies met six times with the lead reviewer. In order to better understand the judgements formed and actions taken by those with responsibility for A, an initial consultation event/briefing for all those involved was undertaken. Individual interviews were subsequently completed with the relevant professionals, and a final consultation event brought them together again to hear the findings and recommendations before the report was presented to Board. A's mother and A's maternal grandmother participated in the review. The female carer with whom (together with her husband) it had been hoped A would live also contributed to the review.

I commissioned this review to inform and facilitate learning and to identify required improvements in service design, policy, systems or practice within local or national services. Specifically, this review considered the:

- quality and timeliness of care planning,
- effectiveness of inter-agency co-operation,
- extent to which A's voice was heard,
- self-harming episodes,
- issues relating to family contact,
- violent and aggressive outbursts and sexualised behaviour,
- sufficiency and quality of psychiatric / psychological support
- formally notifiable incidents and
- any additional issues of relevance.

As well asking for assurance from organisations in Brighton & Hove about the changes they have made since the death of A, the role of the Local Safeguarding Children's Board is to address multi-agency working; the relationship and cooperation between services that should keep children safe, and to tackle areas where joint working could improve. This response sets out what the Board has done or will be doing in the coming months.

The Brighton & Hove LSCB accept this review in its entirety and its Case Review Subcommittee will monitor actions necessitated from this review with progress reported to the Board.

Graham Bartlett
Independent Chair
Brighton & Hove Local Safeguarding Children Board

Strengths of Service Delivery

The review highlighted the following organisational and/or individual achievements that undisputedly assisted A:

- The care, commitment and skill of staff at his therapeutic placement and the consequent stability those features offered A
- An unusual and welcome level of continuity with only 2 allocated workers and 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 the Unit & Brighton & Hove staff to involve both 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 longer-term planning

Findings & Conclusions: Quality & timeliness of care planning

Preparation & placement at A's Therapeutic Unit

It is clear that local family-based placements were not possible for A. The review found appropriate justification for the use of the out of area specialist residential care for A; A was, and arguably remained, incapable of coping with the intensity of emotional demands that prevails in most families. The Board agree that the fact that the independent placement at the unit endured for 5 years offers sound evidence that the choice of placement was a well-informed one. The evaluation by Ofsted of this particular unit as 'outstanding' is likely to have added confidence about its potential use.

The Board acknowledge that the review found no evidence of pre-placement enquiries by the Responsible Authority to determine the existence and potential availability of relevant local facilities e.g. psychological / psychiatric support via Child and Adolescent Mental Health Services or of the likely (and actual) limits to the unit's educational offering.

In response to this review Children's Services will be reminded that if there are planned out of area placements, liaison must take place with relevant providers to ensure the needs of individual children are met. A reminder will also be disseminated to all agencies in the safeguarding partnership that if a child is in a therapeutic placement, the effectiveness of therapy in addressing behaviours that pose a risk to the child and others should be monitored and challenged as required. Following this review Sussex Community NHS Foundation Trust are reviewing their initial and review Health assessments for children in care and Strengths & Difficulties questionnaire for robustness.

The LSCB will be assessing whether these changes have been made and their impact on children.

Support & Oversight of placement

Although 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 (see strengths of service delivery), such a complex case should have been allocated to a registered social worker. The Board are assured, following the Ofsted Inspection in 2015, that all looked after children in Brighton & Hove are now allocated a registered social worker.

Transition planning

The review explains that a number of professionals, as well as A himself, had anxieties about his ability to transition to a foster placement and semi-independent life outside of the unit.

These doubts were articulated in various planning forums but were never fully reconciled. What is clear is the significantly differing perspective between those whose relationship with A was close and more personal (residential staff and his psychotherapist), and their recognition of his façade of confidence and the potential risk he represented, versus those of the commissioning local authority 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 he had. For this agency it was essential that A was able to achieve a degree of independence via a route that maximised continuity of professional input and which would attract a right to post-18 'staying put' arrangements.

The Board consider that had there been more formal challenge or complaint it may have prompted the commissioning of an independent opinion. This issue is further explored in the following section, 'Effectiveness of inter-agency co-operation'.

The Board take the view that a more extended introduction rooted in agreed interpretations (by the unit and responsible authority) of how A was actually coping with incremental steps toward his move to the foster home would have been advantageous, along with more consideration as to the timing of the move. To this end, the Board have requested that Children's Services re-circulate best practice guidance regarding the timing and review of placement introductions to relevant staff.

The Board accept that there was no formulation of a contingency 'plan B' to use in the event of disruption of placement, and will seek assurance that care and placement plans for children in care include a clear contingency position in the case of placement breakdown.

The Board agree that effectiveness of transition planning was undermined by neither the responsible authority, nor the Independent Fostering Agency, providing prospective foster carers with a written summary of A's background, Placement and Care Plan, and other (risk management) advice. Whilst it seems that the social worker probably provided this to carers verbally, the absence of written information may have left them insufficiently informed and able to mitigate behaviours posing a risk to A' himself or others. Furthermore, A himself articulated concerns that the prospective foster carers did not know the full extent of his fears, fantasies and denigrating behaviours. Following this review the Board have tasked the responsible authority with reminding social work staff of the importance of providing carers with written information (e.g. Me & My World assessment) when making placements for children in care and will seek assurance, from the responsible authority, that that young people are aware of information given to prospective carers about them.

Findings & Conclusions: Effectiveness of inter-agency co-operation

Residential Unit & the Police working together

The reports from the unit and Police refer to a total of 27 calls made to report A as absent without authority or missing. The Board is satisfied from the accounts provided that all episodes were handled in a sensitive and proportionate manner by both agencies. Furthermore, the Board acknowledged the review's assertion that the Safeguarding Investigations Unit (SIU) collaborated well with the unit.

Since this review the Local Policing Programme (the LPP), which is Sussex Police's force change programme, has been reviewing its over-arching approach to how they respond to and deal with reports of missing people, including those they have previously dealt with as 'absences'. The Board are aware that this work is continuing.

Residential Unit & the Responsible Authority working together

The Board notes that up until early 2015, records and feedback from those interviewed provide reassurance that the level of inter-agency co-operation was very good.

The incidents which really split agencies working with A were largely centred on:

- 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
- and most importantly (as discussed earlier under transition planning) 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 .

Regarding A's assault towards a member of staff; his conduct represented a significant risk of harm to staff and would have been (in many other contexts) considered criminal. The unit attributed the incident to anxiety and, in accordance with internal policy, did not pursue pressing any charges. The SWRO disagreed with this decision.

The Board supports the House of Commons Committee[1] and Howard League for Penal Reform's objective of reducing the unnecessary criminalisation of children, particularly those looked after by local authority children's social care services. In support of this, the Board hold Sussex Police and Brighton & Hove's children's services to account for the provision of services to divert children away from custody. The Board expects its partners to ensure their frontline staff are equipped to manage the behaviour of children looked after by the local authority so that detention is a last resort. This includes an expectation that Sussex Police have a clear focus on children as a vulnerable group. In this instance the Board believe a conversation between Sussex Police and A may have supported setting boundaries around his volatile behaviours, supporting an understanding that his actions had consequences.

The Board acknowledge that whilst there was a high degree of compliance with elements of the Care Planning and Review Regulations (e.g. frequency of visits, independently chaired reviews) the agreed need for additional therapeutic support was not met for three years and that the possibility of a multi-disciplinary assessment of risk to self or others was not appropriately addressed.

The Board accepts both of the differing vantage points. From the responsible authority's perspective, the therapeutic support should have begun as soon as possible. From the perspective of the unit, the delay was not only about the difficulty of identifying an appropriate psychotherapist but a considered judgment about A's readiness to engage with such therapy.

In terms of A's education, his social worker expressed concerns about a limited educational offer and his seeming lack of educational progress during this time at the unit. The unit however appeared more satisfied with A's advancement. Once again there may have been some over confidence in the unit's 'outstanding' Ofsted judgement, which could have led to the responsible authority not challenging as robustly as it would have done had A not been in this therapeutic placement. The Board acknowledge that there may have been more of a role here for the virtual school (established within each local authority for its children in care) to support, promote and monitor A's educational progress. The Board will want to test the effectiveness of the virtual school arrangements.

Since the review the local authority has confirmed that contracts between provider and commissioner make clear expectations for conflict resolution via its Resolution of Disputes between Parties clause. Further to this, the Board will review and promote use of its Pan Sussex Professional Differences

[1] 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.

policy. The Board needs to be assured that professionals, when they have concerns about any agency's ability to meet the needs of any child, have the knowledge and confidence to formally raise such concerns for reconciliation in the child's best interests. The Board will take steps to become assured that the unit in question has effective processes in place to robustly challenge a care plan with which they have concerns about.

Findings & Conclusions: A's experience living in the placement

Extent to which A's voice was heard

The report highlights positively the extent to which A was involved with social workers, residential link-workers and teaching staff.

A significant challenge faced by unit staff and the responsible authority was how and to what extent A's expressed and variant views were weighed against his non-verbal wishes/ feelings. It appears that to some professionals, (within the responsible authority), A was supportive of the proposal to move to a foster home whilst to others he displayed confusion about the advantages of a foster home over further residential care.

It is believed that A did voice concerns after meeting with his prospective carers about the suitability of the placement. The Board considers that A's voice here should have been given more prominence, acknowledging that such opportunities were diminished by an unfortunate coincidence of Christmas and his social workers annual leave.

Self-harming episodes

A's self-harming was more evident in the early days of his placement e.g. one such episode in 2010, six in 2011 and a further one in 2013. The unit believed that A's self-harm 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. The unit believe the self-harm abated as his underlying distress was being managed well and (until the prospect of leaving and re-entering a family arose) was sufficiently contained.

Issues relating to family contact

The report states that A's attachment to his mother was very anxiety-laden, which presented enormous challenges to all professionals involved. The Board considers that the records reviewed, and interviews held, as part of this serious case review indicate that the relevance and importance of familial contact for A' was recognised and facilitated well.

Violent and aggressive outbursts

The report details A's numerous episodes of violence (a proportion targeted toward females). As already described, there existed a significant difference of opinion on how his behaviours were managed.

Sexualised behaviour

At a young age A was sharing with staff at the unit some of his fears and fantasies around violent sex and concerns that he might, because of his abusive experiences, become a paedophile. His preoccupation with a fear of becoming an abuser was noted to have been 'scary for him'. The Board notes the review's finding that a series of events requiring safeguarding measures were appropriately responded to.

The unit felt that whilst A had 'made huge progress, a less intensive placement would struggle to contain him safely'. The unit told the serious case review author 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'.

The LSCB have made clear an expectation that planning and review of any plan for a young person with extreme sexual inclinations should consider specialist input.

Sufficiency and quality of psychiatric / psychological support

The Board agree that whilst A was in receipt of direct therapeutic care, psychotherapy and social work, there remained an unmet need for a psychiatric perspective. There is likely to have been an overreliance and overconfidence by the responsibility authority in the unit's ability to meet all of A's complex needs, as already discussed in the section above 'Preparation & placement at A's Therapeutic Unit'. What was required here was a truly specialist assessment and recognition from the unit that what was needed was beyond their expertise. Opportunities for a multi-disciplinary and/ or specialist assessment/opinion were not explored at any of the many meetings such as statutory reviews.

As a result of this review the Board will be formally updated on discussions between Sussex Partnership NHS Foundation Trust and the relevant Clinical Commissioning Groups, to facilitate access for children in care to specialist mental health services for those placed out of area, but remaining within Sussex.

Formally notifiable incidents and any additional issues of relevance

The Board takes note that the serious case review author believes (from records provided to the review) that 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.