



Brighton & Hove Safeguarding Children Board

Serious Case Review: Child E

Lead Reviewers:

Sally Trench

Leighe Rogers

April 2016

CONTENTS

	Title	Page
A	Introduction	3
1.	Why this case is being reviewed	3
2.	Succinct summary of case	3
3.	Time frame	4
4.	Family composition	4
5.	Research questions	5
6.	Methodology	5
7.	Methodological comment and limitations	6
B	Findings	8
8.	Introduction	8
9.	Appraisal of professional practice in this case: a synopsis	8
10.	What is it about this cases that makes it act as a window on practice more widely?	24
11.	Findings list	25
12.	Findings in detail	26
	Finding 1	26
	Finding 2	29
	Finding 3	32
	Finding 4	34
	Finding 5	39
	Finding 6	41
	Finding 7	43
	Finding 8	46
13.	Additional learning	49
14.	Conclusion	51
	Glossary: terms and acronyms	52
	References	53
	Appendix 1: Learning Together methodology and process	55

A. INTRODUCTION

1. Why this case is being reviewed

- 1.1 Brighton & Hove Safeguarding Children Board (BHSCB) agreed to conduct a Serious Case Review (SCR) regarding E, a child in care who was seriously injured by hanging on 1st December 2014, and who died in hospital the following day, 2nd December 2014.
- 1.2 The Case Review Subcommittee considered E's death at their meeting of 13th January 2015, and recommended the commissioning of an SCR to the Independent Board Chairperson. This decision was supported by the Chairperson, subject to a peer review from another Independent Chairperson. Once the decision was endorsed, Lead Reviewers were appointed and planning for the SCR began in March 2015.
- 1.3 The decision was in line with the following guidance for undertaking an SCR:
 - (a) abuse or neglect of a child is known or suspected; and
 - (b) (i) the child has died [of suspected suicide] and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.¹
- 1.4 The parallel process of the inquest did not affect the commencement of the SCR, especially as the Coroner's Court can sometimes be considerably delayed. The Board Chairperson was in correspondence with the Coroner to confirm the Board's decision-making.

2. Succinct summary of case

- 2.1 E was a 17 year old boy, approaching his 18th birthday, when he died. He had been looked after by Brighton & Hove Council (via a Full Care Order², conferring Parental Responsibility on the local authority) from the age of 3 years, in a 'Family and Friends' placement with his maternal aunt and her partner³. His mother, who had mental health and substance misuse problems, was unable to care for him, and died of a drugs overdose when E was 8 years old. Her own mother and brother committed suicide, and it appears that she also intentionally took her own life. Before her death, she had continued for several years to have inconsistent contact with E, who was clearly distressed by her absence. His parents had split up when he was a baby, and E's father was absent, and his whereabouts unknown, throughout his childhood.
- 2.2 In these circumstances, his placement with his close maternal relatives was extremely fortunate. The family regarded E as their son, and were committed to giving him a secure and loving family life. Although Adoption and a Residence Order were both considered by the family, neither was proceeded with, on the grounds that they believed extra support for E from the local authority (LA) would be needed as he grew up and especially in adolescence.
- 2.3 E liked school and did reasonably well in his studies. He was charming, polite and willing – thus popular with school staff as well as pupils. Elsewhere, however, his behaviour, especially as he reached adolescence, became increasingly challenging at home, and risk-taking elsewhere; he began to come to the notice of the police, sometimes in association with other

¹ *Working Together to Safeguard Children*, 2013 (since revised in 2015), and Local Safeguarding Children Boards Regulations, 2006 (Regulation 5)

² Children Act 1989, S31

³ E's maternal aunt is referred to throughout this report as 'Foster Mother' (FM) and her partner as 'Foster Father' (FF).

young people, and there were concerns that he was experimenting with alcohol and drugs. There were also signs that he was very anxious at times, and troubled about his identity and his past, about which he wanted to know more.

- 2.4 Just before his 16th birthday, E's birth father (BF) telephoned B&H Children's Social Work Services and expressed his wish to know about and have contact with his son. E was told about this a few months later, after his GCSEs had been completed. Initially, he wanted only 'online' contact with his father, and this remained the situation until shortly before his death.
- 2.5 During E's first year of college, his anti-social behaviour outside the home, and anger and sometimes violence within it, increased. The placement was for many months at severe risk of disruption, and this eventually happened in October 2014. At this point, E went into respite foster care in a nearby town.
- 2.6 E returned home after about 5 weeks, following a burglary in FM and FF's house, for which he blamed a friend and his 'associates'. E's subsequent assault on this boy led swiftly to an exchange of social media threats which apparently terrified E and prompted his desire to leave Brighton immediately. Under extreme pressure from E, a temporary plan was agreed by his carers and Children's Social Work Services for him to stay 'under the wing' of his father in the Home Counties, while an urgent foster placement was sought in that area.
- 2.7 Five days after this move, E was discovered to have hanged himself in his father's friend's house, and died in hospital shortly after.
- 2.8 The Coroner's judgement about causation was as follows:

'I am going to return an open conclusion. There is insufficient evidence to conclude that this was either an accident or suicide.'

3. Time frame

- 3.1 The *Learning Together*⁴ model of case reviews **focuses** on a recent period of time, so that current multi-agency systems can be examined, and staff who have been involved with the child and family are more likely to be available to contribute to the review. In this case, we aimed to capture the major changes for E as he turned 16, and in his last year of school. We therefore chose the period:

January 2013 to date of death, 2nd December 2014

- 3.2 As part of the process of the review, E's earlier history was considered as a backdrop to the events of this period, but not analysed in detail. It was fortunate that many of those involved in the review had known E and his family for many years, and could comment on their story over time. This added perspective and context about how the placement had been managed prior to the period under review.

4. Family Composition

- 4.1 E lived with his maternal aunt and her partner, and his younger cousin. His birth father has a wife and two children, all of whom live in another part of the country. The family are all White British.

⁴ Social Care Institute for Excellence (SCIE) systems model, developed by Fish, Munro and Bairstow, and now used for learning reviews and Serious Case Reviews. Please see Appendix 2 for details.

- 4.2 As a very small child, E began to spend periods of time in the care of his aunt and her partner, because his mother was sometimes unable to look after him. From the age of 3 onwards, he lived full-time with this family, in a 'Family and Friends' fostering arrangement. This report has highlighted the complexity of such an arrangement, especially where it is very longstanding, and where the family members are both relatives (aunt and uncle) and foster carers, and in addition have come to regard themselves as 'parents' of the child.

5. Research questions

- 5.1 The research questions which underpin a *Learning Together* review represent the areas of learning which are expected from a particular case. They do not constrain other potential areas of learning. In this case, Brighton & Hove LSCB set the following questions:

What can we learn about the challenges of working together with looked-after children (and their families) when they reach adolescence, especially for those children where...

- there has been a long-term placement with kinship carers;
- there is a risk of placement breakdown;
- there is a family history of suicide; and
- there may be a vulnerability to group activity.

6. Methodology

- 6.1 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why in that particular context – to identify what may be the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' and which constitute the wider learning which local authorities and LSCBs are expected to pursue. Details of the *Learning Together* model and the process of this review are in **Appendix 1** of this report.

6.2 Review expertise and independence

The review was led by two independent professionals:

- Sally Trench is an accredited SCIE reviewer with extensive experience of writing SCRs, using both traditional Part 8 methodology, as well as more recent systems models. She is also an SCR Panel Chair, with a lengthy background in local authority social work (adult mental health, children and families/child protection, and quality assurance).
- Leighe Rogers was Director of Operations and former Interim Chief Executive with Kent Surrey and Sussex Community Rehabilitation Company and Surrey and Sussex Probation Trust. In both these capacities Leighe was organisational lead for Child Protection. She has been a member of several Local Safeguarding Children Boards and recent Chair of the Brighton & Hove Case Review Subcommittee. Leighe has experience as Chair of SCRs and author of Individual Management Reviews (IMRs). She has completed SCIE training and is working towards accreditation as a SCIE reviewer.

7. Methodological comment and limitations

- 7.1 In this case, all the elements of a full SCR using the *Learning Together* systems approach were adopted. Review Team membership was at a senior level with representation from Children's Services (including Social Work, Education and Youth Services), Health, Education and Police. There was a large Case Group (the professionals who worked with the child/family), with similar agency representation made up of front-line staff, and middle and senior managers.
- 7.2 There were challenges for how the Review Team operated, which affected both the process of the review and the stages of agreeing a final report. The following factors proved to be constraints:
- Appropriate Children's Social Work Services representation was not established until after the review process was well underway, and their nominated member of the group was replaced at the last meeting by someone who had not previously been part of the review. The changes were particularly unfortunate because of the central role of this agency, given E's status as a looked-after child.
 - Membership of Review Team meetings was affected by a number of absences.
 - Contextual information about agencies, and previous LSCB learning which might help underpin this review, were not consistently flagged up and made available during the analysis of the material and formulation of findings. Hard evidence, requested from Review Team members, was not always provided in a timely or reliable way.

7.3 Membership and attendance

7.3.1 The Review Team and Case Group

7.3.1.1 The Review Team met 10 times (more than is usual, given the complexity of the case). Four of these meetings included the Case Group, for one introductory half day and three extended 'feedback' half-days. Whilst the Lead Reviewers feel the commitment to the review process was strong, this was not always reflected in attendance at meetings, for both the Review Team and the Case Group. The initial Children's Social Work Services representative on the Review Team was replaced once his involvement in the case became clear and he then participated as a member of the Case Group.

7.3.2 Limitations on the Review Process

- 7.3.2.1 Some absences from meetings were unavoidable because of illness, leave or other work pressures. In other instances, the distress felt in relation to E's death was a factor, and we were aware how difficult it was at times for some people to take part. However, we (the Review Team) were also conscious that some practitioners, including those under extreme stress, were nonetheless committed to participating as fully as possible, managed to do so, and made important contributions to the learning.
- 7.3.2.2 The review ran in parallel with E's inquest and this had a significant emotional effect for all those involved, first and foremost members of his family. The impact on professionals, many of whom had been working with E over a number of years or for shorter periods before his death, was a palpable and consistent feature within the Case Group.
- 7.3.2.3 Several of the initial meetings for this SCR coincided with the first stages of a major reorganisation in Children's Social Work Services. This meant that, for many staff who were being asked to participate in the SCR, there was at that same time uncertainty in relation to

their jobs and their futures. This was thus not an ideal context for taking part in another stressful process in a positive way.

7.3.2.4 Alongside anxiety and sadness within the Case Group, there were some tensions across different parts of Children's Social Work Services, which appeared to affect people's openness to taking part in a collaborative learning process. These appeared to relate to the different approach of workers with responsibility for the child (the 'looked-after' team) and those who supported the carers.

7.3.2.5 More widely, conflicting views remained within the Case Group as to the validity of the emerging findings and about the appraisal of certain areas of practice. An additional meeting was used to address these, but did not entirely resolve them. This can occur in case reviews when a number of people are involved, and is a reminder that absolute unanimity on conclusions is not always achievable.

7.4 Family participation

7.4.1 Involving family members is an expected and important part of a *Learning Together* review. The adults in this case (FM and FF, and BF and his wife) were invited to meet with the Lead Reviewers and to contribute their views in relation to services provided to E and to them. Several efforts were made in order to achieve this, and a meeting between the Lead Reviewers and BF and his wife was held. This enabled us to share their input with the Review Team at an early stage. Until later in the review, FM was unwilling to meet anyone in person, and instead provided a long written statement giving her views.

7.4.2 After the draft report was completed, all family members were invited and accepted our offer to read it through and give their feedback directly to the Lead Reviewers. As a result, some errors of fact were corrected in the final version, and their views have been inserted at appropriate points in the text of the review.

7.4.3 It was clearly very difficult and distressing for the family members to undertake this work with us. Not only was it time-consuming for them but they had also to make arrangements to miss work and for child care. The process required them to think back in detail about all that had happened for E and for themselves. As might be expected this was a painful process for them. We are very grateful that they have been prepared to participate and help us think about how services might be improved for other young people.

7.4.4 A summary of the views of BF and FM:

BF and FM expressed a very strong sense of anger at the actions of agencies, Children's Social Work Services in particular. They believed that E would not have died had he not been allowed to go to the local authority area of BF.

They felt that there had been 'a total lack of preparation, a failure to follow protocols, and, more generally, a lack of resources offered to E' (an example given was the over-use of agency workers in 2013/14, and E's loss, when he moved teams at age 16, of the Social Work Resource Officer, whom he had known for many years and to whom he was attached).

7.5 Gathering data

7.5.1 Members of the Review Team conducted a total of **24** individual conversations with members of the Case Group. These included contributions from staff from all the services named above, as well as a conversation with E's GP and the Foster Parents responsible for a brief period of respite care. Overall the Review Team was impressed by the quality of the information gained

from individual conversations and the commitment of those concerned to the review process. With large numbers of potential conversations and the time available, there was a need to prioritise. We did not interview Child and Adolescent Mental Health Services (CAMHS) practitioners, who were not involved during the time scale reviewed, although there had been brief contact with E and FM in late 2012. A query about E's mental health needs and his reluctance to use CAMH services will be picked up in a later section of this report (Additional Learning: para 13.1), rather than in a substantive finding. The named nurse for CAMHS took part in the initial Review Team meeting, and later gave feedback on the final report, which has been incorporated. The RUOK worker (who did not know E) was not seen for a conversation, but was a member of the Case Group, and was able to offer advice from the perspective of her specialist agency.

- 7.5.2 The establishment of a consistent evidenced narrative about E, his family history and the involvement of professionals over many years, was hampered by some difficulties in gaining timely access to records and the sometimes conflicting information held by contributors. However, a large amount of useful documentation was reviewed (a list is included in Appendix 1, Para 10.4).

B. REVIEW FINDINGS

What light has this case review shed on the reliability of our systems to keep children safe?

8. Introduction

- 8.1 The Findings – the main body of the report – begin with a synopsis of the appraisal of practice. This sets out the views of the Review Team about how timely and effective the interventions with E and his family were, including good practice but also identifying where practice fell below expected standards. Where possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the detailed findings.
- 8.2 There is then a section to help the reader move from the case-specific detail to its more general relevance: this section explains the ways in which features of this case are common to other work that professionals conduct with children and families, and therefore how they can provide useful organisational learning to underpin improvement ('a window on the system'⁵).
- 8.3 Finally, the report discusses in detail the 8 priority findings that have emerged from the review. The findings explore how well local safeguarding systems are supporting individuals, teams and whole services to offer effective help to children and families. They also outline the evidence that indicates that these are not one-off issues, but underlying patterns – which have the potential to influence future practice in similar cases.

9. Appraisal of professional practice in this case – a synopsis

9.1 Introduction

- 9.1.1 This appraisal section is set out in chronological order, and briefly makes reference to when E first became a looked-after child. E was subject to a Full Care Order for almost all of his childhood, with the LA acting as his Corporate Parent. As a consequence, it is inevitable that

⁵ Vincent, 2004

much of the practice analysed in this report, and most of the findings, relate to Children's Social Work Services

- 9.1.2 The Review Team are aware that some of the practice and systems identified as problematic are already being addressed strategically within and across agencies. In the relevant findings, we give an account of some of the changes that have happened or are underway. The Board's response to this report will have a fuller description of these developments and improvements.
- 9.1.3 The most comprehensive change, since the period covered by the review, has been that within Children's Social Work Services, where their structure and ethos have been redesigned to respond to difficulties identified in recent times. These related to problems of staff retention, and recruitment of managers; of weak management and non-reflective supervision; and of large teams which meant that children and families as service users experienced too many transitions/changes of workers. It is fair to say that most of these featured, in one way or another, in E's case.
- 9.1.4 The new structure has smaller teams (pods) which are aimed at providing continuity of social workers for the service users, the restoral of relationship-based work, and the collaboration of the whole team in cases via weekly group supervision. The aim is to work effectively with individual children and parents, and to promote safe and stable families. Staff support will be provided by developing their skills and through the use of better models of supervision and management.
- 9.2 Overall, E's story highlights many of the complex issues faced by LA Children's Social Work Services in discharging their responsibilities as the Corporate Parent of a child in the long-term care of family members. His placement with his maternal aunt and uncle afforded him the opportunity for permanence and a sense of belonging. Almost everyone we spoke with described close and loving relationships between these family members and saw that E regarded his foster parents as his mum and dad. The foster parents similarly regarded E as their son.
- 9.3 However, we heard from some of those who were closest to him that there were times during his childhood, and especially as E grew older and began to have renewed questions about his past and familial relationships, that his status as a child in care increasingly troubled him. To him, this made him feel different from his foster parents' biological son, E's first cousin and also his 'brother'. (FM has stated that this was not the case. She believes that E was not treated differently within the family, nor did he feel that he was.)
- 9.4 The early involvement of agencies with E and his family – prior to the period under review, January 2013 until December 2014 – is critical to gaining an understanding of how professionals over time approached and understood their roles in managing the case. When appraising the practice of these professionals, we have seen how the more recent context was affected by FM and FF's initial approval as F&F carers, at a time when statutory guidance about their assessment and approval, and the requirements for working with such placements, were very different from current practice. At that time, there were far fewer formal expectations of F&F carers, and the rigorous requirements which are now in place for all foster carers did not apply (e.g., levels of annual training, unannounced visits, etc.) Thus, there was an 'inherited' pattern for the LA of working with this family, formed by earlier decisions and relationships with the carers.

- 9.5 Until early 2013, there was a largely consistent group of Children's Social Work Services workers and managers, as well as the Designated Teacher for Looked-after Children at his secondary school, all of whom had known E for several years. This was positive for all concerned, in that relationships could be sustained, and the professionals' understanding of E's needs was well developed and solid. The social work professionals regarded him and his carers as a family who were generally functioning and looking after E well. There was a strong commitment on both sides to maintaining the placement long-term. This meant that they expected that the family could be allowed to get on with their life and make all day-to-day decisions with minimal intrusion from the LA. This was appropriate to the nature of the placement (F&F) and the known circumstances at the time.
- 9.6 This approach is re-enforced in the recently issued guidance on permanence and long-term placements.⁶ In the new guidance, however, there is the clear expectation that a 'lighter touch' by the LA must be accompanied by a comprehensive and ongoing assessment that the child's needs are being met in an adequate way, which is known about and approved by the Corporate Parent/LA.
- 9.7 In the review period, the Review Team were told of a number of examples of significant actions (or inactions) by FM which were taken without consultation with the LA – something which will be referred to in more detail in sections below. She had historically been given considerable responsibilities through what in time (from mid-2014) became a fully recorded process of 'delegated authority'. In this case the formal record of delegated authority extended to all aspects of parental care, to a point where it was unclear what responsibilities remained to the LA as Corporate Parent. This approach in the end made it complicated and difficult for Children's Social Work Services to take the lead and intervene at points of family crisis and finally placement breakdown. The role of the LA as Corporate Parent and the challenges of holding this in balance with F&F carers is the subject of **Finding 1**.

Just prior to the review period

- 9.8 In the second half of 2012, E's Social Work Resource Officer (SWRO2 – his longstanding worker from the Children in Care Team), his equally longstanding Independent Reviewing Officer (IRO) and his FM observed that he was distressed and sad. Children's Social Work Services made an appropriate referral to the local Child and Adolescent Mental Health Services (CAMHS) and an assessment appointment in October was attended by FM and SWRO1. In preparing for this meeting (filling in a form), FM described a boy who was showing signs of extreme vulnerability and emotional distress, and at the consultation reported that E had made one mention of feeling suicidal in the past year, reportedly 'in the context of not getting his own way'.⁷
- 9.9 E himself attended one CAMHS appointment in November 2012, but declined any further input. As a result, the case was closed by CAMHS. This is routine practice. Given that many (if not most) adolescents are reluctant to engage with a psychiatric service, there is an argument for a more flexible and creative means of reaching young people in need of a CAMH service. Whilst locally we understand that CAMHS do have an outreach service for older teens⁸, there was no evidence that this approach was used in this instance. (There is further information about local CAMHS developments and other suggestions in Para 13.1 below)

⁶ *Permanence, long-term foster placements and ceasing to look after a child: Statutory guidance for local authorities*, DfE, March 2015

⁷ From the notes taken by the CAMHS worker at the assessment interview. FM has told the Lead Reviewers that 'E never mentioned suicide to her'.

⁸ This is the 'Teen to Adult Personal Advisor Service' which is an 'outreach rather than clinic-based service'.

Start of Review Period: First half of 2013

- 9.10 This was a period of major transition for E, who was preparing to move on from his secondary school, which he had attended since the age of 11, and where he had been a popular pupil, having good relationships with staff and other pupils alike.
- 9.11 In early 2013, E was working hard in preparation for his GCSEs. His SWRO2, who knew him extremely well and had developed a good relationship with him, transferred his case to the 16+ Team. The move was required because of his age (at the time Children's Social Work Services had a separate 16+ Team, although this is no longer the case), and also because of a mandated requirement made by OFSTED that only qualified social workers could be 'allocated' for a child in care. Coincidentally there was an unexpected change in the IRO who had chaired E's reviews over the past five years. This meant that some of the organisation's continuity of knowledge and understanding of E and his foster family was broken.
- 9.12 **Findings 2 and 3** consider the risks of loss of continuity and understanding of a child when a case is transferred to a new worker, something which was happening frequently at the time in the 16+ Team. The other automatic change which E experienced when he turned 16 no longer applies, as the 16+ Team was merged into the Support Through Care (STC) Team which kept responsibility for children throughout their time in care – regardless of their age.⁹
- 9.13 SWRO2 made the necessary arrangements to ensure a good handover to the new social worker, including a detailed Transfer Summary, and continued to work with the family until E's last LAC review in February 2013. E urgently needed a Personal Education Plan (PEP) meeting, and SWRO2 arranged for this to happen shortly thereafter.
- 9.14 It is not clear from records or discussions with the Case Group how the impact on E of the change of SWRO2 and the appointment of a new IRO was considered. Both had been involved with the family for a large part of his childhood, and SWRO2 in particular was fond of E and had been able to establish a good working relationship with him. In our view, an assessment of the likely impact on E of these changes should have been undertaken with E and his carers, with consideration given to how the consequences of these changes might have been formally acknowledged and if possible mitigated. Lack of detail in records also makes it difficult to know what was addressed in E's last LAC review (February 2013). This review did not, according to its record, address some important aspects of transition for E, nor mention preparation for the Pathway Plan¹⁰ process, which would then take over from his LAC Reviews – including the requirement for an assessment¹¹ to be undertaken as the starting point for Pathway Planning. In E's case this could have included the extra support for E and the family.
- 9.15 The B&H format for the Social Worker's report for LAC reviews (and, later, for PPRs) covers all the required headings, with a dedicated space for the child/YP's views under each area for discussion. This makes it a useful tool, only let down if the information shared in the review is

⁹ In late 2015, after the events covered by this review, Children's Social Work Services underwent a major reorganisation into a new structure, shifting from large teams into far smaller practice groupings ('Pods'), a change described in detail above, in Para 9.1. One of the key drivers for this change was to support relationship-based social work with the child and family, team supervision and an 'ownership' of the work by all members of the team. The elimination of 'artificial' case transfer points was just one way of supporting this.

¹⁰ 'The assessment and pathway planning process for a care leaver must include a measured evidence-based analysis of the young person's continuing need for care, accommodation and support...', Children Act Regulations, Volume 3, Para 3.8

¹¹ The Children (Leaving Care) Act 2000

not full and accurate enough, as was the case with some of the reviews conducted during the period under review.

First contact from E's birth father

- 9.16 Before that review, E's birth father (BF) made his first contact with the LA, with a view to meeting him. Children's Social Work Services had made many previous attempts to reach BF, but never with any success. E knew very little about him, and SWRO2 was aware that BF's emergence would be 'huge' for him, given his desire to know more about his parents, including BF who had disappeared from his life when he was a baby. She completed the necessary identity and police checks and shortly after met with BF to confirm these with him. This was expected practice.
- 9.17 The foster carers were consulted and agreement was reached on a decision to delay informing E about his father's reappearance, given that E was at this point preparing for his GCSEs. The decision to delay telling E before his exams was on balance a reasonable one, as there clearly were risks attached to sharing this information with E at a critical phase in his education. However, there were also risks in withholding the information, as became apparent later when e-communication was established between E and BF, without the knowledge of Children's Social Work Services. A formal record of decision-making regarding BF's approach, and evidence of any related risk assessment would have been appropriate and might also have alerted practitioners to the absence of up to date 'Life Story' work, and the complexities arising from different narratives, from the two sides of the family.
- 9.18 There was nothing recorded in relation to planning and preparing for managing the contact (whether direct or indirect) between E and his BF. Given the potential emotional impact of the initial contact, whenever it came, and that the LA ran the risk of not being able to manage when this happened, there should have been a structured process of planning together (the Corporate Parent, the foster carers and BF) – not only for E, but for BF (and his family). This should have included consideration of the risks attached to free access to communication via social media. This work could have commenced among the adults before E's GCSEs, in the period when he did not yet know about BF.
- 9.19 With insufficient planning, and the apparent drift in thinking about this complex/anticipated relationship, E's eventual meeting with BF was unprepared for.
- 9.20 How E would eventually be told about the contact from his BF was not clear within Children's Social Work Services' records, although the review was told that there was social work agreement that FM and FF should undertake this after his exams were over. Afterwards, they were told that e's initial response was that he did not want face-to-face contact with BF at that point. **Finding 1** considers how and why the LA's and the carers' different roles and responsibilities were not always clear and agreed.
- 9.21 It was important for E to be supported to develop his own understanding of why he was in care, and to be enabled to place his past into context and to gain a perspective to assist him with establishing his own identity. Key to this was the completion of 'Life Story' work appropriate to his age and understanding. The gathering of this information and discussion with E should have been a continuous process and would have assisted him to build resilience. It seems highly likely that staff initially working with him may have relied on E's carers to share the details of his early life with him, and thus undertake the very important 'Life Story' work throughout his childhood. Records are unclear on this point and our conversations with staff shed insufficient light on the plans in this respect. There is very little

evidence of sustained 'Life Story' work being undertaken with E (either immediately prior to or during the period under review), which would have helped him to prepare to meet the emotional challenges of his teenage years. There was limited 'Life Story' work done with him when he was very young (before his mother's death), and a record of further intensive work being undertaken between the ages of 11-12. Some of his later PPR Meetings commented on the need for this work to be resumed.

- 9.22 This review has found that, although sources of information about E's history were available in records, including some contained in Transfer Summaries, there was inconsistent use of these records. During the time scale of this review, it was not clear that all his workers or managers themselves had an adequate understanding and knowledge of his history – without which it would be difficult to undertake Life Story work, or to have an adequate understanding of E's overall needs and vulnerability. Whatever the circumstances of a placement, there is a clear expectation that Children's Social Work Services workers will read and digest the history of a child in care. In this case, this was an area of practice which we found to be poor, and in need of improvement. **Findings 2 and 3** explore some of the barriers to this good practice, including difficulties in accessing the full range of records, and (for some workers and managers) insufficient time to explore these.

Changing workers for E

- 9.23 E continued to work hard towards his GCSEs, but nonetheless his behaviour at home/outside school was increasingly troubled, and included experimenting with drugs, coming to the notice of the Police, and defiance and anger towards his carers and cousin. His FM was well supported by her SWRO1 (what is often, elsewhere, called the Supervising Social Worker), who had known the whole family for several years. SWRO1 understood E's past and his current difficulties, and was in many ways the lynch pin for communicating about these to the new SWs who followed on from March 2013. SWRO1 ensured that there were useful joint visits to the home, and made appropriate referrals to other services (such as RUOK), which was good practice.
- 9.24 During the period under review there were four changes of social worker, and in the last 22 months of his life, the records indicate that no social worker saw E more than five times. Inevitably this led to difficulties for each social worker in being able to establish a relationship with him, with E becoming increasingly elusive. BF described E, when they were together, as bitterly complaining about his changes in SWs: *'Why am I going to confide in someone I have only known for 5 minutes?'*. E also spoke to his BF about the earlier loss of SWRO2. We know that children in care can feel particularly let down and alienated when they experience repeated changes of social worker, and the loss of a familiar relationship seems to have affected E, his family, and co-workers in the F&F Team.
- 9.25 Some workers were involved for a very brief time (one, SW2, never meeting E), and held varying degrees of understanding about E's personal and family history. SW4 (see below), who was allocated the case in May 2014, was given a verbal handover that E's case was stable and without problems, and the transfer summary she received, unlike previous ones, had very little in the way of case history included.
- 9.26 The disadvantages of using a succession of agency workers for a child in care are well understood by Children's Social Work Services. Unfortunately for E, the 16+ Team, at the time when he transferred into its care, was struggling with an absent manager and a far higher than usual number of agency staff (this was in contrast to the rest of the service). He thus

experienced 4 social workers in a period of 18 months, and this lack of continuity inevitably affected the ability of both sides to work effectively together.

- 9.26.1 A new manager for the STC Team (which had subsumed the 16+ Team) had arrived in early 2014, and by the end of that year had successfully reduced the use of agency staff.
- 9.26.2 The reliance on a proportion of agency staff, in all agencies, will vary over time, with many factors affecting this, some of which may not be quickly remedied by the organisation. It is therefore important that plans are in place for the best use of these staff. The risks of lack of continuity for a child like E need to be carefully considered, and plans made with clear reasons for choosing to use a temporary or permanent member of staff.
- 9.27 During the spring of 2013, although E was working towards his exams, he was also demonstrating increasing levels of anxiety and 'outbursts' at home. In response to a worrying situation, SWRO1 and SW1 carried out a joint visit on 2nd April 2013 – a useful step, as it involved teams across the service. However, 3 days later, matters had escalated to the point where there was police involvement, and E was removed from home overnight. FM did not inform the LA about this incident for 3 days (nor did the Police send the required notification to alert Children's Social Work Services for their attention), and then only reported that E had been violent, not that he had been removed. **Finding 8** addresses the inconsistent notification of police-recorded incidents to Children's Social Work Services.
- 9.28 There was no plan in place which enabled all concerned to focus on the growing concerns of the FM or on E's deteriorating behaviour, and there is no record of E being seen in response to this incident. This was an insufficient response to a serious and risky event. A strategy meeting or professionals meeting would have been an appropriate means to bring together all of the agencies who were providing interventions to E and his foster family, even after the delayed reporting of the most recent violent incident. It would have enabled knowledge of the deteriorating situation to have been shared, along with FM's worries about E's potential mental health difficulties. Again, the role of the Corporate Parent should have come to the fore at this point.
- 9.29 E's social workers (between April 2013 and May 2014) met the requirements of statutory visits to E, in line with Children Act regulations. It is not always clear what their purpose or focus was or whether E was seen alone or in the company of his FM. There was no chronology attached to the case which might have alerted practitioners to repeated patterns of behaviour. This resulted in successive practitioners responding to the immediate issues, for the most part presented by FM, and failing to deal with them in a coherent and planned way. The overall **Finding 3** comments on the inconsistent use of chronologies in B&H Children's Social Work Services and the effect on practice. **Finding 7** addresses issues related to poor recording.
- 9.30 The lack of a chronology became increasingly important throughout the remaining period as opportunities to identify patterns of behaviour and their meaning, including extreme examples of risk-taking, self-medication with drink/drugs, and signs of depression or anxiety were lost. One exception to this observation was the RUOK worker, who recognised a pattern of escalation in E's drug-taking and other risky behaviour, and who therefore took up the referral regarding E (which he refused to accept) in order to give advice to the professionals working with him.

- 9.31 One of the most notable features of this case was E's presentation at school (and later college), as a 'model pupil' and a hard working, 'cheeky cheerful chappie', which was in stark contrast to the angry and potentially self destructive behaviour acted out elsewhere. Whilst it was important for workers to be able to recognise and praise E's many positive attributes, it was noticeable (from records seen) that at that time, they were less likely to reflect on aspects of his behaviour and activities which told a different story and indeed suggested an underlying emotional struggle. Much of what was going on for E was seen as 'typical adolescent behaviour', including cannabis use and coming to the attention of the Police.

Summer 2013: Leaving school and E's first Pathway Plan Review

- 9.32 By the summer of 2013 E had secured sufficient passes at GCSE to gain a place on his chosen course at college, several miles from his home town. Both he and his foster parents were pleased with his results and they helped him buy a motorbike – a real reward for his hard work, and one which enabled him to travel to undertake a part-time job. The summer months passed without further known incidents.
- 9.33 Children's Social Work Services' records are unclear about the level of contact with the family and E during this summer. The departure of SW1 is given different dates (in May and June) on the e-system, and there was no clear record of a formal handover of the case – although a Transfer Summary usefully included case history sections copied from a previous summary. Transfer of E's case, consecutively, to two agency social workers took place through July and August. E never met the first of these (SW2), although she prepared a records-based report for his Pathway Plan Review (PPR) meeting in August.
- 9.34 There is a general sense of drift and loss of momentum in this period. The requirement for 'an assessment of E's needs for advice, assistance and support'¹², as a 16-year old 'eligible' young person¹³ is not mentioned, and appears not to have been undertaken by the succession of SWs in 2013. By the time the first PPR meeting was held, FM and FF had told E about the approach from his BF. E was reported as not wanting to have face-to-face contact with his BF yet. This was seemingly not questioned by the professionals involved and we found no evidence that recorded plans were put in place to support E with his decision-making or to prepare BF and his new family for a meeting, should E change his mind. There followed e-contact between E and BF, which could be presumed to affect E considerably. In the view of the Review Team, this was a further missed opportunity to take responsibility for a key element of preparing this young person for eventual contact with BF and his family.
- 9.35 The PPR meeting in August, looking back at the past 6 months, presented an occasion and setting to explore important issues with E in a supportive structured setting. However, the review was of limited value, for reasons which will become clear, because it did not address the key issues with which E was grappling. (see **Finding 4**, for details of what was missing (also ref Care Planning and Case Review Regulations 2010).
- 9.36 It was a small meeting, with only E, his FM, SWRO1 and new Social Worker SW3 present. The FF was not present at this review or indeed at any of the reviews in the timescale of this review. The Review Team understand that the absence of a carer is not unusual because of

¹² Children Act Regulations and Guidance, Volume 3: Planning transitions to adulthood for care leavers, DfE, revised January 2015, p10.

¹³ Defined as a child who is a) looked-after, b) aged 16 or 17, and c) has been looked after by a local authority for a period of 13 weeks, or periods amounting to 13 weeks, which began after he reached 14 and ended after he reached 16 (Para 19B of Schedule 2 to the 1989 Act and regulation 40 of the Care Planning Regulations).

the work commitments of some foster parents, particularly foster fathers (not just in B&H, but around the country). There is a very real difficulty in ensuring formal attendance when a foster parent is working, and this was particularly the case for E's FF who worked away from home very regularly. But there are no records to suggest that efforts were made to solicit FF's views – for example by meeting with him beforehand. The widespread absence of many male carers from planning meetings and reviews for children in care is discussed in **Finding 6**.

- 9.37 The PPR meeting (and the process) had no input from education providers. This was a case where involvement from the LAC lead at E's school had been very active in supporting E over many years. She had attended all his LAC Reviews and had developed a good understanding of his educational needs – and was still involved with him during the past 6 months under review. This was also a potential opportunity for E's new college to be represented and to be part of future planning. We understand that this did not happen because E had to agree membership and he did not want his new college to be represented at the review. The purpose of the PPR meeting and the enhanced role of the young person in its conduct are explored in **Finding 4**.
- 9.38 The limitations of such a small PPR can be got round by the use of other forums, such as a professionals meeting, when the LAC Review or the PPR has not included all the relevant people or has not talked about what was needed to be done. During the 2 years before E's death, there were strong reasons to be concerned about aspects of his behaviour. One consistent professional, SWRO1 from the F&F Team, requested a professionals meeting on two occasions (November 2013 and in late summer 2014). This was sensible and good practice, but did not result in a meeting happening. The limited use of professionals meetings is discussed in **Finding 5**.
- 9.39 Had the professionals from all settings been able to share their knowledge of E, this might have resulted in a more comprehensive assessment of his relationships, his levels of anxiety and general emotional wellbeing. It is not clear what understanding professionals had about differing presentations of people with mental health problems, particularly depression. Whilst we found no evidence to suggest a formal diagnosis of depression for E, there were recorded concerns about anxiety and low mood from FM, and some from E himself. Given his family history we would have expected that professionals would have considered this aspect of his health more closely.
- 9.40 E was at times offered services (persistently so, in relation to drug use, by SW3) but, like many adolescents, he was not willing to accept these. This is a well-known challenge to services tasked with engaging with adolescents in different ways. A recent Brighton & Hove LSCB Learning Review (J)¹⁴ commented on the difference in services which are
- '...established in a way that enables a more flexible approach to the young person and are able to be more responsive to individual need and those that are office or clinic-based and are less able to provide a customised approach. CAMHS generally has a clinic based service delivery that is less flexible although the doctors do attempt to provide an individual service as was shown by the last doctor from CAMHS who worked with J. The nature of the Youth Service is that it is most able to provide an intuitive service that is driven by the young person. RUOK attempts to straddle the divide between these two approaches and was very successful at engaging J in productive work'. (Para 4.6.4)*

Please see Para 13.1, under 'Additional Learning', for further comment.

¹⁴ Brighton & Hove LSCB Learning Review J, F. Johnson and A. Gianfranco, August 2014

First year of college

- 9.41 In autumn 2013 E began the college course in aeronautical engineering which he had hoped to do. Aside from some reportedly 'silly' behaviour at the start, he quickly settled down and progressed well with his course. His attendance through that **academic** year was very good, with only two absences recorded over the entire period. However, the pattern of concerning behaviour outside college continued; in his first term he was found unconscious and admitted to A&E following excessive use of alcohol and drugs, and subsequently told his FM about experimenting with cocaine. The carers were informed and on this occasion Police completed the required notification to Children's Social Work Services (MOGP/1). **Finding 8** discusses the inconsistent use of this notification in relation to children allocated to Children's Social Work Services, including children in the LA's care.
- 9.42 This was an example of risk-taking behaviour by E, which, in the Review Team's view, should have prompted a strategy meeting or professionals meeting to include all agencies involved with him.
- 9.43 SWRO1 continued to support FM in trying to manage and help E, but this was becoming increasingly difficult for all parties. She suggested to SW3 that this case needed more input from him, and towards the end of the calendar year, SW3 increased his visits to E to monthly, rather than the statutory three months. SW3 said in conversation that he had reviewed E's records, which suggested that he did not know, and 'was not meant to be told', about the details of his mother's death.
- 9.44 SW3 made regular attempts to engage E with discussing his cannabis use and encouraging him to meet with the appointed RUOK worker, which was good practice. It is an ongoing and wider practice challenge about how to engage meaningfully with young people around substance misuse, particularly if the young people see this as unproblematic.

First half of 2014

- 9.45 The next PPR meeting was held in February 2014, and E's good work at college was noted. As before, membership was limited, and FF again was not present. College personnel who had direct contact with E were not invited and in accordance with E's expressed wishes did not know that E was in care, nor about his reported behavioural difficulties outside college. As with all his reviews, E participated in the whole process – a circumstance that was reported by his IRO as 'rare' among young people. The placement was again described as stable. Concerns about drug taking, and the serious incident that led to E being hospitalised were not discussed in the meeting (again at E's request). Contact with the BF was again confirmed as a matter to be dealt with by E and his carers.
- 9.46 In the following months, E's presentation and behaviour at college was in marked contrast to a deteriorating situation at home, where he was increasingly out of the control of FM and FF. He began to be missing more frequently, to come to the attention of police, and to be defiant and aggressive towards family members, as well as stealing from them. In June 2014, he was arrested, with others, for burglary and theft. FM was informed of this incident, but it was not reported by Police to Children's Services. Police should have completed a MOGP/1 referral to Children's Social Work Services. E also told FM about breaking into a Children's Centre and letting off fire extinguishers. As the frequency of his going missing from home increased, the family's anxiety and exhaustion increased. SWRO1 continued to support FM and to give clear messages about the need to inform Police when E was missing (something that FM did not do consistently).

- 9.47 A further change of social worker took place in May (SW4, another agency worker), without any handover by SW3 – whose departure was reportedly unknown to the family. On allocation, SW4 recalls being told by the previous Practice Manager that E is a ‘nice lad, settled, there are no problems’. (The manager concerned has no recollection of this description, and refutes the words as coming from him.) Within two weeks, however, a very upset FM informed both her and SWRO1 (via emails) that respite care was needed for E, who would not be allowed to go on holiday with the family because of his increasingly defiant behaviour. In the end, the matter was resolved within the family, all of whom had a harmonious holiday together.
- 9.48 Perhaps because of the increasing stresses in their family life, and the absence for over a year of a consistent SW for E, it was likely that the family would struggle to engage with another new SW. For SW4, it was thus a challenge to make a positive and trusting relationship with E and his carers. Both she and her Practice Manager (PM2) identified this as an essential part of the social work task. This was made more difficult as during this period the FM was often unavailable, and at times refusing to meet with SW4 or SWRO1, or to agree to a Placement Stability Meeting, as proposed by SWRO1 and her manager in the F&F Team.
- 9.49 In the midst of this very difficult situation, the F&F Team requested a meeting with the STC team, with a view to agreeing a joint way forward. This did not happen, though the reasons are not recorded. It is not clear whether escalation to a team manager was considered, as a means to achieving joint discussion. (Lack of recording is discussed in **Finding 7.**)
- 9.50 E’s college studies went well and he successfully completed his first year. Although a second year was an option, E made a decision, supported by FM and FF, not to return to college. The next course would be harder and E had achieved enough to pursue a career with the RAF when he was ready. He still needed to pass his English GCSE and plans were in place for him to resit this exam. SW4 made, and pursued, a referral for E to be seen by the Youth Employability Service Worker for the Virtual School. As already noted, this was a period when it was hard for professionals to reach E or FM, but the meeting eventually happened, and E confirmed that he was working in a variety of part-time jobs (thus, not NEET¹⁵).
- 9.50.1 The Review Team felt that this decision to leave full-time education should have been discussed more thoroughly, including at the next PPR meeting (see below).
- 9.51 In 2014, professionals were concerned about how FM was dealing with E’s challenging behaviour. SWRO1 in particular worked hard to offer support to FM, who regularly shared with her many of the difficulties attached to this behaviour. However, FM was reluctant to accept professional support and advice which challenged how she managed E.

Late summer/autumn 2014

- 9.52 The summer months were regarded by SWRO1 and SW4 as a time of almost complete family breakdown. FM continually requested respite care (though there was no clear plan about its purpose), while E would not agree to this. The idea of a referral to Functional Family Therapy was also discussed on a number of occasions (see below).
- 9.53 A further PPR meeting took place in August 2014. Shortly before this meeting, E had a serious accident with his motorbike which ‘wrote off’ the bike and meant he lost his part-time job.

¹⁵ Not in education, employment or training

He felt upset that this experience was not properly appreciated by his FM, and this added to the bitterness and anger in the family relationships.

- 9.54 The PPR meeting: membership remained limited to a small core group in accordance with E's wishes. The IRO recognised that the family was under immense stress because of E's behaviour and deteriorating relationships in the household. She also noted that E was sad and upset about how (he felt) he was treated differently from his cousin/'brother'.
- 9.55 E's decision not to return to college could have featured more prominently in the review and been explored with him in detail, and the involvement of education would have assisted this process. However, a useful plan was made for him to retake his English GCSE – something he needed in order to join the RAF, which remained a goal for E.
- 9.56 For a very long time, email had been FM's preferred means of communication with social workers. During these summer months, she was letting workers know in her emails how badly things were going downhill in the family. At the same time, it was becoming very difficult to arrange other forms of direct contact, especially for the workers and manager in the STC Team. FM was not available for arranged visits, or did not agree to these. At a point of crisis, when communicating and working well together were needed more than ever, those jointly responsible for E were struggling to work together effectively.
- 9.57 A few days after the PPR meeting, recognising that the placement was at risk of collapse, SW4 and SWRO1 were proactive in trying to seek out both E and his carers. An unannounced home visit was finally successful, which enabled them to meet with FM, and then to have a detailed discussion with E on his own. This was good joint work and demonstrated both persistence and assertiveness on their part.
- 9.58 SWRO1 and SW4 urged that a referral to Functional Family Therapy (FFT), previously discussed, was needed if the placement was to continue. This was agreed by FM, but not by E – and thus, it could not be accepted by FFT, as their model relies on the participation of all family members.
- 9.59 The specialist health nurse also saw E during this period (just after the PPR meeting). In preparation for the visit she reviewed the previous year's health report and consulted with her colleague. This was good practice.
- 9.60 E's annual health check was reported as largely 'unremarkable'. E's emotional wellbeing was covered in this and the previous annual health check, and he did not disclose anything of concern in relation to mental health or emotional difficulties. However, the nurse recognised that E was in distress, apparently because he was struggling to deal with the practical consequences of his bike accident, mainly dealing with insurance matters. E was clear with her that he did not want these feelings to be shared with the social worker. The nurse persisted and was able to get E's permission to share some of her concerns with SW4, specifically about his needing help with insurance as a means of supporting him.
- 9.60.1 The health action plan which the SW is sent a copy of covered all the issues discussed at both reviews, which is helpful in ensuring that the SW remains aware of the process.
- 9.61 The managers of both SWRO1 and SW4 were both now involved in addressing the serious breakdown of the placement. FM had notified professionals (via email) that E was out of their control, and she had renewed concerns that he might be using cocaine, as well as cannabis;

she again mentioned his 'mental health' history – something which was only infrequently raised with professionals. The need for a different kind of meeting (and a different strategy) was acknowledged, and at SWRO1's instigation, a professionals meeting was agreed across their two teams. Unfortunately, this had to be delayed because of SW4's annual leave (mid-September).

- 9.62 As the placement problems escalated, the difficulty for workers in communicating directly with FM became critical, as she was refusing visits or meetings entirely in the second half of September – communicating only by email. There was no clear joint strategic response to this from the professionals involved, when a more robust insistence on partnership with the Corporate Parent was needed (**Finding 1**).
- 9.63 A move to respite care had been offered from July onwards, but was repeatedly resisted by E, who at times resorted to breaking into his own home in order to remain there. In October, a move to alternative foster carers was finally brokered, in response to FM's persistent requests. She was struggling to deal with E's increasingly aggressive behaviour, as well as his further lengthy periods outside the home. The foster home was at some distance from E's home area, but the move, to experienced foster carers, was appropriate.
- 9.64 The status of this move was not understood in the same way by all concerned. Was it 'respite' or an open-ended/permanent move? The new foster carers and FM believed it to be permanent, while most professionals (as reported in conversations) saw it as respite (although at the beginning, likely to be of uncertain length). It is not known what E understood about the nature of the placement. The ambiguity was increased by FM's packing up all E's belongings into bags to be removed by SW4. What was clear was that the SW team wished to preserve and support E's links to his family whilst away from home. Despite the anger at this point for both E and his family, their ongoing attachment was never in doubt.
- 9.65 E's BF has said in conversation with the Lead Reviewers that he feels professionals in Children's Social Work Services should have contacted him at this point, about E's need for care. It seems unlikely that this would have been thought of, given the fact that E's relationship with his BF had been left to E, and had received little professional attention for some time. The nature of the growing relationship and its impact on E should have been the subject of an ongoing assessment process.
- 9.66 Shortly before E's move to the new foster carers, Children's Social Work Services staff (PM2 and SW4) visited the home, met with FM, and as a result were concerned about her wellbeing. They wondered whether she had problematic alcohol use, and a discussion with SWRO1 afterwards suggested that there had been 'issues' about excess drinking in the past (this is denied by FM).
- 9.67 On the day that he moved, in response to a question from SW4, E made allegations about his foster parents' excessive use of alcohol. As a result, a 'Standards of Care' investigation¹⁶ took place. Local procedure suggests that this should commence with a joint visit by the SWRO for the carers and the SW for the child, and that the outcome should be determined across both parts of the service. However, neither team appeared to recognise what needed to happen, and the F&F Team undertook and completed the investigation alone. The Team have

¹⁶ Standards of Care investigations are carried out in relation to foster carers where there are allegations or concerns about how they are caring for the child in their care. This process covers the kind of concerns which are not deemed to need a child protection, or S47, investigation.

acknowledged that this was an oversight on their part, regardless of whether E was to return to FM and FF or not.

- 9.67.1 The outcome of the investigation was a request for FF to seek advice from his GP about his alcohol consumption.
- 9.68 E was reported not to be entirely happy with the arrangement, as he saw it, of becoming a 'foster child' and being looked after by professional foster carers. However, he was active in finding work (at a local locksmith), and was pleased to have an income of his own. He spent time with his girlfriend and remained in some contact with FM and FF, via a wider family gathering to which they invited him.
- 9.69 E initiated more Facebook/email contact with BF during this period, and was upset and angry after learning from him a different description of some of the events of his very early years: a reminder of the complexity of identity and Life Story work. Had there been planned work with both E, his BF and BF's immediate family prior to their contact, the impact on E might have been altered.
- 9.70 Whilst away from home, E also attended a GP appointment at which he sought help for feeling anxious and depressed. The GP offered a follow-up appointment to continue assessing E's needs, but the date for this was after E had left Brighton. Neither Children's Social Work Services, nor FM and FF, were aware of this consultation.
- 9.71 In late November, E was in the vicinity of his old home, when he discovered a burglary had just taken place there. He let FM and FF know that he wanted to move back home immediately. They agreed, and collected him from his new foster carers' home without initially approving this with the LA (the foster carers challenged FM about this, but she removed E without official sanction). The decision between E and FM was checked with Children's Social Work Services after the fact. In response, SW4 and PM2 insisted that this return home had to be with input from Functional Family Therapy, and SW4 and a worker from FFT visited to outline how this would be taken forward. This was an appropriate condition to be given to E and the family.
- 9.72 E was convinced he knew who had committed the burglary. He visited and confronted the alleged perpetrator (a close friend), and in doing so unintentionally assaulted the young man's carer. E was aware that his friend was associated with a particular group, and had been the victim of a stabbing in the recent past. Now, E became extremely fearful that he too would be harmed because of what he had done – possibly by the young man's associates (the reasoning is not entirely clear). What was apparent was that E became utterly determined to leave Brighton in order to escape harm.
- 9.73 This crisis coincided with the ongoing e-communication with BF, and E now had the idea that he could move away from the area, to BF, to ensure his own protection. BF had been told about this by FM, and they had discussed the need to keep E safe. All this occurred immediately prior to the PPR Meeting on 27th November.

PPR Meeting 27th November 2014 and following events

- 9.74 The PPR Meeting on 27th November had been brought forward because of E's move into respite care. After his unexpected move home, PM2 proposed a professionals meeting outside the PPR, and this was sensible and good practice. It appears time ran out for this to

happen, as events unfolded. A visit to the family between SW4 and FFT was also reported to have been made in the week before the PPR Meeting (but not recorded – see **Finding 7**).¹⁷

- 9.75 The meeting had the usual attendees, but this time, prompted by recent events and E's precipitate return home, it sought to address concerns and put a plan in place to support E and the family. SWRO1's manager was present and this was a clear indication of the seriousness with which the F&F team regarded the situation. The preparatory report for the PPR dealt with some underlying issues, and the IRO spoke about E's anxiety and reinforced the need for Life Story work about his past and identity. The idea of input from FFT to support his principal placement with FM and FF was confirmed. This was good practice.
- 9.76 However, E's level of fear about his personal safety, and his insistence on leaving Brighton immediately, overshadowed all the other discussions. The professionals present saw that he was genuinely in fear for his life, and that he would not consider any option short of going right away from Brighton, and to stay in BF's care. E was now 17 years and 10 months old, almost an adult, and would clearly be able to 'vote with his feet'. A decision had to be made about his immediate future, and there were attendant risks attached to each potential course of action as well as to inaction.
- 9.77 The decision-making after this point has had to be pieced together to a large degree from the recollections of people involved at the time, because the records in Children's Social Work Services relating to particular decisions and the rationale for them are poor. Adequate recording has been an issue throughout the case (see **Finding 7**) and it is particularly unfortunate that it was not more carefully attended to at the time, given the influence hindsight will now have, in light of the known and tragic outcome.
- 9.78 What is clear is that the Children's Social Work Services' position moved in a short space of time. It started at the point of the PPR Meeting as one that acknowledged E's perception that he was in danger, but which saw his desire to go to his BF as potentially risky and inadvisable, given that the two had never met. Attempts were initially made to find an alternative foster placement that he could move to as soon as practically possible, while involving the police in a risk assessment. Police who spoke with us were clear that they saw the risk to E as low (but see following paragraph).
- 9.79 Children's Social Work Services' initial reservations about E going to the local authority where his birth father lived were shared by FM, but she was seen to be in support of the plan, if it was the only way to protect him. In the afternoon, the police visited E and FM to advise on personal safety and appropriate protection measures¹⁸. E's apparent unwillingness to comply with these, together with his refusal to stay with FM or to use any other offered local placement, made it difficult, if not impossible in the view of Children's Social Work Services, to keep him safe while he remained in Brighton. They now accepted that a) E was determined to leave Brighton, and b) that he could not be kept safe by the Police while remaining in Brighton (this 'view' has been denied by Police with whom we have spoken, and it remains unattributable).
- 9.80 By the end of the day, after a number of earlier telephone calls between E, FM and BF (although accounts differ on this), and a critical afternoon conversation between PM2 and BF, stressing the apparent high risks in Brighton, the move to BF had been agreed, as it was seen

¹⁷ FM says that this meeting was cancelled.

¹⁸ FM states that the visit was mainly about mediation between E and the young man he had assaulted. She also states that the police officer did not say E could not be kept safe in Brighton.

by Children's Social Work Services to be the 'least worst' option in circumstances where E reportedly refused to consider any alternatives. By this stage it was also known that BF, although willing to help, could not have E to stay in his home as he had not had time to prepare his family for E's existence. E was to stay with BF's friend/neighbour, allowing him time to do this. The move of E was made by FM taking him to meet BF at a designated place, so that he could be driven to the local authority where BF lived.

- 9.81 Efforts to find an alternative arrangement continued. In fact, by the following day, a potential foster placement in Bedford had been identified, to be explored the following week.
- 9.82 Whether the situation was as grave as E perceived it to be will never be known. What does seem to be clear is that the social work response became reactive; rather than seek to slow things down in order to assure themselves of E's safety in an unknown placement and in line with regulations, their responses reflected that they had become convinced that he was in immediate danger. The degree to which this reaction was driven by E's age – almost 18 and old enough to make his own decisions – is a matter for debate. Notwithstanding his age, the regulations regarding placement of a looked-after child still applied, and still required the LA to act as his Corporate Parent, in line with these regulations.
- 9.83 The approval of a senior manager, as a final gate keeping safeguard, is necessary for any 'unregulated' placement even in an emergency. This was not sought, as it procedurally should have been, although the service manager was later that day informed of the decision to move E and saw this as a *fait accompli* – and one made by managers whose judgement he trusted. The events, as described to the Review Team, suggest that the significance of an 'unregulated' placement and therefore the need for senior management approval were not clearly apprehended and considered by any of the managers during this process. This should be a matter of concern for the department, given that these regulations are there for the safety of all concerned – both officers and service-users alike.
- 9.84 As already noted, the decision-making in this crisis was poorly recorded, including the rationale for it. It is likely that at the time the move was judged to be a pragmatic, temporary solution in line with what E wanted. Our conversations with the staff involved support this assessment, but the lack of records gives us no firm evidence for this.

FM's and BF's views

- 9.85.1 Both FM and BF dispute the account outlined above. BF believes he was pressurised into providing a solution to an immediate crisis. He only agreed because he was convinced of the reality of the risk to E, and because of his desire to help his son in these circumstances. He was reluctant on the grounds of meeting his child for the first time in this way, and also because his other children did not know of E's existence.
- 9.85.2 FM states that she never agreed to E's move, and in fact says that by the end of the afternoon, he had calmed down and agreed to remain at home with her and FF. This was not communicated to Children's Social Work Services. She feels the decision was taken out of her hands by PM2 negotiating the plan directly with BF.
- 9.85.3 Both FM and BF believe that Children's Social Work Services exaggerated the risk to E and were determined to move him away. They find it hard to understand how the decision in the morning (that he should not be moved to BF) was changed in the afternoon.

- 9.86 B&H Children's Services remained in phone contact with BF and E on 28th November (Friday). His SW4, in her own time, kept in touch with him by telephone over the week-end. However, there was no contact with BF's friend/neighbour with whom E was staying, and no checks were carried out regarding him. The minimum of a Police check was agreed, but not carried out due to a misunderstanding about who would do this. Having made the arrangement, there should have been immediate follow up to risk assess, including a home visit to both BF and his friend/neighbour before the weekend (possibly by local Children's Services).
- 9.87 A foster placement in/near the area that BF lived had been identified for discussion on the Monday. E died as a result of self-strangulation (by hanging) on the following day.

Conclusion

- 9.88 The Review Team have given much thought to the events immediately preceding E's death and have scrutinised the decision-making by all parties. After a tragedy such as this, it is natural to seek explanations and sometimes to want to blame an individual or an organisation; this is not the position of this review. It is the case that practice could and should have been better at different times and in ways that the Findings (below) consider in broader terms. It is also the case that there were examples of good individual practice in what we have seen. It is our view that there is no justification for making a causal link between practice, even poor practice, and E's death.
- 10. What is it about this case that makes it act as a window on practice more widely?**
- 10.1 The initial research questions for this SCR (Para 4.1 above) suggested that this individual case might identify general findings about working with young people and their families in long-term kinship placements, including those where the turbulence of adolescence brings greater challenges for carers and young persons alike. This has proved to be true, and these patterns are ones which affect the work of agencies (especially Children's Social Work Services) far beyond this LA.
- 10.2 We found a number of additional local challenges, in the inconsistent use of case history, record-keeping, and, in one team, a period of over-reliance on agency staff. There were recognised problems in the number of electronic record systems (3 separate ones, at the time; now reduced to 2). There were also some familiar 'attitudinal' patterns, in relation to male carers and connecting with young people who do not easily share their underlying distress or vulnerabilities.
- 10.3 The research question relating to 'vulnerability to group activity' has not proved fruitful, in that we have found no information to suggest that E was linked to any anti-social or criminal 'group', nor involved in any identifiable activity by such a group (bar a peripheral friendship with one other young person).
- 10.4 Similarly, it was difficult to reach any broader conclusions about working with a young person where there is a family history of suicide, save to say that this is a relevant factor in any assessment of emotional vulnerability.

11. Findings list

11.1 A list of the **findings** follows below, each matched with a category, which names the type of systems finding it is, according to the SCIE list of categories (Appendix 2, Para. 5).

1. There is an inherent tension regarding the respective roles of the local authority as Corporate Parent, and Family and Friends Carers who are seen as 'parents' or 'family'. This can result in unhelpfully blurred boundaries and a difficulty in asserting the LA's statutory responsibility for a child or young person when this is required.	Communication and collaboration in longer term work
2. In Children's Social Work Services, it is difficult to access the various sources of a looked-after child's past records, leading to an associated response of not prioritising this essential preparation; the result in many cases is that the Corporate Parent does not easily know the life story of its children.	Tools
3. The tools for transmitting background information about a child or YP (transfer summaries and chronologies) are not produced to a consistent standard, meaning that a new SW may not have the background and qualitative information which would support a holistic understanding of the child/YP and family and their needs and risks.	Communication and collaboration in longer term work
4. Is there a risk for professionals, in following Care Planning, Placement and Case Review Regulations, to give too much responsibility to young people over their Pathway Plan Reviews, with the result that difficult subjects are not raised if the young person objects?	Communication and collaboration in longer term work
5. Nationally, there is no routine framework for multi-agency professionals to meet outside of Pathway Plan reviews, leaving the responsibility with an individual practitioner to convene such a forum. The result is that planning and decision-making for a child often proceed without the benefit of a joined-up discussion of others' perspectives and concerns about a child.	Management systems
6. There is a pattern of focusing only on the primary (usually female) carer for a child in care, and not giving sufficient attention to the role of the non-primary carer (usually male). This can result in professionals' lack of awareness of both positives and negatives that the other carer may bring to his/her role.	Human biases
7. In B&H Children's Social Work Services, there is inconsistent recording. Without a complete and accurate record, it is difficult for practitioners and their managers to analyse the facts and context of a child's situation, and to make appropriate decisions and plans.	Management systems
8. Sussex Police do not always act in accordance with their own guidelines by informing Children's Social Work Services about their observations of, contact or interventions with young people. This means that opportunities for joint thinking, decision-making and interventions may be lost.	Communication and collaboration in longer term work

12. Findings in Detail

12.1 Finding 1. There is an inherent tension regarding the respective roles of the local authority as Corporate Parent, and Family and Friends Carers who may be seen as 'parents' or 'family'. This can result in unhelpfully blurred boundaries and a difficulty in asserting the LA's statutory responsibility for a child or young person when this is required.

(Communication and collaboration in longer term work)

12.1.1 F&F carers are rightly regarded differently from other foster carers. Their motivation to care for a member of their family is unlike that of professional foster carers who wish to undertake this role as a job. The expectations placed on F&F carers are defined differently, and they are paid at a lower rate. However, in choosing to be F&F carers, family members are electing a formal, supervised arrangement over a private one – one for which they get an allowance and within which they can expect support and supervision for themselves, and appropriate services for the child in their care. These formal expectations should be agreed on both sides, including the minimum standards of care which are the legal responsibility of the LA as Corporate Parent. National statutory guidance outlines these as follows:

'Whilst many of the issues that go with being a family and friends carer are likely to be the same whether or not the carers are approved as foster carers, being a foster carer brings with it additional responsibilities and obligations which have to be met. The local authority will be responsible for the child's care plan and for supervising the family and friends foster carer, whilst the family and friends foster carer will exercise delegated authority within the overall framework of the care plan and the placement plan and will be expected to demonstrate they are meeting the child's needs as set out in the care plan and engage in appropriate learning and development'.¹⁹

12.1.2 B&H's F&F policy²⁰ outlines these expectations and gives descriptions of what is on offer to carers locally, how they will be treated, and the commitment to the child in placement.

12.1.3 Neither national nor B&H local guidance and policy documents address the issues highlighted in this finding, nor do they refer to the extra complexity and stresses that many F&F placements experience. In other words, the nature of the partnership required between LA and carers, and potential difficulties in this, are not included in guidance and policy documents – thus leaving individual services to work this out for themselves. This finding suggests that where longstanding F&F carers have virtually all authority delegated to them, the LA may find it difficult to intervene when needed to ensure a child's needs are being met.

How did the issue feature in this case?

12.1.4 FM and FF were approved to care for their nephew at a time when this agreement was not required to be ratified by a Fostering Panel or Agency Decision Maker, as has been the case now for several years. A relationship with the LA developed over time which saw them as the 'parents' of E, who were well able to get on with his care and their family life with minimal input from the LA. FM and FF loved E and were seen by professionals as highly committed to ensuring he would grow up safely in their care. This was true of the workers from both teams (F&F fostering team and Children in Care Team) and E's Independent Reviewing Officer (IRO),

¹⁹Family and Friends Care – Statutory Guidance for Local Authorities, DfE, 2010, Para 5.2

(<http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/Family%20and%20Friends%20Care.pdf>)

²⁰ Family and Friends Policy, Brighton & Hove City Council, July 2014

all of whom knew the child and family for a very long time (up until age 16, when there were several changes of workers).

12.1.5 However, E was a child with a complex and sad history of repeated separation and loss, which extended until the death of his mother when he was 8 years old. Thus, he had very complex needs, and the placement was not always straightforward, including in its early years. The difficulties for E and his carers were to be expected, given his early experiences of abuse and neglect, and then a protracted period of uncertainty about what would happen to his mother and who would care for him in the long-term.

12.1.6 This review has focused on the two years of E's 'transition' from adolescence to adulthood, a period which often brings real distress for young people who are unsure about many aspects of their lives, including the distant loss of parents and their own identity. In the turmoil of E's mid-teens, there were important aspects of the LA's role which were not sufficiently dealt with on both sides. The delegation of decision-making to FM and FF exposed areas where the Corporate Parent needed to be more assertive in order to ensure that E's complex needs were being met. For example:

- The re-surfacing of E's need for Life Story work – in particular, explanations about his mother's death and what had happened to his father – were not agreed by FM and therefore not addressed in his Care Plan.
- The LA and the carers did not work together to prepare E for contact with his birth father, but rather let this be handled by E and the family, in a way which did not prepare E for meeting him.
- The responsibility of the carers to inform the LA and Police about all missing episodes was not well established or consistently adhered to – although they were reminded of this by SWRO1.
- Important decisions (e.g., dealing with E's contact with his BF, and about E's return home from respite care) were taken by his carers, without input from Children's Social Work Services.
- Face-to-face meetings between the carers and Children's Social Work Services (SW4 and SWRO1) were eventually declined by FM, in a period of serious crisis in the placement, when there needed to be a strong partnership with the LA.
- There was a pattern of FM's seeking help from Children's Social Work Services when things were going wrong with E, but, once things were 'right' again, of her unwillingness to work together to try to prevent future problems or crises.

12.1.7 FM had consistently been given considerable responsibilities through what in time (from mid-2014) became a fully recorded process of 'delegated authority'. In this case the formal record of delegated authority extended to all aspects of parental care, to a point where it was unclear what responsibilities remained to the LA as Corporate Parent. This approach in the end made it complicated and more difficult for Children's Services to work in partnership and to intervene at points of family crisis and finally placement breakdown.

12.1.8 As the placement was under such very great strain in 2014, a stronger intervention by the LA could have been considered – e.g., developing an action plan with E that included steps to address behavioural and relationship issues.

What makes this an underlying issue?

12.1.9 There is nothing to suggest that practice in this case was fundamentally different from other cases of F&F or network care in B&H (although the length of this fostering arrangement may

have been unusual). The F&F Team are clear that the way of working with F&F Carers is very different from the relationship with professional foster carers. National minimum fostering standards are maintained, but in most other respects, F&F carers have delegated authority which covers virtually all aspects of the child's care.

- 12.1.10 In many if not most cases, this does not cause problems. But in some circumstances, the rights of the carers/'parents' to make decisions for the child and to deal with matters of all kinds can become overriding, and may not be challenged when it is needed to do so.
- 12.1.11 The current B&H Delegated Authority form does not adequately spell out and distinguish the respective roles and responsibilities of the LA as Corporate Parent and of the carers, thus leaving room for confusion and disagreement.

What is known about how widespread or prevalent the issue is?

- 12.1.12 This is not just a local issue. Nationally, F&F Carers (often termed 'Connected Persons' carers) are appropriately regarded as the first alternative placement for a child who cannot be cared for by birth parents. They make up 11% of placements for all LAC children and 15% of all LAC children in foster care (Figures for end March 2015: 7,910).
- 12.1.13 The importance of family links for looked-after children is universally acknowledged, both in terms of research evidence about outcomes, and in the statutory framework for looked-after children. As a consequence, there is a different kind of approach to how such placements operate. Many, if not most, children in F&F placements would rather be there than anywhere else (this was definitely true for E), so removal by the LA is something to be avoided wherever possible.
- 12.1.14 For long-term placements, new statutory guidance²¹ regarding permanence and long-term foster placements confirms a 'lighter touch' approach, albeit one which must be carefully assessed in each case. This is likely to push practice in the direction of giving more responsibility and independence to the carers, in a way which this finding might wish to challenge – or at least provide a cautionary note.
- 12.1.15 Alongside all the positives for a child, it is also the case that many F&F placements are very emotionally complex, with carers often distressed about the family member (mother or father) who has not been able to care for their child. The demands on F&F carers are increasingly being recognised, so that specialist support groups and separate training to support them are being developed in many places. B&H has a comprehensive set of workshops and training packages to meet the needs of F&F carers. These are not compulsory, but carers are encouraged to use them.

Why does it matter?

- 12.1.16 The LA retains Parental Responsibility for children under Full Care Orders, although as in this case considerable responsibility for day-to-day decision-making is delegated to carers. The LA are required to follow the legal procedures for promoting the wellbeing and safety of a looked-after child, and providing a dedicated social worker who is responsible for ongoing assessment of the child's needs and for making and reviewing plans to meet these.
- 12.1.17 In order to carry out this responsibility, both the LA and carers need to be clear from the outset about what their respective roles and responsibilities are in implementing the child's

²¹ *Permanence, long-term foster placements and ceasing to look after a child: Statutory guidance for local authorities*, DfE, March 2015

Care Plan/Placement Plan. Thus, it is essential that the LA's complex relationship with F&F carers is better defined and agreed, so that the needs of the child for safety, stability and healthy development can be met as well as possible – including at times of conflict and vulnerabilities in the placement.

Finding 1: There is an inherent tension regarding the respective roles of the local authority as Corporate Parent, and Family and Friends Carers who are seen as 'parents' or 'family'. This can result in unhelpfully blurred boundaries and a difficulty in asserting the LA's statutory responsibility for a child or young person when this is required.

The lack of clarity about the respective roles of the Corporate Parent and F&F carers for a child in care means that when the Corporate Parent needs to assert its authority to ensure the wellbeing and safety of a young person, they may be severely compromised. This is because the LA as the Corporate Parent has not found a way to properly distinguish between:

1. *Delegation* with its obligation to oversee the decisions of the F&F Carers whilst retaining ultimate responsibility
- and
2. Effectively *relinquishing* decision-making to F&F Carers whilst calling it "delegation".

Considerations for the Board and member agencies

- How can the Board satisfy itself that B&H Children's Social Work Services retains the necessary authority invested in it as Corporate Parent to ensure the best possible outcomes for a child or young person?
- How can the Board satisfy itself that F&F carers are provided with specialist support groups and training, which meets their particular needs?
- How can the Board ensure that Children's Social Work Services staff and F&F carers are unambiguously clear about each other's roles, rights and responsibilities – including when there are disagreements or problems in the placement?
- Would it be helpful to review the local policies and procedures for F&F carers, in line with the issues raised by this finding?

12.2 Finding 2. In Children's Social Work Services, it is difficult to access the various sources of a looked-after child's past records, leading to an associated response of not prioritising this essential preparation; the result in many cases is that the Corporate Parent does not easily know the life story of its children. (Tools)

12.2.1 There is not a routine habit by new workers (Social Workers/SWROs/Practice Managers) to review a child/family's history when picking up a case; indeed, to achieve this is regarded as extremely difficult. Reasons given are: not enough time, combined with inaccessibility of old files, and profusion of records in different formats which do not join up to make a comprehensible whole.

12.2.2 This situation acts as a detriment for planning, decision-making, and working directly with the child, as well as inhibiting the Corporate Parent's responsibility to record and maintain an account of the child's story and experiences – for the child and workers alike.

How did the issue feature in this case?

- 12.2.3 E's changing social workers in 2013 and 2014 had a weak understanding of his history (although one, SW3, said he knew about the 'secret' kept regarding his mother's death). They had not read old records, and did not have access to a complete chronology for E and his family. This inevitably affected how they saw some of his risk-taking behaviour, his relationship with his carers, and his questions about his parents and his past. For example, the history of multiple suicides in his close family was not part of his 'story', nor the several years of dysfunctional contact (on/off) with his birth mother. A link between a pattern of familial suicides and the vulnerability of a young person²² or adult was therefore not explored in relation to E.
- 12.2.4 The Practice Manager/supervisor (2013 and part of 2014) equally had limited information about E's history, and was thus unable to fill in any gaps for his workers.

What makes this an underlying issue?

- 12.2.5 Members of the Case Group were adamant about the general difficulty in accessing previous Children's Social Work Services records. This is because they are held in different forms (paper and electronic) and in many different places, and more than one electronic system is in place (previously 3; now 2). The Review Team were told that piecing the jigsaw together is daunting, and requires more time than most workers or their managers have. (This fits with the description of agency workers being required to 'hit the ground running'.)
- 12.2.6 It does not help that chronologies are inconsistently used in B&H Children's Social Work Services, making it more difficult to see patterns in behaviour, clusters of incidents, and thus to be alerted to worrying cycles or repeated signs (see the next **Finding 3**).
- 12.2.7 But: a member of the Review Team managed fairly quickly and easily to access social work records for E from several years ago. Even E's earliest history is available to be read in legal files, offering a coherent account of essential background material, especially about his experiences with his mother and the decisions made regarding his long-term care. It is the responsibility of managers and front-line staff to prioritise the time for such reading. Similarly, managers and staff are responsible for maintaining an awareness of relevant research relating to vulnerable young people and areas of particular risk.

What is known about how widespread or prevalent the issue is?

- 12.2.8 This is a national issue, given that all the barriers described above are complaints familiar in Children's Social Work Services departments around the country: a mixture of old paper records, sometimes in archives some distance away, and newer/mixed or incompatible electronic systems which are not easy to navigate and rarely have a section which provides a full and coherent history of the case, or the child/family. A recent SCR²³ suggested that 'cut and paste' functions used for updating documents in some systems do not allow for 'old' material to be sifted, resulting in a confused account, not useful to anyone.
- 12.2.9 A number of SCRs nationally have confirmed the poor attention and time given to reading historical records, in whatever form they are.

²² Research findings relating to greater vulnerability to suicide, across countries and internationally (e.g., the World Health Organisation), consistently cite a family history of suicide as 'a predisposing factor'. Please see References for examples of such research.

²³ SCR regarding Child B, Kingston LSCB, 2015

Why does it matter?

- 12.2.10 There are two critical reasons to know about and reflect on a child's (child in care) story. The LA, as Corporate Parent, has the same responsibilities of a 'natural' parent, who must try to understand their child and to keep him safe and developing well, in the context of his individual experiences and needs. For the LA, this must underpin the ongoing process of care planning and review.
- 12.2.11 Secondly, the current Social Worker for the child needs to be able to use the same historical picture to guide their understanding of the child, and to gauge the effectiveness and suitability of plans and interventions – especially in the tumult of adolescence.
- 12.2.12 Despite a sense of 'something missing', there does not appear to be a robust debate about the risks of undertaking complex work with the child/YP without a proper understanding of his or her psycho-social history. It is vital that the organisation and the worker who represents it at the front line must feel that this is *their child*, and behave accordingly. Without this level of knowledge, understanding, and informed involvement, the child will not feel (nor be) held safely and securely.

Finding 2: In Children's Services, it is difficult to access the various sources of a child's past records, leading to an associated response of not prioritising this essential preparation; the result in many cases is that the Corporate Parent does not easily know the life story of its children.

Typically social work staff taking on a new case do not undertake a review of a child's history. This seems to be due to a combination of believing there is not enough time and that the task is too complex with records being difficult to access. There is also a lack of awareness of the dangers in failing to do so. This results in a failure to see patterns of behaviour indicating a change in risk. The absence of an effective tool for chronologies makes it difficult to maintain 'life story' work.

Considerations for the Board and partner agencies

- What is the LA's expectation in relation to workers' knowledge and understanding of an individual case at the point of transfer?
- What is the current policy for guiding staff to appropriate source material?
- What review systems are there in place to ensure 'life story' work is maintained for children in care?
- What is Children's Social Work Services' expectation in relation to staff recording new information from whatever source?
- What kind of training is needed, and for which groups of staff?
- Is the Board aware of the limitations of Children's Services' IT systems?

- 12.3 **Finding 3. The tools for transmitting background information about a child or YP (transfer summaries and chronologies) are not produced to a consistent standard, meaning that a new SW may not have the background and qualitative information which would support a holistic understanding of the child/YP and family and their needs and risks.**
(Communication and collaboration in longer term work)²⁴

12.3.1 The idea that 'background' information is necessary in order to provide an effective and appropriate service to a child/family is a familiar one, but one which is often overlooked when workers can find no readily accessible sources for that information. Transfer summaries (and, where possible, face-to-face handover meetings) and chronologies are essential tools for workers and their supervisors to rely on. Where these are not consistently available and well used, the work with children will be of a lesser quality, and may not be safe.

How did the issue feature in this case?

- 12.3.2 E's SWRO2 provided both a Transfer Summary and a face-to-face handover meeting when E moved to the 16+ Team and a new Social Worker – excellent practice. After that change of workers, there were no further handover meetings, so the function of the Transfer Summary became extremely important.
- 12.3.3 SWs (1 and 2) both created Transfer Summaries, cutting and pasting the useful history which had been included by SWRO2. Some, but not all, current issues were 'flagged' by SW1, but the next worker was unfamiliar with the case and had nothing else to add. SW3's Transfer Summary had lost all the 'history' material, leaving SW4 with little to go on, apart from an inaccurate description (at that point) of the placement as 'stable'.
- 12.3.4 Chronologies were not available for E's recent (or more distant) history, and this meant that, e.g., patterns of 'incidents' and crises in the placement, as well as clusters of offending, were not able to be identified as a build-up of troubling signs.

What makes this an underlying issue?

- 12.3.5 The Review Team were told that Transfer Summaries do not consistently provide the right kind of in-depth information and analysis which would support a new worker's understanding of the child/family. A different problem, of accessing them electronically, was identified in the recent Baby Liam SCR, but the report responds that this is '*... not a problem within Brighton & Hove because the CareFirst IT system has a specific, standalone case transfer record that requires management sign-off.*'²⁵ This suggests that it should be possible to use this tool more effectively.
- 12.3.6 There is no evidence of chronologies being used consistently across the teams in Children's Social Work Services. It is not clear whether this is because the electronic system(s) doesn't offer an appropriate tool, or whether there is not 'custom and practice' of ensuring a chronology is maintained and used in the work.
- 12.3.7 'Not enough time' to attend to these essential tools has also been mentioned in this case review, as being a common context for the work in Children's Social Work Services. This challenge, linked with the fact of a churning staff group, almost inevitably results in a weaker understanding of a child or YP and their needs. It also means that these useful structures are

²⁴ This finding links closely to the one above, as they have similar results: the reduced understanding of the child/young person

²⁵ SCR Baby Liam, Brighton & Hove LSCB, 2015, Para 4.7.4

unavailable for reflecting on and analysing information in assessment, planning and supervision.

What is known about how widespread or prevalent the issue is?

- 12.3.8 The Review Team has been unable to find wider information about the production and use of good Transfer Summaries, around the country.
- 12.3.9 In relation to chronologies, there is more evidence. After the Victoria Climbié Enquiry promoted the idea of a composite chronology at the front of every Children's Services file, there was evidence nationally of improvement of practice, but this did not persist. The introduction of the Integrated Children's System (and its translation into many varieties of electronic systems) failed to deliver an effective tool for chronologies, nor a single, easily accessible system to view a child's long-term story.
- 12.3.10 The other constraint is 'not enough time available', and that too is a widely shared context in services which are undergoing significant changes, including cuts and staffing constraints. With fewer workers, and fewer permanent workers, the pressure of workloads becomes greater. Another recent SCR²⁶ describes a situation in which pressed workers in a busy team '*were not encouraged to undertake chronologies*'. The author comments on how this can lead to a failure to '*build up a more coherent and clear pattern of family functioning*'.

Why does it matter?

- 12.3.11 In Beyond Blame, Peter Reder et al's analytic review of 35 child death inquiries²⁷, the value of information from the past is underlined – as a means by which to understand and respond appropriately to current behaviour: '*The importance of history cannot be overemphasised*' (p124). The power of chronologies is also illustrated dramatically in the text, showing how patterns and signs of risk are highlighted when (even a skeleton) chronology is maintained as an active tool for working a case. Guidelines for good practice include allowing time to review the background of a case when staff take it on (p122).
- 12.3.12 Given the pressure of complex and challenging workloads, the help that is available from transfer summaries, chronologies, and other key documents (such as specialist assessments, court judgements) should be used in all cases. Without this, workers will struggle fully to understand what is going on for a complex or troubled young person.

Finding 3: The tools for transmitting background information about a child or YP (transfer summaries and chronologies) are not produced to a consistent standard, meaning that a new SW may not have the background and qualitative information which would support a holistic understanding of the child/YP and family and their needs and risks.

Where full and accurate sources of the history of a looked-after child are not reliably available, there is the obvious risk that this history will be poorly understood by workers, and equally importantly that the child will not be given his own 'life story' by his Corporate Parent. The issues of identity and personal history are highly significant to children who have lost a parent or parents, and should be at the top of the Corporate Parent's list of responsibilities.

²⁶ SCR anonymised (2015 – C5641), NSPCC archive, Para 11.4

²⁷ Reder et al, 1993

Considerations for the Board and member agencies:

- What is the current policy regarding the production of chronologies – in B&H Children's Services? In partner agencies?
- How are handovers of cases generally handled?
- Apart from transfer summaries and chronologies, are there other 'key documents' which could be signposted?
- What is the LA's expectation in relation to workers' knowledge and understanding of an individual case at the point of transfer?
- Is there a commitment by managers to prioritising the time needed by staff for reading key case material?
- What are the most important tools to underpin the work?
- What are the changes in 'culture' which would be required in order to prioritise a) the production of chronologies and effective transfer summaries, and b) the time to read these.
- See recommendation from SCR²⁸: *'The Boards should look to establish a Practice Working Group to look at creation of a Simple Chronology Tool that could be completed across agencies'*.
- What would signify improved practice for children if these tools were well produced and well used?

12.4 Finding 4. Is there a risk for professionals, in following Care Planning, Placement and Case Review Regulations, to give too much responsibility to young people over their Pathway Plan Reviews, with the result that difficult subjects are not raised if the young person objects? (Communication and collaboration in longer term work)

12.4.1 Care Planning, Placement and Case Review Regulations (2010) require young people who are in care to be at the centre of decisions that are made about their life, and for older young people to be given more responsibility regarding their PPR meetings. While this is right and proper, the professional responsibility remains to assess their needs in the round, so that these can be met insofar as possible. In order to do this effectively requires that PPR meetings do include significant information about a young person's level of risks and needs, so that he/she can be helped to think through things that are difficult, as well as the things they feel more comfortable about discussing with the range of professionals who know them and who are present in a review meeting.

12.4.2 There is evidence in this case that difficult matters, and sometimes essential information, were not raised or addressed directly with the young person in their PPR meetings. We have

²⁸ SCR Child CH, Enfield and Haringey LSCBs, 2015 (Para 61)

made this an indicative finding only, as further investigation is required by the Brighton & Hove LSCB in order to demonstrate whether this is commonplace.

- 12.4.3 Where there is no other meeting to discuss such matters, this can result in important issues and concerns getting lost and not shared throughout the network around the young person (see link to **Finding 5**, below, which considers how additional multi-agency meetings are not routinely convened for children in care).
- 12.4.4 *The Children Act Guidance and Regulations, Volume 3: planning transitions to adulthood for care leavers* (revised 2015) makes it clear that, for 16-17 year olds ('eligible young people'), the LA retains all its responsibilities of care planning and review, which are now folded into the Pathway Plan Review process.²⁹
- 12.4.5 The regulations also outline the function of the PPR meetings, and what should be addressed, to include:
- Health and development
 - Education, training and employment
 - Family and friends social network
 - Financial capability
- 12.4.6. In all of these areas, it is clear that the LA has responsibility for maintaining a plan which will meet the young person's assessed needs, and include 'who, what, how, when' in the plan. To be meaningful, the PPR meeting will need to consider what has happened since the last review and how this has affected the plan, taking into account the views and wishes of the young person, whilst also balancing these with the known facts and opinions of key professionals – for example, from health, education and related services.
- 12.4.7 A number of Pathway Plans have been criticised in the courts³⁰ for not meeting this responsibility, and for not carrying out the required assessment (described above). (Studdert, p2) Case law has clarified that a Pathway Plan '*must clearly identify a child's needs, and what is to be done about them, by whom and when*', and that it ought to be a 'detailed operational plan' so that it can be used '*as a means of checking whether or not [the] objectives are being met*'.
- 12.4.8 It is clear from all the guidance that the young person's full involvement and participation are at the heart of the Pathway Planning process, but that this does not diminish the responsibility of the LA (Corporate Parent) and that of other agencies for contributing to the plan.

How did the issue feature in this case?

- 12.4.9 During the period under review there were four PPR meetings each chaired by an IRO. In accordance with E's wishes these meetings were limited to a small core group involving E and his FM, together with the SW at the time, and SWRO1. E was able to determine both the membership and overall content of the meeting. This meant that, in accordance with his wishes, several key pieces of information and significant events were not shared. This significantly compromised the review and planning process, and meant that at different

²⁹ Para 2.9. '*At the point at which a young person becomes an eligible child and it is envisaged that s/he will be leaving care, the pathway plan must be prepared which must include the child's care plan. This is in order to capture the actions which will be necessary from the responsible authority, the young person's carer, young person, parent, and other identified parties in order for the young person to make a successful transition from care.*'

³⁰ Studdert, O.

times there was a lack of clarity as to who had knowledge of events and where responsibility lay. With so much of what was actually happening to E not being discussed, it is reasonable to speculate that this may have undermined E's confidence in professionals involved, and their ability to plan for his safety and wellbeing.

- 12.4.10 The way in which this meeting was constituted meant that at a time when the people working with E needed all the relevant information about him to be shared as part of the assessment and planning process, there were significant gaps. Information was not routinely sought or shared for planning purposes. This resulted in fragmented multi-agency involvement. Individuals could try to address and minimise the risky behaviour known to them, whilst unaware of a wider and more concerning pattern.
- 12.4.11 For example, at PPR1 (August 2013), key events, including contact with E's birth father and episodes of disruptive /violent behaviour were not discussed, and there was an absence of reflection on significant events. Accordingly, no realistic plans and contingency arrangements could be put in place to deal with either. Instead, the PPR record states that E's relationship with his foster carers '*continues to be up and down but no more than most adolescents*'. The placement is described as stable. The Review Team found this surprising given the turbulence described by FM and the involvement of police in this period, alongside FM's ongoing concerns about E's drug-taking.
- 12.4.12 PPR2 (February 2014) noted E's good progress at college, and again described the placement as stable. E's admission to hospital having been found unconscious as a result of excessive drink was not mentioned, and other Police concerns (e.g., about E's 'doing drugs' with a mate) were not known to those at the meeting. SWRO1's concern about the fragility of the placement was not shared (this links to **Finding 5**, below).

What makes this an underlying issue?

- 12.4.13 The LA as Corporate Parent, and those to whom it delegates authority, hold ultimate responsibility for the care and wellbeing of children in their care. In order to fully exercise this role it needs (particularly within the forum of PPR meetings) to: 1) understand and review what has happened with the delivery of the care plan, and 2) assign responsibilities and develop decision-making protocols in a way that is clear to all concerned. These responsibilities need to be balanced with the imperative to place the young person at the centre of care planning and to enable them to take an increased share in decision-making commensurate with their chronological age, emotional wellbeing and level of maturity. Relationships and attitudes established early on in the management of a case will in most instances influence the success of later work.
- 12.4.14 Conversations and discussions with the Case Group confirmed that older children/YP in care are given a leading role in how their reviews are conducted. A member of the Review Team, the Head of Service for youth offending and drugs services (RUOK), commented that it was routine for workers from these critical areas to be told they were not invited to a LAC Review or a PPR meeting. Their absence could be mitigated by the inclusion of written factual reports to inform the planning process. Their exclusion makes it likely that important issues for the young person may not be discussed or recorded (and see **Finding 5**, below, which suggests that alternative forums for discussion are not routinely used).

What is known about how widespread or prevalent the issue is?

- 12.4.15 There have been a number of legal cases which have challenged the inadequacy of Pathway Plans. Oliver Studdert (Partner Maxwell Gillott Solicitors), writing an article for Family Law

Week, (www.familylawweek.co.uk/site.aspx) entitled 'The importance of pathway plans and Local Authorities Duties to Care Leavers', argues that they are frequently limited to a short narrative which fails to meet the Regulation 8(2) of the Children (Leaving Care) (England) Regulations 2001 which provides:

"The pathway plan must, in relation to each of the matters referred to in the Schedule, set out –

- (a) The manner in which the responsible authority proposes to meet the needs of the child; and*
- (b) The date by which, and by whom, any action required to implement any aspect of the plan will be carried out."*

The Schedule identifies these matters to be dealt with in the pathway plan and review as being:

- 1 The nature and level of contact and personal support to be provided, and by whom, to the child or young person.*
- 2 Details of the accommodation the child or young person is to occupy.*
- 3 A detailed plan for the education or training of the child or young person.*
- 4 How the responsible authority will assist the child or young person in relation to employment or other purposeful activity or occupation.*
- 5 The support to be provided to enable the child or young person to develop and sustain appropriate family and social relationships.*
- 6 A programme to develop the practical and other skills necessary for the child or young person to live independently.*
- 7 The financial support to be provided to the child or young person, in particular where it is to be provided to meet his accommodation and maintenance needs.*
- 8 The health needs, including any mental health needs, of the child or young person and how they are to be met.*
- 9 Contingency plans for action to be taken by the responsible authority should the pathway plan for any reason cease to be effective."*

12.4.16 Studdert cites recent cases where a challenge to the inadequacies of Pathway Plans has been made and judges have commented upon the legal expectations placed upon LA staff in this respect.

12.4.17 ([1] R (J) v Caerphilly County Borough Council [2005] EWHC 586 (Admin); [2005] 2 FLR 860 In the *Caerphilly* case Mr. Justice Munby stated that

"a care plan is – or ought to be – a detailed operational plan. ... but whatever the level of detail which the individual case may call for, any care plan worth its name ought to set out the operational objectives with sufficient detail – including detail of the "how, who, what and when" – to enable the care plan itself to be used as a means of checking whether or not those objectives are being met. Nothing less is called for in a pathway plan"

12.4.18 The *Caerphilly* finding is supported by several other cases notably (R (A) v LB of Lambeth [2010] EWHC 1652 (Admin); [2010] 2 FCR 539; R (G) v Nottingham City Council and Nottingham University Hospital [2008] EWHC 400 (Admin); 11 CCLR 280, 290; R (Birara) v London Borough of Hounslow [2010] EWHC 2113 (admin). Together these judgements reiterate that an assessment must determine a child's needs, how those needs are met and evaluate the progress made. In this way anyone examining the plan would be able to ascertain the progress made and the areas which remain to be addressed.

Why does it matter?

12.4.19 The PPR process is designed to ensure that the goals and milestones for a child in care are set out, agreed and met, in a plan which covers all aspects of wellbeing including emotional, educational and social development and issues related to identity. The views of the child or young person are central to the PPR process, and it is right that the active participation of the young person in their review is encouraged – especially as they enter the transition period of leaving care and becoming an adult. However, a balance must be struck in relation to their wishes, and the need for input from professionals and family members, especially where there are risks and problems which need to be addressed together.

Finding 4: Is there a risk for professionals, in following Care Planning, Placement and Case Review Regulations, to give too much responsibility to young people over their Pathway Planning Reviews, with the result that difficult subjects are not raised if the young person objects?

There is a tension between giving older young people greater responsibility for their own 6-monthly reviews, as part of an appropriate preparation for independence, and ensuring that the Corporate Parent remains able to address areas of serious concern for the young person in the care planning process. Where these areas are ‘vetoed’ by the young person, and vital information is not shared, then areas of risk and need may not be addressed, leaving the YP without appropriate help and support.

Considerations for the Board and member agencies:

- What does the Board think about the ‘balance’ that is described above? Does it need to be re-examined?
- Can IROs as a group assist in thinking about what makes for a helpful/unhelpful balance?
- Is there an agreed approach locally for older YP in relation to the content of their PPR meetings?
- Is there a regular review of the quality of Pathway Plans? If so, what are the lessons learned from this?
- What ideas do the Board and member agencies have about supporting better uptake by YP of services that they more than often decline, but which they need?
- What would provide evidence that the balance in PPR meetings was working well, both for the YP and for the Corporate Parent?

12.5 **Finding 5. Nationally, there is no routine framework for multi-agency professionals to meet outside of Pathway Plan reviews, leaving the responsibility with an individual practitioner to convene such a forum. The result is that planning and decision-making for a child often proceed without the benefit of a joined-up discussion of their perspectives and concerns about a child.** (Management Systems)

12.5.1 Unlike the formal Child Protection system of planning and review, 6-monthly LAC review meetings do not involve all the professionals who are working with or involved with the YP. Nor is there anything equivalent to Core Groups which meet every 6 weeks to share information about progress, shifting circumstances/events, and difficulties. If an 'extra' meeting is needed to discuss a child in care and the concerns of professionals, this has to be specially requested.

How did the issue feature in this case?

12.5.2 The Key Dates chronology for this case conveys a powerful picture of ongoing difficulties, leading to the breakdown in E's relationship with his carers. These were not adequately addressed in his LAC Reviews and his PPR Meetings in 2013/14 (see **Finding 4** above), and there were no other meetings where the professionals met to discuss E's and the family's situation, and consider what better strategy there might be to help them.

12.5.3 SWRO1 was the worker with greatest awareness of the stresses and strains in the placement, and received the most communication from FM about when and why the relationships in the family were at breaking point. Partly because new SWs knew less about E and his carers, a professionals/briefing meeting would have been extremely helpful, to bring people together to share both information and views about E and the family. For example, PM2 was shocked to read in parts of the chronology prepared for this review about E's historic mention of suicidal thoughts (2012). The degree of conflict in the placement was shared less over time by FM, as workers continued to change.

12.5.4 There were two times when SWRO1 requested an 'extra' professionals meeting (2013 and 2014, both at a low point in the placement), but neither of these happened. It is important to understand why they didn't: was it because of staff not having enough time, especially for workers with what were deemed higher priority duties and tasks? This is something which the service needs to explore.

What makes this an underlying issue?

and **What is known about how widespread or prevalent the issue is?**

12.5.5 This is a national issue, based on different procedures and structures for the work of Children's Services and fellow agencies. The LAC Review/Pathway Plan Review process does not offer a regular and inclusive forum for the 'team around the child/YP' to meet to discuss him/her, how well their interventions are working to meet the child's needs, and indeed how well they are functioning as a professional network.

12.5.6 In contrast, CAF, Child in Need and Child Protection work is carried forward by means of such regular multi-agency meetings and reviews, with contributions via reports when professionals cannot attend.

12.5.7 The ease and confidence with which fellow professionals in other areas can convene 'extra' meetings regarding a child in care (or any other child being worked with by Children's Social Work Services) is not known to the Review Team. We suspect that the pressures of work and the view of Children's Social Work Services as holding lead responsibility may leave the

wider network out of the loop, and possibly unaware of when things are going wrong. In some areas, the idea of having a meeting without a child, especially an older child, or parents/carers present is resisted, making another reason why professionals may not ask for a professionals-only meeting.

Why does it matter?

12.5.8 There are many reasons why extra meetings might be required, given how much can transpire in the 6-months time frame between LAC reviews and PPR meetings. Where things are going badly wrong for a young person, or where the plans and partnership work of professionals are ineffective – for whatever reason – it is vital that any member of the professional network can confidently request a professionals meeting, or simply for an extra review meeting to be called forward. We have seen in this case that professionals can be left with appropriately rising concerns but still struggling to pull together a professionals meeting to share these with colleagues and make effective plans. This can leave the young person without the timely care and attention that may be needed in response to serious problems.

Finding 5: There is no routine framework for multi-agency professionals to meet outside of Pathway Plan reviews, leaving the responsibility with an individual practitioner to convene such a forum. The result is that planning and decision-making for a child often proceed without the benefit of a joined-up discussion of their perspectives and concerns about a child.

The lack of any formal or regular meeting which includes the *full range* of professionals involved with a looked-after child, or other children in need, tends to weaken partnership working and information-sharing. Professionals are less likely to recognise concerning patterns which need to be addressed. The result is a loss of effectiveness and a potential for drift in dealing with the child/young person's problems. This problem is exacerbated when the young person's PPR Meeting (see **Finding 4**, above) does not have key professionals present.

Considerations for the Board and member agencies:

- Does the Board regard this as a problem?
- Are there any perceived barriers to the use of professionals meetings for a child in care? For other children? If so, what might these be?
- Would it be helpful to formulate agreed criteria, which agencies could use to support the request for a professionals meeting?
- Is there an escalation policy for use when it is difficult to set up a professionals meeting?
- Would it be helpful for a multi-agency meeting to be held as a 'preparatory meeting' in advance of the PPR Meeting or LAC Review?
- How would the Board know if this situation was improved?

- 12.6 **Finding 6. There is a pattern of focusing only on the primary (usually female) carer for a child in care, and not giving sufficient attention to the role of the non-primary carer (usually male). This can result in professionals' lack of awareness of both positives and negatives that the other carer may bring to his/her role. (Human biases)**
- 12.6.1 Fostering gender roles are often no different from those in many typical families in this country, where the male partner is less involved in child care than the female. For fostering families, this may be reflected in how communications are managed, and in minimal expectations about input from the male carer, including attendance at key meetings. However, a lack of partnership with both carers risks ignoring the significance of the man in family life – for good or ill. This may include how he is a role model for the child (in this case, a boy – almost a young man), the nature and quality of their time together, and the support he can offer to his partner when, again, in this case, there are major problems with the young person's behaviour.

How did the issue feature in this case?

- 12.6.2 Like FM, FF was approved as a foster carer and there were formal requirements attached to this status. But he was rarely seen by workers, on visits, at meetings, and even at the annual Fostering Reviews. Efforts to include him were not successful.
- 12.6.3 FF's views about E and his wishes and feelings in relation to the deteriorating situation of the family during 2014, were not ascertained in advance of E's PPR meetings, which meant that he had no input into professionals' understanding E's lived experience for the previous 6 months under review.
- 12.6.4 One result of this lack of contact with FF was that SWRO1 and E's social workers remained unaware of his heavy drinking, which was considerably above the recommended level for a man. This was in the context of FM's concerns about E's drinking and drug use.
- 12.6.5 The Review Team heard repeatedly, and read in case records, that E saw FF as his 'father'. He wanted to have the same surname as his cousin/'brother'. This fact makes it even more significant that FF's absence was, over time, accepted and he was routinely left out of any dealings with the LA.

What makes this an underlying issue?

- 12.6.6 All the professionals involved in this case took the view that this was widespread and 'normal' practice in B&H – and could be explained largely in terms of the working life of the male carer and hence their 'unavailability'. The idea of arranging meetings to be able to include male carers was not deemed generally practicable, although meetings with parents/carers and family will frequently be scheduled to take place outside of core hours.
- 12.6.7 The recently published Brighton & Hove Serious Case Review regarding Baby Liam pointed to a different way in which a male carer may be ignored (in that case, within the Midwifery Booking Form), and noted that '*many agency procedures are insufficiently robust in their approach to men*'³¹. The common feature in these (and instances given below) is an underestimation of the significance of the role played by men in the lives of their children.

³¹ SCR Baby Liam, Brighton & Hove LSCB, 2015, Para 4.2.1

What is known about how widespread or prevalent the issue is?

- 12.6.8 This is a national issue. It is not confined to foster carers, but is regularly reflected in services' dealings with fathers and male carers generally. For example, it is commonplace for fathers not to be present at key health events, such as the New Birth Visit, when vital information about infant care is provided (such as advice about shaking babies and co-sleeping). There are exceptions, illustrated by a growing commitment in some services to the inclusion of fathers/male carers (e.g., in commissioning Children's Centre services to provide programmes for fathers).
- 12.6.9 This pattern of insufficient attention to fathers or male partners is starker in relation to what are regarded as 'absent men', as described in Brandon et al's review of SCRs (2009). They found that men who are deemed (perhaps incorrectly – cf the case of Peter Connelly) to be absent, are often ignored within the professionals' work with the mother and children, and not included in assessments. This has two very different consequences: children might not be adequately protected from poorly understood risks, but children might equally be denied potentially positive contact with fathers and their extended family. Brandon writes:

Our approach to making sense of men in households is taken primarily from the child's perspective. We work from the premise that men who are regularly part of a family are likely to have a high level of day to day contact with the child. Even if this is not the case, their presence will have a crucial impact on the care giving environment generated for the child.³²

- 12.6.10 Scourfield (2001, 2006) reminds us of common ways in which men are not included in the work of agencies – e.g., 'the failure to take men into account in an assessment', and even 'the dearth of information about men in most SCRs'.

Why does it matter?

- 12.6.11 Children who live with two foster carers have relationships with both and are inevitably affected by them both. So female and male carers are and should be seen as critical resources for the child, whatever the allocation of family roles and relative levels of time spent in the home. Where the local authority (the Corporate Parent) has very little idea about how the male carer relates to the child, what role he has, and what more he might have to offer, they are in danger of ignoring and under-using this resource, including the knowledge and insights they have about the child.

Finding 6: There is a pattern of focusing only on the primary (usually female) carer for a child in care, and not giving sufficient attention to the role of the non-primary carer (usually male). This can result in professionals' lack of awareness of both positives and negatives that the other carer may bring to his/her role.

Children who live with two carers almost inevitably have a relationship with both, and are therefore affected by both in different ways. The risks of not involving the second (usually male) carer in assessing the child's needs and making plans are plain to see. A young person may be at some risk from that carer, or (conversely), missing out on positive contributions that could be strengthened and supported – e.g., from a male role model.

³² Brandon et al, 2009, p51

Considerations for the Board and member agencies:

- Is this an area which has come to the attention of the Board?
- Has the Board considered the evidence (noted in many SCRs) about how the roles of males with children are ignored?
- Is there a culture that values the primary carer (usually female) to the exclusion of the non-primary carer?
- Is there a local 'custom and practice' about this in the fostering service? Or in other services? Are men expected to take part in key processes, such as LAC reviews, New Birth Visits, Midwifery Booking appointments?
- In relation to looked-after children in placement, are non-primary carers clear about the expectations of them and their role?
- What do services think would be the benefit to children to include both carers more fully? What might be significant barriers to doing this (apart from people's working hours – something which should be able to be dealt with)?
- What do the S11 reports say about how practitioners in agencies consider 'fathers, male partners and other significant adult males in the family when gathering family information as well as in all assessments addressing the needs and welfare of children and young people'?
- How would the Board and constituent services be able to measure any difference for children of involving both carers more fully?

12.7 Finding 7. In B&H Children's Social Work Services, there is inconsistent recording. Without a complete and accurate record, it is difficult for practitioners and their managers to analyse the facts and context of a child's situation, and to make the most appropriate decisions and plans. (Management Systems)

12.7.1 Complete and accurate record keeping is integral to the social work task (Swain; Kagle, 1991). This is acknowledged within B&H practice guidelines, which require that practitioners' records:

'should be contemporaneous notes and should be recorded at the time wherever possible. This is especially important if there is a particular crisis/high risk issue. If there is unavoidable delay on recording, the expectation is that case notes should be no longer than 3 weeks behind.'

12.7.2 Qualification and subsequent related training make clear the expectations of staff in relation to the recording of all communications, whether it be a face-to-face contact, e-mail exchange, or professional conversation. Clear, timely unambiguous case records aid both decision-making and report writing. Records are the means by which staff are able to evidence their work and be held to account for what they do. It follows that the poor maintenance of appropriate records undermines the quality of the service being provided

and renders the service provider open to criticism. A movement towards simpler, less detailed recording does not affect the requirement for completeness and accuracy.

How did the issue feature in this case?

- 12.7.3 The SCR was hampered at a number of points by Children's Social Work Services records that were slim or non-existent. The Review Team was told that some visits and meetings had happened but were not recorded (examples are cited in the Appraisal section of this report). This leaves the service in a very vulnerable position, if records cannot be relied on to be complete and accurate. This is especially true in relation to recording about evidence and rationale for decision-making.
- 12.7.4 The most striking specific example of this deficit was the 'muddle' of what happened in relation to E's sudden move to be near his BF. Our understanding of who was involved with this and how the decision was reached was limited by the absence of detailed recording of events over the course of that afternoon and by the absence of a recorded rationale for the decision itself. This applied to workers and managers at all levels of those involved.
- 12.7.5 More generally, gaps in recording have a particular impact when workers change frequently. In this case, there were several changes of staff in the STC team (where E's case was held), and we were told they had to '*hit the ground running*'. An understanding of the case could only come from records and summaries. This meant that each practitioner taking on the case could potentially be relying on incomplete records, and a lack of time to search for a case history. This would inevitably reduce the effectiveness and the quality of their work with the child and family, and limit their understanding of the complex nature of E and his family and the issues with which they were all grappling.

What makes this an underlying issue?

- 12.7.6 There were several examples where social work practitioners have said that a visit had taken place or a professionals meeting was held for which we could find no written record. Similarly there were occasions where important decisions have been made (e.g. regarding contact with BF; the move to permanent/respite care; the move to stay close to BF) with no accompanying record to show how the decision was made, what factors were taken into account and how these were balanced with other factors.
- 12.7.7 Managers during this review have acknowledged that this is an area where improvement is needed. A recent Ofsted report in B&H commented that 'The rationale for decisions is rarely recorded'.

What is known about how widespread or prevalent the issue is?

- 12.7.8 Deficits in recording practice are well known in social work practice and have featured in a number of SCRs. Communication and recording errors were noted by Lord Laming in his report into the death of 7 year old Victoria Climbié:

In some cases nothing more than a manager reading a file, or asking a straightforward question about whether standard practice had been followed, may have changed the course of these terrible events. (para 1.17)

Resolving this conflict of evidence has not been helped by Ms K's poor note taking. There is certainly no record of a telephone conversation between Ms A and Ms K in Ms A's contact notes on Victoria's case file. (para 6.284)

12.7.9 In publishing his progress report on the protection of children in England following the Baby P case, Lord Laming wrote of...

'the vital role good record-keeping plays in underpinning supervision and sharing of information. Local leaders must ensure that children's and young people's information is managed and recorded effectively to reduce their risk of harm.'

Why does this matter?

12.7.10 The coherence of social work, clarity of goals and how decisions are made are all dependent on the maintenance and accessibility of accurate written case records. The importance that an individual agency attaches to recording and the reading of files is of equal importance to that of the professional who has the responsibility to both read and add to case records and to ensure that they have a detailed understanding of their cases. Where either of these is compromised, good practice is undermined, decisions may be taken without a full understanding of or recognition of the facts, and it is then difficult for those not previously involved with the case to understand how these were reached. Good recording, the retrieval of and reading of case records support good decision-making and support effective organisational lines of accountability.

Finding 7. In B&H Children's Social Work Services, there is inconsistent recording. Without a complete and accurate record, it is difficult for practitioners and their managers to analyse the facts and context of a child's situation, and to make the most appropriate decisions and plans.

Inconsistent and incomplete recording presents a challenge to effective multi-agency work and to the professionals' ability to analyse the facts and the context of a child's situation and the interventions that are necessary to safeguard and promote a child's welfare. Good case records should contain relevant and accurate information about a child, which can be relied upon to inform reviews, analysis and decision-making. When these records are not maintained, a sound understanding of the case is harder to achieve, and this makes it particularly difficult for a new worker to understand the child/family and the immediate circumstances, concerns and issues.

Considerations for the Board and Other Member Agencies

- How can the Board satisfy itself that case records are being appropriately maintained?
- In individual agencies, what are the expectations by senior managers regarding good quality and accurate recording by staff?
- Are they confident that staff have time to carry out this area of their responsibilities?
- Are there perceived barriers – cultural and/or administrative – to the maintenance of timely records?
- What kind of training is needed, and for which groups of staff?
- Is the import of maintaining records fully understood by all staff – i.e., if it is not recorded, 'it did not happen'?
- Do staff recognise what needs to be recorded and how to record it?
- Is the import of maintaining records fully understood by all staff i.e. If it is not recorded it did not happen?
- Do managers make use of case notes in staff supervision?
- What kind of measures would support improved record-keeping?

12.8 Finding 8: Sussex Police do not always act in accordance with their own guidelines by informing Children's Social Work Services about their observations of, contact or interventions with young people. This means that opportunities for joint thinking, decision-making and interventions may be lost. (Communication and collaboration in longer term work)

12.8.1 In Sussex Police any direct contact by police with a child should be recorded on a SCARF (previously MOGP/1 form) and forwarded to the relevant Child Protection Team before the relevant officer goes off duty. These forms should then be shared with Children's Social Work Services. In this case these forms were not completed on all relevant occasions, and therefore information was known to police that was not shared with other parties.

How did the issue feature in this case?

12.8.2 During 2013 there were 10 incidents recorded on police computer systems that related to E:

- One incident related to police officers attending his home address in response to a call from FM, who stated he was 'smashing up his room'. It records that E was removed from home.
- Three of the incidents involved his FM reporting him absent/missing.
- Another three incidents all related to the same occurrence on 02/10/13, where E was found slumped on the pavement, and was taken to hospital, where it was believed that he had taken controlled drugs.
- The remaining three incidents related to intelligence reports regarding E being seen with other associates who were known to the police.

12.8.3 Only one of these incidents was shared by the attending police officers with the Child Protection Team. This was the only one where an MOGP/1 was created and it relates to the suspected drug use linked to E's admission to hospital. This incident was shared with Children's Social Work Services.

12.8.4 Between January and November 2014 there were twenty-five incidents recorded on police computer systems. Of those incidents:

- Only two were shared with the Police Child Protection Team.
- One was shared with Children's Social Work Services.
- Nine of these recorded incidents were when E was reported as absent by his FM.
- There were also incidents that involved him coming to the attention of police and his arrest in relation to an alleged burglary.
- The remaining records concerned the alleged burglary at E's home address and the subsequent threats made towards him and his family prior to his move from the area in late November.

12.8.5 Not all the recorded incidents were of a nature which would have required for notification to be sent to the Child Protection Team. However, some were and the failure to submit a SCARF/MOGP/1 meant that information known to the police was not shared with other agencies.

12.8.6 Throughout the period of their involvement, police were unaware of E's status as a Looked-after Child. In responding to reports of E being absent/missing from his home, they engaged with his FM who they understood to be his legal parent. In common with other police forces, their response to young people reported as missing from home by their parent will vary according to categorization. The categories are:

- **Missing:** Anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of a crime or at risk of harm to themselves or another.
- **Absent:** A person not at a place where they are expected or required to be.

- 12.8.7 In this case from the information available to the police and taking into account E's age and the views of the FM whom they understood to be his legal parent, officers were satisfied that E was 'Absent' from home. This seems to be a reasonable decision given the facts known to police at the time. At the same time this does raise a question about thresholds for sharing information about repeated absences of a young person particularly in the context of other police-recorded incidents.
- 12.8.8 There were several instances during the period under review where E came to the attention of police in circumstances where the sharing of information through a SCARF/MOGP1 was warranted and did not happen. Examples where it would have been appropriate to complete the required notification include their attendance at his home address and removal from the family home following an incident where he is reported to have been 'smashing up his room', and his arrest and detention in connection with an alleged burglary. Although in each instance E's FM did inform Children's Social Work Services of this (and some of the other recorded incidents), this was not always the case and in some instances (particularly where notification was about the absences from home) did not happen at all.
- 12.8.9 In any event police were unaware of E's status as a child in care and so would not have been aware that any information known to the FM would be shared with Children's Social Work Services. Had the police routinely shared all their knowledge in relation to all recorded incidents, this would have presented a further opportunity for Children's Social Work Services to review risks connected to the management of the case, and arguably might have acted as a trigger for a professionals meeting and with that a more joined-up approach to his care.

What makes this an underlying issue?

- 12.8.10 The Police response to a child or young person being categorized as 'absent' from home differs to that of one being reported as 'missing'. A person designated as missing will be recorded on COMPACT the Sussex Police Missing Persons database, with the Police making enquiries to trace them. The investigation into the missing person will be regularly reviewed by the duty Sergeant and duty Inspector with a Detective Inspector carrying out a review if the person is still missing after 48 hours or they are regarded as being at high risk. A person designated as absent will not be entered onto COMPACT and the expectation is on the person reporting to make enquiries to trace the person, albeit the Police will carry out some basic enquiries such as address checks. The designation is periodically reviewed. Audits undertaken by the police have consistently shown that MOGP/1s are not always completed for every contact with a child.

What is known about how widespread or prevalent the issue is?

- 12.8.11 The failure to share information with other agencies is a common finding in many Serious Case Reviews frequently resulting in missed opportunities for multi-agency action to help families and protect children. Information sharing is crucial if children are to be effectively safeguarded and protected.
- 12.8.12 The MOGP1 and its replacement SCARF are the formal written means through which police information is shared by police officers following a recorded incident in which a child is

involved. Since the MOGP/1s were first introduced (over 20 years ago), the dynamics of police contact with children has changed. There is now far less casual contact with children, and any interventions are now more likely to arise from police responding to incidents, such as domestic abuse. This has resulted in a significant increase in the numbers of MOGP/1s completed, and the request from Children's Social Work Services in one area for the police to reduce the number of MOGP/1s forwarded to them.

12.8.13 Police recognize that there is now a need for more specific guidance on when a SCARF, which replaced MOGP/1s, should be submitted. Given the rise in incidents, specifically domestic abuse, that police are now attending there is an argument which says that it may be unrealistic to expect a SCARF to be completed for every contact with a child, when the significance of any contact may vary significantly.

12.8.14 We understand that a further audit of SCARFs is now being considered by police to review their number and content, and consideration being given to adding to the current risk indicators on the SCARF and giving officers further guidance in order that there is more consistency in when SCARFs are completed/shared, and more assessment of the risk any child may be facing. It is further understood that the completion of SCARFs will be the subject of a routine audit through the introduction of new audit measures for the Safeguarding Investigation Units. This development is welcomed by the review team.

Why does it matter?

12.8.15 The sharing of relevant, evidenced and accurate information in accordance with agency guidelines is inextricably linked to good joint decision making and coordinated interventions. These are the foundations upon which good practice in child safeguarding is built.³³

Finding 8. Sussex Police do not always act in accordance with their own guidelines by informing Children's Services about their observations of, contact or interventions with young people. This means that opportunities for joint thinking, decision-making and interventions may be lost

Sussex Police do not always follow procedure for the sharing of information using a MOGP1 (now SCARF). This means that information only known to themselves is not always shared with Child Protection/Children's Social Care. In this case the child in question was a Looked After Child (LAC) and the police were unaware of his LAC status. Irrespective of his status as a LAC there were numerous police recorded incidents over a 24-month period some of which should have been the subject of a MOGP1 referral. This finding raises questions for police and Children's Social Work Services about current guidelines about the circumstances that should lead to a MOGP1/SCARF being raised. As with all procedures /guidelines there will remain some judgement/discretion about their use which balances the need to share the information with the risk identified by both agencies of system overload.

Considerations for the Board and partner agencies

- Is the Board aware of the current mis-match between guidelines for police staff with respect to initiation of a SCARF referral and current practice?
- How can the Board satisfy itself that SCARFs being completed and shared in accordance with the law and police policy and guidance?
- Do the Board think there should be a threshold for raising a SCARF in circumstances where a child has been reported as multiply absent from home?

³³ Brandon M et al (2011) A Study of Recommendations Arising from Serious Case Reviews 2009-2010, London, Department for Education

13. Additional learning

13.1 Accessing CAMHS

- 13.1.1 E was a boy whose early experiences of parental care could be predicted to result in his needing help from therapeutic services. He had some counselling input as a younger child, and again, just before the time scale of this review, he was referred to CAMHS because of persistent distress and low mood. E himself, while he was in respite foster care (October 2014) approached his GP asking for anti-depressant medication for anxiety and depression.
- 13.1.2 At other times, E was adept at covering these feelings, and was seen by many as a cheerful, cheeky lad who got on with adults and children alike.
- 13.1.3 E declined to use the CAMH service to which he was referred in autumn 2012. He went for one appointment, and decided it wasn't for him. The case was closed by CAMHS shortly after E's decision.
- 13.1.4 E's reluctance to engage with CAMHS echoes the findings in two recent Learning Reviews in Brighton & Hove, both in relation to the deaths of vulnerable adolescents. These have highlighted what is a local and national issue: the need to create different, 'young-people friendly' ways of improving access to CAMHS for adolescents. In the second of these reviews, which also used the *Learning Together* model, its Finding 4 asserted that:

'There is inadequate choice in mental health service provision to meet the preferences of many young people, leaving them with the option of attending, or not, the available medically-focused option.'

The associated action point for Brighton & Hove LSCB was that it needed...

'to be assured that mental health and emotional wellbeing services for adolescents are receptive, responsive and attractive to the needs of young people'.

- 13.1.5 The idea of 'assertive outreach' is not accepted as critical, in order to create services which 'reach out to where children and young people are within the community, not just receiving support in clinical areas'. In this spirit, B&H CCG have reviewed their CAMH Services in the past 12 months, and have developed a Local Transformation Plan for Children and Young People's Mental Health Services, as part of a 5-year Strategy of Change and Development across the whole system.
- 13.1.6 There is increasing recognition that the work to support children and young people may sometimes of necessity be carried out via CAMHS' input to their parents/carers, to enable them to understand and help their child/young person with their emotional distress. And parents/carers may themselves benefit in a number of ways from such support, to help them cope better with the demands on them of helping their child.
- 13.1.7 Finally, the introduction of materials to raise awareness about adolescent mental health for all those working with young people (not just mental health practitioners): in February 2016, the Government issued a newly developed resource, MindEd, in association with the Royal College of Paediatricians and Child Health which offers free educational resources on

children and young people's mental health.³⁴ It would be helpful if this could be promoted as part of the toolkit for staff in all agencies who work directly with vulnerable adolescents.

13.2 Support for staff

- 13.2.1 The Review Team were told that the introductory meeting for the Case Group was for many people the first time they had had a chance with others to speak about what had happened to E, and their responses to this. We know that some services/agencies routinely convene some kind of debrief/support meeting for staff involved very shortly after such an incident, and it is expected that they will attend. We felt this was a good model.
- 13.2.2 We were also informed that staff in need of counselling after E's death were offered telephone counselling only (or possibly face-to-face counselling after a telephone 'triage' assessment). This was not acceptable to some members of the Case Group, and it seems appropriate to use this report to give feedback to the local authority, in relation to their responsibility towards staff.
- 13.2.3 Generally, we felt that all services needed to adhere to a principle of being 'pro-active' in relationship to the needs of staff in such circumstances. Experience tells us that it is not only those involved with a child for a long time who may need sensitive support.

13.3 Timing of the SCR

- 13.3.1 E was a young person who had been known to some members of the Case Group for most of his childhood, and there was a great deal of warmth and fondness towards him. The grief that followed from his death was profound for many, and they found taking part in the Serious Case Review extremely distressing.
- 13.3.2 The Review Team suggest that such circumstances need to be thought about very carefully when planning to commence an SCR. It may or may not be possible or helpful to postpone its beginning, but this should be given some thought. In the event that the SCR does need to proceed quickly, then the support needs of the professionals who knew and worked with a child or young person should be assessed and given as much attention as possible.
- 13.3.3 In many regards, the same factors should apply when thinking about the ability of family members to take part in the SCR.
- 13.3.4 The Review Team are aware of the expectations within Working Together (2015) regarding timeliness of SCRs³⁵, so that lessons are learned and implemented as swiftly as possible. There is clearly a tension between this and any consideration for delaying the commencement of an SCR.

³⁴ www.gov.uk/government/speeches/childrens-mental-health-new-online-resources-for-adults

³⁵ Chapter 4 (Learning and Improvement Framework) sets out expectations for timeliness: that the LSCB should notify any incident to the DfE within 5 working days; that a decision about carrying out a SCR should be made within 1 month; and that the SCR should be completed within 6 months.

14. Conclusion

- 14.1 This systems review has had two principal aims: to report and learn from what happened, and why, in a particular child or family's story; and to consider what this tells us about the wider safeguarding of children in Brighton & Hove, and how this might be improved.
- 14.2 Overall, the review has highlighted the complexity of working long-term with a child/young person in the care of family members (but who remained under a Full Care Order to the local authority), whose early experiences were extremely sad and distressing, and not fully resolved for him.
- 14.3 It explored the initial "research questions" in relation to multi-agency working, and identified findings which related to the first three of these (see Para 4.1). The question about 'vulnerability to group activity' was not answered, given the evidence that E was not involved in this area.
- 14.4 The findings have focused on the learning for Brighton & Hove which will improve agencies' response to all children in care, and to their relationship with Family and Friends carers. The involvement of all services, as part of a team around a child in care, is seen as valuable and important.
- 14.5 There were no findings, nor any data captured in the review process, that suggested that any agency's actions (by commission or omission) could have predicted or prevented E's death. The Coroner's judgement supported this conclusion, as the inquest determined that there was no sign that E might harm himself when he made the decision that he would stay with his BF, nor was there any current or past suggestion of suicidal thoughts.³⁶ As a result, the Coroner concluded that although E had died by strangulation, having hanged himself, there was not sufficient evidence that he intended to take his own life (required for a verdict of suicide).
- 14.6 The contents of this report have been the product of the Review Team and Case Group, who contributed their knowledge and experience in relation to this case, as well as their wider understanding of how safeguarding systems operate in Brighton & Hove and elsewhere. The process has been extremely demanding for staff, given their various relationships with E and the shock and sadness at his death.
- 14.7 The report's findings were enhanced by additional information provided by E's BF and his wife, and a written contribution from his FM.
- 14.8 It is hoped that this review will support learning and improvement across the safeguarding network, and will lead to better outcomes for children and young people as they move through care and into young adulthood.

³⁶ The Coroner presumably had no knowledge of the CAMHS records (November 2012) which refer to E's speaking about suicide.

GLOSSARY: TERMS AND ACRONYMS

BF	Birth father
B&H	Brighton & Hove City Council
BHSCB	Brighton & Hove Local Safeguarding Children Board
CAMHS	Child and Adolescent Mental Health Services
Case Group	The group of professionals involved, from all agencies, with the child/family
FF	Foster Father (for E) – married to E’s maternal aunt
FFT	Functional Family Therapy (an intensive/specialist service used with families who are at risk of breakdown)
FM	Foster Mother (for E) – E’s maternal aunt
FTE	Full Time Equivalent (in staffing statistics)
F&F	Family and Friends Fostering Team
GCSE	General Certificate of Secondary Education
HMCI	Her Majesty’s Chief Inspector (in this case, of Education, Children’s Services and Skills)
IMR	Individual Management Review (single agency reports which form part of some Serious Case Reviews)
IRO	Independent Reviewing Officer (chair of required 6-monthly reviews of a child/YP’s care plan/Pathway Plan)
LA	Local authority
LAC	Looked-after child (child in the care of the local authority)
Learning Together	The systems model of case reviews developed by SCIE (fully described in Appendix 2)
MOGP1	Memorandum of Good Practice1: Notification from Police to partner agencies, regarding a child who has come to their notice (now incorporated into the SCARF – see below)
OFSTED	Office for Standards in Education, Children's Services and Skills
PEP	Personal Education Plan (required for all children in care)
PM	Practice Manager (Children’s Services) – first line manager/supervisor of social workers
PPR	Pathway Planning Review
Review Team	Senior manager representatives from all the agencies involved with the child/family
RUOK	Drugs misuse service for adolescents
SCARF	Single Combined Assessment Report Form. This incorporates the MOGP1 form for children and includes vulnerable adults as well.
SCIE	Social Care Institute of Excellence – developers of a systems model of case review, ‘Learning Together’. This model was used for this SCR.
SCR	Serious Case Review
SW	Social Worker
SWRO	Social Work Resource Officer, used in the Friends and Family Fostering Team and (previously) in the Looked-after Children Team
YP	Young person (a term sometimes used for 16-17 year olds, who are not yet adult, but who legally remain a child)

REFERENCES

- Brandon, M., Bailey, S., Belderson, P., 2009, Gardner, R., Sidebotham, P., Dodsworth, J. Warren, C. and Black, J. *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005–2007*, DCSF, 2009
- Care Planning, Placement and Case Review Regulations, 2010
- The Children Act 1989
- The Children (Leaving Care) Act 2000*
- The Children Act Guidance and Regulations, Volume 3: planning transitions to adulthood for care leavers*, DfE, revised January 2015
- Family and Friends Care – Statutory Guidance for Local Authorities*, DfE, 2010, Para 5.2
<http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/Family%20and%20Friends%20Care.pdf>
- Fish, S., Munro, E., and Bairstow, S., *SCIE Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews*, Social Care Institute for Excellence (SCIE), 2009
- Fostering Service Regulations and National Minimum Standards for Fostering Services*, DfE, 2011
- Learning Review J*, Brighton & Hove LSCB, August 2014
- Pathway Plans*, Chapter 5,
www.dhsspsni.gov.uk/leaving-after-care-ch5.pdf
- Permanence, long-term foster placements and ceasing to look after a child: Statutory guidance for local authorities*, DfE, March 2015
- Reder, P., Duncan, S., and Gray, M., *Beyond Blame: Child Abuse Tragedies Revisited*, Routledge, 1993
- SCR C5641 (NSPCC archive), 2015
- SCR Baby Liam, Brighton & Hove LSCB, October 2015
- SCR Child CH, Enfield and Haringey Safeguarding Children Boards, 2015
- Studdert, O., *The Importance of Pathway Plans and Local Authorities' Duties to Care Leavers*
- Vincent, C., 'Analysis of clinical incidents: a window on the system not a search for root causes', *Quality and Safety in Health Care*, vol 13, pp 242–3, 2004
- Working Together to Safeguard Children*, 2013, and *Local Safeguarding Children Boards Regulations*, 2006 (Regulation 5)

A sample of research findings relating to patterns of familial suicide

The following studies reflect a much wider number (references in the WHO document below) of studies which identify a close familial history of suicide as a 'predisposing factor' for a child or young person who has emotional difficulties.

Ferguson, D.M., Beatrais, A.L., Horwood, L.J., '*Vulnerability and resiliency to suicide behaviours in young people*', *Psychological Medicine*, 2003, Jan; 33(1) 61-73

Sarchiapone, M., Carli, V., Cuomo, C., Balore, A., '*Vulnerability to Suicidal Behaviours: Risk and Protective Factors*', Department of Health Services, University of Molise, Campobasso, Italy (no date given)

Public Health Action for the Prevention of Suicide – A Framework, World Health Organisation, 2012

APPENDIX 1

Learning Together Methodology and Process

1. This review has used the SCIE Learning Together model – a ‘systems’ approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *WT 2013* now requires all SCRs to adopt a systems methodology.
2. The Learning Together model is distinctive in its approach to understanding professional practice in context; it does this by identifying how systems influence the nature and quality of work with families. Solutions then focus on redesigning systems to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.
3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.
4. The basic principles – the ‘methodological heart’ of the Learning Together model – are in line with the systems principles outlined in *Working Together (WT) 2013*:
 - a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the ‘view from the tunnel’). What was influencing and guiding their work?
 - b. **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
 - c. **Move from individual instance to the general significance** – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
 - d. **Produce findings and questions for the Board to consider.** Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.
 - e. **Analytical rigour:** use of qualitative research techniques to underpin rigour and reliability.
5. **Typology of underlying patterns:** Findings are described using the categories developed by SCIE to provide a means of grouping together the kinds of systems issues which are found.

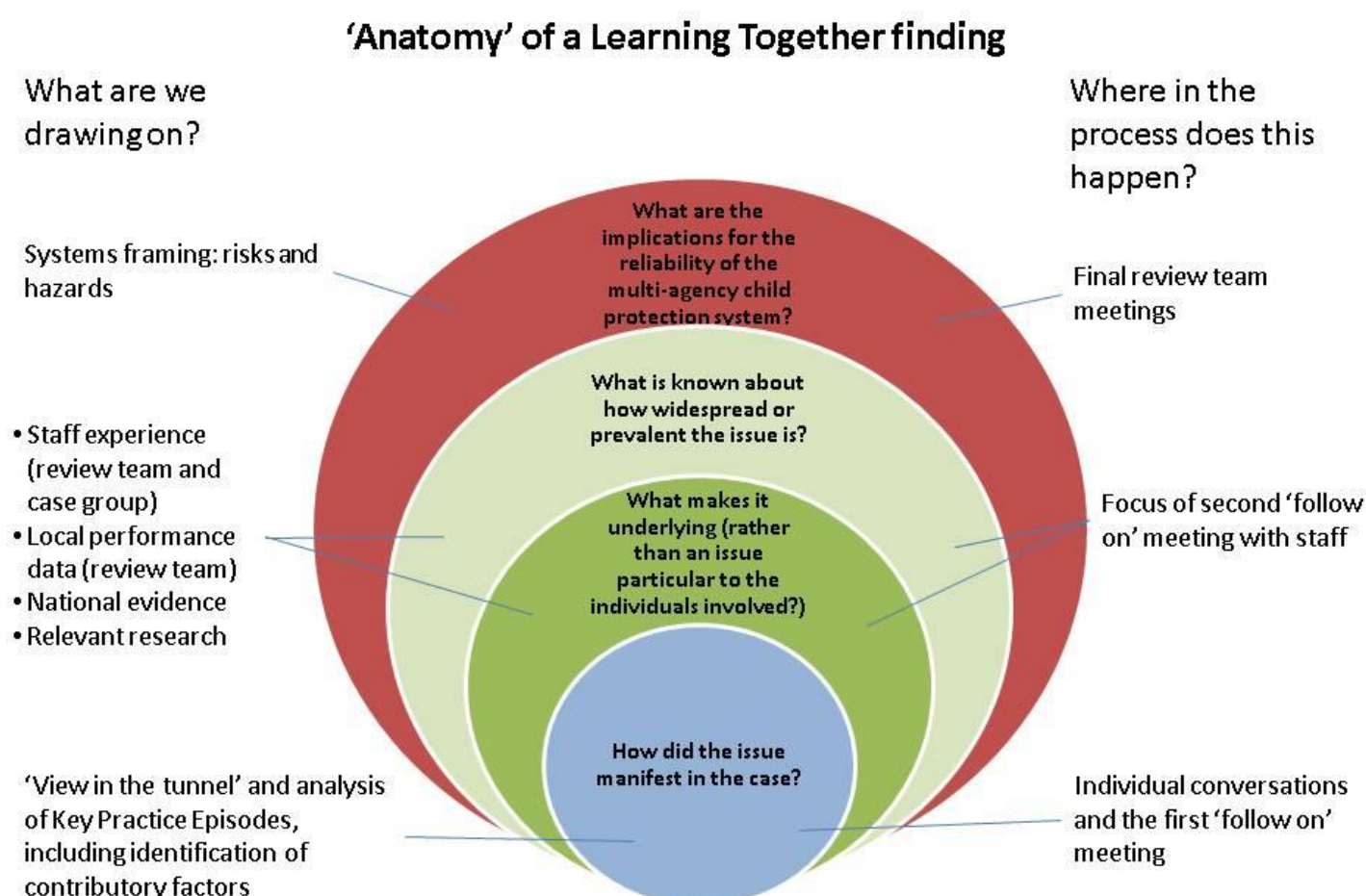
There are six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

6. **Anatomy of a finding:** For each finding, the report is structured to present a clear account of:
- How did the issue feature in the particular case?
 - How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
 - What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
 - What are the implications for the reliability of the multi-agency child protection system?

These 'layers' of each finding are illustrated in the Anatomy of a Learning Together Finding (below).



7. Review Team and Case Group

7.1 Review Team

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by at least one and often two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Name	Agency
Mia Brown	Brighton & Hove LSCB Manager(Champion)
Sally Trench	SCIE Independent Lead Reviewer
Leighe Rogers	SCIE Independent Lead Reviewer
Sue Donald	Nurse Consultant for Children In Care, Sussex Community NHS Trust
Anna Gianfrancesco	Head of Service: YOS & RUOK, Brighton & Hove City Council
1.Andy Whippey	Service Manager, Children's Social Work Services, Brighton & Hove City Council
2. Richard Hakin	Child Protection Reviewing Officer Manager, Brighton & Hove City Council
3. Helen Gulvin	Assistant Director, Children's Social Work Services, Brighton & Hove City Council
Chris Parfitt	Head of Service, Youth Service, Brighton & Hove City Council
Mark Storey	Head of Virtual School for Children in Care, Brighton & Hove City Council
Natasha Watson	Principal Lawyer, Brighton & Hove City Council
DS Jane Wooderson	Review Team, Sussex Police

Throughout the review process, the Lead Reviewers and the Review Team have been fully supported by the Brighton & Hove LSCB Business Manager and Senior Administrative Officer. Their efficiency and professionalism in arranging meetings, obtaining copies of documents, and generally enabling effective communication throughout the review, have contributed considerably to the process and to the production of this report.

7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 22 Case Group professionals, and two family members. Case Group members were invited to an Introduction Meeting (to explain the Learning Together model and the SCR process) and later to three feedback meetings. Attendance was generally good, although a couple of absences were caused by the distress of the member of staff.

Health: GP LAC Nurse Specialist Nurse for YP in Brighton
CHILDREN'S SERVICES: IROs (2 – previous and current) Practice Managers (3) – Family & Friends Fostering Team, and Children in Care Team Team Managers (1) – Children in Care Team Social Workers (3) – Children in Care Team Social Work Resource Officers (2) – F&F Fostering Team and Children in Care Team Head of Service – Looked after Children Foster carers
Education: Designated Teacher for Looked-after Children 16+ Advisor for the Virtual School College Tutor College Pastoral and Learning Mentor
Police: DS, Safeguarding Investigation Unit Police Officer, Integrated Offender Management scheme in YOS

8. **Structure of the review process:** A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the 'engine' of the process, working in collaboration with Case Group members. The Review Team held an introductory meeting for the Case Group at the beginning of the process, to explain the Learning Together model and the process they would be part of. Case Group members were then involved via individual conversations, and in three multi-agency meetings/Workshops, where they were asked to give feedback on interim/draft reports. There was a considerable amount of helpful feedback received from the Case Group in response to different parts of the emerging report/findings, not only in meetings, but in ongoing correspondence, and production of relevant records for the Review Team to consider.

The Review Team were involved in collecting and reading data, including a multi-agency chronology and key documents. Together with the Lead Reviewers, they met to analyse the material and contribute to the findings (9 meetings).

9. **Scope and terms of reference**
Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference. In this review, we noted and explored the questions (Para 4 of the main report) which the Brighton & Hove LSCB had posed as of particular interest.

10. Sources of data

10.1 Data from practitioners

Workshop Days were held at which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of the material presented. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provided a 'window on the system'?

10.2 Key Practice Episodes and Contributory Factors

Following on from individual conversations, the first two Workshop Days aimed to piece together the practitioners' 'view from the tunnel' and a selection of Key Practice Episodes (KPEs). These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the **why** questions – an exploration of the Contributory Factors which were affecting their practice and decision-making at the time.

10.3 Participation

The Learning Together model relies on professionals contributing very actively to the review and the resultant learning, as it is their unique experiences which help us understand what happened and why.

We know that participation in a case review can raise anxieties and distress about what has happened to children, and this was especially so in this sad case, not least because some members of the Case Group had known E over most of his childhood, and were very fond of him. In addition, there was a parallel process (the inquest) underway, and this added to the anxiety of some witnesses. The lead Reviewers and the Review Team are grateful for the willingness of the professionals to attend difficult meetings and to engage actively in the review.

10.4 Data from documentation

The Lead Reviewers and members of the Review Team were given access to the following documentation:

Documentation	Agency source
LAC Reviews (report and record of review): February 2013	Children's Services
Pathway Plan Reviews (report and record of review): August 2013, February 2014, August 2014, November 2014	Children's Services
Records of Statutory SW visits to E, throughout review period	Children's Services
Transfer summaries	Children's Services
Email correspondence SWRO1 and FM, throughout review period	Children's Services
Email correspondence between FM and various social workers, throughout the review period	Children's Services
Email correspondence between professionals in Children's Services, throughout review period	Children's Services
Standards of Care letter	Children's Services
Standards of Care guidance	Children's Services
Pathway Plan Reviews guidance	Children's Services
Police IMR	Police
Facebook records E and Child X	Police
Fostering Service Regulations and National Minimum Standards for Fostering Services (2011)	DfE

10.5 **Data from family, friends and community**

The Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

In this review, E's BF and his wife met with the two Lead Reviewers during the review and gave helpful information. E's FM initially did not wish to take part in a face-to-face meeting, but provided a detailed statement for the SCR. Both sides of the family were involved in giving helpful feedback after their opportunity to read the draft report (including FF).