# SERIOUS CASE REVIEW

**In respect of**

**YOUNG PERSON F**

**Report by: Birgitta Lundberg, Independent Reviewer and Overview Report Author**

**November 2017**

# Contents

# 1. Introduction

This Serious Case Review concerns a young person (hereafter 'Young Person F') who had been a Looked After Child since the age of one. During that time Young Person F had been in placements arranged by the same local authority, Dudley Metropolitan Borough Council, and most of that time Young Person F had been placed together with an older sibling. For a period of nearly nine years they had been with the same foster family.

When the death of Young Person F took place, a Missing report had been issued from an address in the Birmingham area where he was expected to reside. The placement had been agreed on Young Person F's release from custody in mid-August 2016 on a Detention and Training Order (DTO) License with Intensive Supervision and Surveillance (ISS). When a young person receives a DTO half of their sentence is spent in the community on a license, which can include specific conditions. Young Person F's license required compliance with an ISS program. This is an intensive package of support and interventions which is used to try and reduce the risk of further offending. The conditions included a curfew from 8 p.m. to 7 a.m. and daily reporting to the police station.

The Youth Offending Service (YOS) Case Manager had applied to Birmingham Youth Court for a warrant without bail as Young Person F's whereabouts were unknown. Young Person F had been missing for several days. This application was made on the same day that Young Person F died.

Young Person F was seriously injured as a result of being stabbed and died the following day from these injuries. Information has emerged that in early October 2016 Young Person F was in the Gloucestershire area selling and distributing drugs, having become involved over the previous fifteen months with a gang based in the Wolverhampton/Birmingham area.

On March 9th 2017, the person charged with the offence pleaded guilty to Young Person F's murder and was sentenced to life imprisonment, to serve a minimum of twenty four and a half years. The judge commented that "it had been a well-planned and callous attack to rob Young Person F of any money and drugs Young Person F might have had."

Another person was investigated in relation to Young Person F's death in relation to obstructing the course of a criminal investigation. The case was presented in the criminal court for trial, but after the jury failed to reach a conclusion, the case was not continued. It was decided in August 2017 that it was not in the public interest to pursue a retrial.

Young Person F had just had his 17th birthday prior to this tragic death. Young Person F had experienced some longer settled periods with foster carers especially between 2005 and 2013, when Young Person F and the older sibling were placed together. The sibling, although now an adult, is still living with the foster family, who as a result of Young Person

 

F's death have decided to cease being foster carers. Both Young Person F and the older sibling had chosen to use the foster family's surname.

This Serious Case Review has primarily focussed on the period in Young Person F's life from the year 2013 to Young Person F's death in 2016.The reason for exploring and examining the events and services provided specifically during that time is that Young Person F experienced a number of significant changes in 2013. The outcome for Young Person F was an increasing record of risky behaviour and criminal activities and, subsequently , numerous changes of placements, which distanced Young Person F from the older sibling and the foster family and fragmented Young Person F's education and training.

When Young Person F had moved from primary education to a comprehensive school , the sats results were reported to be of 'national average' and although there had been some challenging behaviour this had been managed in school. From 2013 his educational progress was affected by increasingly challenging behaviour and multiple placement moves.

Young Person F was described by the family and in reports as a child and young person who was friendly, engaged in family and leisure activities , took good care of his appearance and was loved by the foster family.

The significant people in Young Person F's life are noted below and in order to preserve their anonymity in this review they will be referred to as follows on the next page:

| Designation | Relationship | Age | Ethnic origin | Contact with Young Person F |
|---|---|---|---|---|
| Young Person F | Subject | 17 years shortly before the death | White British/Asian | |
| Sibling 1 | Older sibling | Two years older | White British/Asian | Not much at that time but still in foster carers family home. |
| FC siblings | Younger siblings adopted by foster carers. | | | In foster home when Young Person F was in contact. |
| Foster carers | Had been Young Person F's foster carers for a number of years. | | White and Asian | Were still in intermittent touch with Young Person F. |
| Mother | Had not cared for or been active in Young Person F's life for many years. | | White | There had been past brief contact on Facebook. |

# 2. Decision to undertake a Serious Case Review

The serious injuries of Young Person F were reported by the Gloucestershire police to the West Midlands police (WMP) in an email requesting that WMP officers conduct enquires to locate the next of kin details for Young Person F. (See Section 5. Foster family and older sibling's views and issues.)

Following Young Person F's death the next day the West Midlands police passed the information about the circumstances of the death to the Dudley Safeguarding Children Board (DSCB).

As a result the information was considered by the DSCB Serious Case Review Sub-Group and referred to the Independent Chair of the DSCB on 9 December 2016. The Independent Chair agreed on 11 December 2016 that the criteria for a Serious Case Review were met in accordance with chapter 4 in Working Together to Safeguard Children 2015 and Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, which set out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

*5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.*

*(2) For the purposes of paragraph (1) (e) a serious case is one where:*

*(a) abuse or neglect of a child is known or suspected; and*

*(b) either - (i) the child has died; or (ii) the child has been seriously harmed 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.*

In accordance with the DSCB Serious Incident Protocol each agency and organisation was required to secure their records and arrange for a formal chronology to be provided in relation to their involvement with the family. They were asked to identify an agency report author as soon as possible.

This Serious Case Review was commissioned to be carried out by an Independent Serious Case Review Panel Chair and Report Author and a nominated panel of the DSCB.

The DSCB notified Ofsted, the DfE and the National Panel of Independent Experts as per statutory guidance at the time. In addition using the ''Notification form for serious childcare

incidents in relation to a Child in Care'' Ofsted was alerted to the death. The Youth Justice Board was notified in accordance with the Community Safeguarding and Public Protection Incident Procedures ( CSPPI)[1] in place at the time as Young Person F was under license and on a YOS case load.

[1]Now updated to 'Community Safeguarding and Public Protection Incidents (CSPPI) – Standard Operating Procedures for Youth Offending Teams Version 3 March 2017'.

# 3. Brief summary of the Terms of Reference

The Terms of Reference were expected to include the generic terms of reference from 'Working Together to Safeguard Children 2015' with a particular focus on Young Person F and his experiences as a Looked After Child .

The agencies involved with Young Person F were required to examine their decisions and actions and to scrutinise the process of multi-agency working with a view to learning lessons from the case, both of good practice and to make improvements, where needed.

The review should examine the effectiveness of practice in line with procedures and the information and management / supervisory systems, both internal to agencies and multi-agency, in place at the time particularly in relation to Looked After children and young people.

The time frame for the review was agreed as starting on January 1st 2013 up to the time of death in October 2016. Any significant information that would assist the analysis and learning outside this time frame could be included after discussion with the Review Panel.

The foster family and older sibling should be invited to participate in the review and supported to do so. Their involvement with Young Person F had been active in the period leading up to 2014 and had continued with intermittent contact since then.

The Review Panel decided that it would not be in the best interest of the learning process for other family members ,who had not been involved in Young Person F's care since he was a very young child to be spoken to as a part of the review process.

Appropriate consideration should be given and reference made to issues of gender, race, culture, religious identity and disability.

The key elements that should be addressed were identified as follows:

1) Examining how the Local Authority met its responsibilities as a Corporate Parent to Young Person F.

2) Considering how Young Person F's needs were met and how his views and wishes were heard?

3) Examining the effectiveness of multi-agency working to meet his needs by:

    - Establishing whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
    - Identifying clearly what those lessons are, how they will be acted on, and what is expected to change as a result.

- Whether any other action is needed now within any agency.
- Whether the analysis of the information and the consequent response by all agencies was appropriate.
- Whether appropriate casework and management decisions were made.
- Whether Care Plans and Placement plans were in place and reviewed as required.
- Whether appropriate actions were taken with regard to referrals, reports of 'missing' episodes and subsequent placements.

For full details of the Terms of Reference see Appendix 1.

# 4. Brief summary of the Review process

When the decision had been made to proceed with a Serious Case Review, a Lead Reviewer and Overview Report author was appointed by the end of January 2017. A Review Panel of senior professionals in the agencies ,which had been identified as having had contact with Young Person F, was established. The members of the Review Panel had not had direct involvement in the services provided to Young Person F.

This Review Panel was chaired by the Lead Reviewer supported by the Dudley Safeguarding Children Board Business Unit. The Chair /Lead Reviewer had not been employed by any agencies in Dudley Metropolitan Borough Council prior to this Review.

From the end of January 2017 a number of meetings were held by the Review Panel to progress the work including a briefing with the internal agency Reviewers and authors of the internal Agency reports (generally referred to as IMRs). A part of this process involved examining an integrated Chronology of the involvement of all agencies as documented in records.

Once the draft Overview Report had been discussed by the Review Panel a ''Consultation and Learning'' day involving frontline practitioners and managers had been planned. This event was intended to explore the information and findings with practitioners ,who had been involved in the review process, in order to ensure that their views and comments could be heard and discussed with the Review Panel and Lead Reviewer. Any corrections of facts and changes and amendments following on from this consultation process would have been incorporated in to the Overview report prior to the presentation to the Dudley Safeguarding Children Board.

The Review Panel decided to change the review format as the key practitioners in question were no longer available in the employment of the local agencies. However, some of the Agency reports ( IMRs) were undertaken with input from the previous practitioners, which was helpful and useful for the learning process.

For full details of the process, agencies involved and meetings see Appendix 2.

# 5. Older sibling and Foster Family views and issues

## 5.1 Information from the visit to the foster home

A home visit was arranged to the foster family, where Young Person F had been placed in 2005 with a Care Plan describing it as a ''long term fostering placement with a view to adoption''. The older sibling was a part of the family with a similar plan. The placement for Young Person F broke down during 2013 and was officially declared as having ended in May 2014.

The home visit was undertaken by the Chair/ Lead Reviewer and the DSCB Business Manager and was recorded with full agreement of all participants. Respecting confidentiality the recording will be deleted on conclusion of this report. The foster carers and older sibling were present.

The conversation ranged from the services provided to Young Person F , to the carers and the older sibling to the feelings by the participants about Young Person F , his death and the events following his death. As a result of the experience of the past few years the foster carers have decided to retire from fostering.

It transpired that the foster carers had been part of an Independent Fostering Agency established in 2000, which is also a part of an international group founded in 1988 providing among other services, Health and Social Care services.

The foster carers had been approved two years prior to Young Person F and the older sibling being placed with them. The carers had participated in extensive training and were supported by the Agency supervising social workers , education advisors and placement support workers.

The placement was planned with a program of introductory visits and as the carers were a dual heritage couple it was judged to be a placement that would meet Young Person F and his siblings needs.

There was some hesitancy initially by the practitioners given that the carers belong to a smaller faith group with some specific beliefs. However , the agencies involved assessed that the carers were able to offer a caring environment without their beliefs having a negative impact on their care of the children. The issue of the faith group, its beliefs and practices was discussed in statutory reviews as a part of evaluating the fostering environment.

From the conversation a picture of Young Person F emerged as a child and young person, who had been well cared for and loved by the family members. There were photos displayed around the house of family events and holidays with a smiling Young Person F at

different ages. Young Person F was described as being very fond of his family including the more recently placed younger children from another family.

These children were placed with and adopted by the foster carers in early 2013, which was an event that the family as well as practitioners at the time, and subsequently, have identified as a turning point for Young Person F.

The plan for Young Person F and the older sibling had also been for adoption but the foster carers had requested an adoption financial allowance , which was declined by Children's Services. The carers felt unable to afford the care of several children without any additional financial support and therefore the plan for Young Person F and his sibling reverted to '' long term fostering''. The foster family moved to a smaller property to downsize having lost the allowances for the younger children following their adoption and for the first time Young Person F and his sibling had to share a room.

The family noted that they had received support from their own agency and Children's Services during 2013 with a number of strategies being tried out to keep the placement going. However, between the challenging behaviour at home and in school leading to exclusion, Young Person F was becoming more and more reluctant to work with any practitioners or accept any support or authority and was increasingly getting involved in criminal activities. Young Person F now rejected the faith group the foster carers belonged to and started to spend time away without explaining where he was or with whom.

By April 2014 the foster carers felt unable to continue in view of the challenging behaviour and increasing episodes of Young Person F 'going missing' and felt that it was not safe for Young Person F to remain in the placement. The Independent Fostering Agency gave notice to the Local Authority but agreed to hold off as the social worker was trying to get an agreement for funding for a 12 week therapeutic residential course for Young Person F, which might lead to an improvement and continuation of the placement. The foster carers and Young Person F were told that the funding was not available and this option fell through.

It was clear that the foster carers felt that Young Person F had been let down by decisions that had been made based on funding requirements. In their view the considerable number of residential placement moves ,which followed on from the breakdown, must have cost the Local Authority a great deal more and were not in Young Person F's best interests.

The foster carers expressed the view that Young Person F ''*was going through a bad phase but would be ok once he was 18 and an adult, then he would no longer be ' in care'*.'' They had expected that Young Person F would then feel able to become a part of the family again.

They were all aware that Young Person F had some involvement with drugs but did not think that it was '*that bad'* as they had not observed him with drugs.

The foster carers and older sibling expressed anger and distress at the manner in which they were informed about Young Person F's hospital admission and subsequent death. They were told by the police after Young Person F's death. They felt that they had been left out and had not been provided with information in good time. They were especially taken aback by the way that the older sibling had been ignored by agencies given that Young Person F and the older sibling had spent most of their lives together. They felt that the agencies by informing the birth mother ,who was able to be by the bedside prior to Young Person F's death , and who was then assisted to make the funeral arrangements , the older sibling and the foster family had been pushed aside.

They expressed the opinion that Young Person F would not have liked the funeral arrangements and invitations the way they were done and the older sibling has considered drawing up a Will to express his wishes to avoid a similar situation.

*Learning point*

The information sharing when a Looked After Child is seriously injured or dies is set out in the Children' Services procedures but there is no reference to informing siblings . Similarly , the advice about funeral arrangements and supports make no mention of siblings.

http://dudleychildcare.proceduresonline.com/p_death_serious.html

The Dudley Safeguarding children procedures in chapter 1.17 sets out procedures for 'Unexpected deaths' including for Looked After Children and again there is no mention of siblings.

http://westmidlands.procedures.org.uk/ykpzz/statutory-child-protection-procedures/child-deaths#

*Learning point*

The procedures mentioned above clarify what should be done and who should be informed once one of the key agencies become aware of an unexpected death or serious injury of a child in the local area.

However ,the procedures do not clarify the mechanism for hospitals, when a request for finding a next of kin of a child /young person is made to the police, prior to the child's status as a Looked After Child having been identified. Similarly the procedures do not address the need for the police to ascertain the child's status with Children's Services prior to notifying a parent.

It is at this point that there is a gap where the notification to a next of kin could be mistakenly directed to a birth parent with no recent contact with the child or where the child or young person did not wish to have contact with them.

The foster family noted that Victim support services had been very helpful and had engaged with them including arranging a period away for the family .

## 5.2 Outstanding concerns for the older sibling and the foster carers

Although a manager from Children's Services had come to visit the foster family two weeks after Young Person F's death and had apologised for the lack of information about his death and the funeral , the family still feel that there are lessons to be learnt for the future, for other looked after children, their siblings and foster families.

There is also an issue about explaining to foster carers how the legal aspects of Care Orders impact when a child / young person is ''in care'' as compared to adopted and the child/young person then dies. Technically the Care Order comes to an end when the child / young person dies but this may not be an aspect that is generally shared with carers.

The older sibling noted that they did not feel that they had been kept '' in the loop'' about Young Person F's progress and whereabouts ,once Young Person F left the placement, and that more might have been done to promote contact between them especially given the amount of time they had shared together previously.

The older sibling would have liked to have been able to see Young Person F in hospital prior to Young Person F's death.

# 6. Significant issues, decisions and actions

During the three year period covered by this Review there were a number of developments which took place in relation to Young Person F and the services provided for his care. There are statutory requirements in place underpinning the services which were provided as well as internal procedures in the agencies, which were involved with his care. The regulations underpin the notion of the local authority as the ''Corporate Parent'' with the responsibilities that it involves: ''*The role of the corporate parent is to act as the best possible parent for each child they look after and to advocate on his/her behalf to secure the best possible outcomes.*''[2]

For example the Placement regulations for a Looked After Child[3] set out the expectations of Looked After Reviews, Health assessments , plans for the child's education and supports such as Advocates or Personal Advisors. There are clear guidelines for the timescales, frequency and contents of meetings in these regulations. This refers to Independent Reviewing Officers ( IROs) and their appointment and role as well.

The Review has explored how the regulations and procedures were implemented and if the implementation led to an outcome that was in the best interest of Young Person F.

The Review has identified some significant events and issues which in all probability and with the benefit of hindsight influenced the outcome for Young Person F during this period . The selection of the significant events and issues are based on the analysis by the Overview author through the process of examining internal agency reviews, Review Panel discussions, the information in the integrated chronology and the meeting with the older sibling and foster family. The purpose of this section is to identify the points, where decisions and actions had an impact on the welfare of Young Person F. The aim is to come to an understanding of how and why those decisions and actions were arrived at in the context of the agencies and the policies, procedures and guidance in place at the time.

The internal agency reviews, IMRs, have covered a number of issues in detail and the agencies have made changes to systems, guidance, policies and procedures, where there was a need for improvement and learning during the progress of the Review.

This Review report should examine the multi-agency aspects of the decisions and actions related to Young Person F and consider if the key agencies worked together effectively to meet Young Person F's needs.

[2] The duty to co-operate under section 10 of the Children Act 2004.
[3] See The Children Act 1989 guidance and regulations Volume 2: care planning, placement and case review June 2015.

The significant issues and events highlighted were:

## *6.1 The impact on Young Person F's emotional well being*

At the beginning of 2013 a number of events took place which on reflection had a negative impact on Young Person F, who was at that time entering adolescence and becoming more challenging of adults ,especially adults in a role of authority. The same events affected the older sibling , who did not respond to them in the same way as Young Person F, which serves to emphasise how individual children respond to the same events according to their individual circumstances , needs and personalities.

*Learning point*

Where children are looked after with siblings the importance of assessing the needs of each child separately and devising Plans to meet their individual needs cannot be stressed enough. Their records in all agencies should be kept separately and reflect the progress and development of each child and meeting notes should not be copied and pasted .

Their individual Plans should take in to account an overview of their history and current needs and should not focus solely on the current 'problems' or negative behaviour .

The two most significant events were the changes in the foster placement as the two younger children ,who had been placed more recently, were adopted by the foster carers and the sudden death in May 2013 of the Young person's Advisor with whom Young Person F had a good, supportive relationship. There was no evidence on record in any agency of support having been provided to address the loss of the practitioner with Young Person F.

The process of decision making around the adoption of the younger children followed the agencies' procedures in place at the time. However, the impact of their adoption whilst the Plan for the adoption of Young Person F and the older sibling was changed back to 'long term fostering' caused the practitioners involved serious concerns given the message that this course of action would send to Young Person F and the older sibling. The concerns were discussed in Looked After Reviews and other meetings and services were put in place to counsel and support Young Person F and the older sibling.

How effective that approach was can be questioned as the records contain the information that a Respite placement was arranged for both Young Person F and his older sibling as the adoption was formalised. They both protested about having to go elsewhere and the Children's Services records noted that " they barricaded themselves in their bedroom to resist being taken to the respite placement" ( April 2013).

 

The foster carers had requested adoption allowances for Young Person F and the older sibling but this was declined by Children's Services. The foster carers moved the household to a smaller house in June 2013 to manage financially as they had lost the allowances for the younger children. Young Person F and the older sibling now had to share a room for the first time.

During this period Young Person F displayed more challenging behaviour in school with a number of exclusions leading to permanent exclusion in October 2013. Prior to the escalating behaviour in school in 2013 there had been a school counsellor working with Young Person F for the past two years and a request for a referral for a psychological assessment had been made. There was no evidence on record that this referral had taken place or that an assessment had been undertaken. The school counsellor reported during an interview for the Agency review that they had had real difficulties accessing background information, which had been requested from Children's Services. The counsellor did not escalate the request for information within the agency.

This Review also noted that there was no representative from the school attending three of the Looked After Children Reviews ( LAC Reviews) ,which took place in the foster carer's home. Notes of the meetings were sent to the school SENCO ( Special educational needs Co-ordinator) but it was not clear from the school records, if this information was shared with the school counsellor.

*Learning point*

The gap in the records at school and in Children's Services about the involvement over a period of time of the school counsellor with Young Person F demonstrates the need for close communications and collaborative working between all school staff, social workers and foster carers . The school counsellor had been working in isolation from other practitioners. There should have been earlier opportunities to work more effectively with Young Person F to prevent the permanent exclusion ,which was followed by a fragmented education experience for Young Person F from then on.

At this time Young Person F ,who had previously been positive and had participated in the foster carers' faith group and related activities , now became disruptive and rejected the faith group and its structures. Young Person F expressed negative and sometimes offensive views to the foster carers about it.

This period saw an increasing pattern of 'missing episodes' and criminal activities such as shop lifting as the foster placement was put under considerable strain and the foster carers expressed their worry 'about keeping Young Person F safe'.

As Young Person F had previously had good support from the Young person's Advisor ,there was no evidence in the Plans/services provided that another practitioner had been found as a replacement. As young person F was reported to reject any attempts to speak to people Young Person F saw as ''authority'', Young Person F was left to navigate through feelings of loss on his own during this period of many significant changes in his life.

*Learning point*

The importance of collaborative work across the key agencies for looked after children is demonstrated in this Review as the emotional needs of Young Person F should have been addressed by Children's Services with Health agencies, Education services and schools.

*Above all, children and young people need consistent relationships with adults who are committed to loving and caring for them. However, some young people will not experience this stability unless the right support is put in place for them and their carers. This requires services that take an individual approach to understanding children's and carers' needs, that give children opportunities to shape their own care, and provide proactive support rather than allowing problems to get worse.*

*Therapeutic services have an important role to play, and must be made more accessible – but this support must be provided in a range of different ways across social care, health and education. Research shows that the everyday environment that children and young people experience in care is central to their wellbeing.*[4]

## *6.2 The impact on Young Person F's educational development and health*

Once the foster placement had broken down there followed a number of placements, some within the Dudley LA borders and some in other parts of England and Wales. The placements included residential services provided by the Dudley LA and private providers as well as other foster placements and placements in Young Offenders institutions. Young Person F was remanded to custody on a number of occasions.

The Education Agency report noted that thirteen different educational establishments could be identified in the records. The various places were in different parts of the country where Young Person F had been placed and some of the education services were delivered within

[4] Achieving emotional wellbeing for looked after children ;a whole system approach .June 2015 .L.Bazalgette et al NSPCC research

the residential establishments where Young Person F was living at the time. There were no consistent education plans in evidence after November 2014 when Young Person F was in a residential placement out of borough for two months .

Young Person F had been assessed in accordance with statutory requirements as having academic achievements ,which were in line with his peers at the completion of primary education, aged 11 (year 6 Key stage 2).

On two occasions there were proposals for referrals for psychological assessments , once while still at school in the neighbouring Local Authority, where the foster carers lived, and once in 2015 when a referral to CAMHS and a proposed assessment for Autism Spectrum Disorder (ASD) by a Clinical Psychologist were not followed through. There was no evidence of an explanation in either instance as to why these proposals had not been actioned.

In the interview with the foster carers they were clear that at one point they had at Young Person F's own request asked, if Young Person F could be home educated as they all thought this might solve some of the behaviour problems. According to the Education Agency report the records had no note of this request. The foster carers recollection was that they were told that it was not possible because Young Person F was Looked After.

*Learning point*

Given the dates of the emails the references to Home Education have not been clarified but the inquiries as a part of the Review have led to a discussion about the possibilities of a Looked After Child placed in long term foster care receiving Home Education. The Education Service had no records of an instance where this had taken place and queried whether the Local Authority could agree to such an arrangement for a Looked After Child.

This issue must be clarified and guidance to practitioners and foster carers provided to ensure that, if this is another option for some children /young people, the services can support this option. If Home Education is not an option for a Looked After Child then the guidance to Fostering services and the relevant practitioners must state this.

The outcome for Young Person F was that the number of moves in a short space of time led to his education becoming fragmented and lacking a consistent Plan. As a result Young Person F had achieved no qualifications by the time of his death.

The Health assessments as required in statutory guidance followed a similar path. Due to the multiple moves between placements and local authorities the ability of the Looked After Children Designated Nurse to track Young Person F and arrange for services to undertake the health assessments was impeded. Additionally the systems in place to track

 

looked after children were not securely in place at that time and relied on social workers notifying the Designated LAC Nurse of the child's whereabouts on form Part A [5].

Young Person F underwent only one health assessment from 2013 onwards because the placements subsequently were out of area and all services, whether universal or supplementary, should have been provided in the area where Young Person F was living. The LAC Nursing team should have requested review health assessments to be undertaken in those areas ,when they were sent Part A forms and a current address by Dudley Children's Services, usually the child's social worker . However, the Part A forms were often not provided or by the time the administrator had chased up the form Young Person F had moved again.

The health assessment in December 2013 took place in the foster home and Young Person F had signed the consent form. The assessment was described as *''holistic and Young Person F participated in the main ,sometimes needing prompting by the foster carer. Health, school, home and social life were discussed with Young Person F and it was noted that CAMHS were to be involved with Young Person F and the carers.''* A copy of the report was sent to the GP, social worker and school nurse. As previously noted no follow up can be evidenced in any records with CAMHS.

*Learning point*

The Agency report ( IMR) by the Named Nurse for Safeguarding Children in the Black Country Partnership NHS Foundation Trust sets out the history and development of the systems for health assessments of children, who are looked after, in detail. The report offers significant recommendations to improve the systems and therefore the outcomes for all children looked after.

The importance of the message in the report is that collaborative working and information sharing must be recognised and understood by all practitioners and managers to ensure that Dudley LA and key partners in the Health agencies meet the needs of the children they are responsible for.

In August 2015 Young Person F was seen by the YOS Case Manager following a court appearance and the details of the order were explained to Young Person F. Referrals were made to the YOS CPN, YOS substance misuse worker, YOS nurse and the YOS education,

[5] Part A is the first part of the British Association of Adoption and Fostering (BAAF) form which details all children's demographic information and consent for the health review to take place.

training and employment worker (ETE). The YOS case manager emailed the following information to support the referral to the Substance misuse worker:

*'Young Person F admits to drug dealing/ running and personal cannabis use. Staff at the residential placement believe Young Person F may be using other substances'.*

The Substance misuse support worker tried to engage Young Person F, who denied that he was using drugs when released from custody and refused to attend the appointment.

Young Person F was assessed and offered health support services within some of the placements for example the Secure Training Centre ( STC) from March 2016, where :

"*Healthcare is provided by G4S under a service level agreement, with appropriate access to community-based services. Education is provided on-site by G4S."*[6]

The services were declined in a number of instances by Young Person F but the registered CPN using the SASH (suicide and Self Harm) process assessed Young Person F, who had threatened to harm staff and himself. A SASH meeting took place at 2.30 am in response to an incident and: "*the decision was made to place Young Person F on a strategic management plan for the rest of the night. There would be constant observations for the rest of the evening with the emphasis on staff trying to talk with Young Person F to attempt to reassure and calm him down to prevent any further self-harming. The self-harming ceased although the decision was made not to open Young Person F's door given the potential risk to staff , along with the decision that Young Person F was not judged to be an immediate risk of suicide based on his actions and comments to staff. Young Person F openly stated that self-harming was a control mechanism to prevent the transfer out of the Centre the following morning ."*[7]

The lack of consistent health monitoring and the slow responses to referrals for specialist services led to a situation where Young Person F became more involved in drug use and may have needed mental health support in view of the losses and confusion in his life. Young Person F was described as presenting as '' neglecting himself '' by the foster carers and older sibling during 2016. The final placement Information report stated that:

"*Staff had concerns about Young Person F because his personal hygiene started to decline and he wasn't eating properly*."

Young Person F was also placed in 'one to one' or segregated situations in some of the placements due to his aggressive and hostile behaviour towards staff and other young people. Taking an overview and looking at Young Person F from a young person 's perspective he had no' neutral person' to speak to about his circumstances and feelings,

[6] Agency IMR report STC
[7] Agency IMR report STC

although there were references in records to the need to appoint an Advisor or Advocate, this was never actioned.

The last placement provided an Information report to the Review where they noted that:

" *Young Person F was a young man who just really wanted a sense of belonging. Staff witnessed Young Person F call friends asking them to come and see him but they never did, it was clear to the see the disappointment and frustration which would make Young Person F rebel and break unit rules. Young Person F liked to be the centre of attention and liked acting "the big Man", when challenged for his bad behaviour Young Person F would become aggressive and verbally abusive*."

## *6.3 The impact of the foster placement breakdown on Young Person F*

The various Agency review reports and Panel discussions explored the impact of the foster placement breakdown on Young Person F's well-being and noted the increase in criminality, missing episodes , challenging behaviour in school leading to permanent exclusion and generally aggressive behaviour, which followed on from that point. However, the placement breakdown did not happen suddenly but over a period of time from early 2013 to May 2014.

There were a significant number of meetings between the Children's Services , the Fostering Agency and the foster carers including the involvement of the Independent Reviewing Officer where interventions to prevent a breakdown were discussed. A formal Placement breakdown meeting was not convened in view of the number of meetings that had taken place to address the issues.

The tensions affecting the foster placement arose from Young Person F's challenging behaviour in all settings towards adults and peers. This challenging behaviour had been described as being managed in the primary school setting and the foster home prior to the change in the Care Plan for Young Person F and the older sibling from its aim of adoption by the foster carers to long term fostering again. Although Young Person F could have demonstrated resentment towards the two younger children who were adopted by the foster carers , he did not. In fact Young Person F had tattooed the younger children's names on his wrists and spoke of them very positively.

During this period Young Person F became more and more involved in criminal activities starting with relatively minor thefts from shops in the locality to more serious involvement in thefts, abusive and threatening behaviour .There was a significant increase in periods of time missing from the fostering placement and then being hostile to the foster carers.

The Fostering Agency provided a range of support services to the placement with a view to preventing the placement breakdown. They were willing to wait with closing the placement contract for Young Person F ,if the 12 week Therapeutic resource which the social worker

was pursuing for Young Person F was implemented. However, the LA Resource Panel concluded that the Therapeutic placement was far too costly and it could not be provided for Young Person F.

The social worker ,who had been allocated to Young Person F for some time, in the interview for this Review was of the opinion that if more had been done to prevent the placement breakdown it could have worked. For example the decision about the 12 week therapeutic placement was counterproductive as the costs incurred following the breakdown with numerous placement moves must have been higher than the cost of that one resource.

A Research report commissioned by the NSPCC in the section, which addressed the costs of care and support services to prevent placement breakdowns concluded for example:

''*These cost estimations suggest that providing improved support for looked after children's emotional health and wellbeing could avoid costs overall. Local authorities should analyse their own budgets and explore the extent to which they can rebalance their spending to support a more proactive and preventative approach to supporting looked after children's emotional wellbeing.*''

The pattern throughout Young Person F's time as a Looked after young person after the foster placement breakdown was described in the Children's Services IMR as "*a cycle of "beginning to settle" shortly being followed by the placement giving notice due to their inability to keep Young Person F and others safe."* The integrated chronology has 26 entries referring to placement moves in this review period.

The aspect that was not evident in the records throughout this period following the adoption decision and placement breakdown was Young Person F's own views about his situation and his feelings. The Children's Services IMR report commented on the fact that the case recording was primarily concerned with incidents prior to the placement breakdown and afterwards with finding placements. The case recording therefore gave a negative picture of Young Person F as all problems were itemised with little positive comment.

The social worker agreed that given the overall workload at the time the service had been focussed on reacting to problems as they arose and then talking to Young Person F about the practical aspects of resolving those immediate problems. There had been little scope to explore Young Person F's feelings about the adoption issues and the possibility of the placement breakdown and what would then follow.

As previously noted the absence of a neutral adult ,whom Young Person F could speak to freely , was a significant missed opportunity to offer support and advice to him. An advocate could have provided a pathway for Young Person F's views to be heard and to feed into planning the services with him.

 

## *6.4 The Missing episodes and the vulnerability of Young Person F*

The Review noted that there were a significant number of reports of Young Person F '' going missing'' from all the different placements. The missing episodes could vary from a few hours in the early stages to several days or weeks later on during the review period. Young Person F rarely gave an account of his whereabouts or the other people he spent time with.

The records evidence that staff in some placements were aware of reports that Young Person F had become involved with a group of people , many older than himself ,who were understood to be part of an organised group distributing drugs across the region. This information was available in records from June 2015 onwards.

In addition Young Person F was open about using cannabis himself and services from Substance misuse workers were offered to him on more than one occasion. Young Person F generally declined services with the explanation that he was no longer using drugs.

During most of this period Young Person F had one consistent social worker and one consistent YOS case manager. Young Person F became increasingly aggressive and hostile towards both practitioners which led to placement visits and meetings taking place with security measures provided or without Young Person F attending.

Both agencies were aware of the circumstances and the matter was discussed in supervision. However , neither agency seriously considered a change of worker in order to try to re-engage Young Person F and/or to protect the practitioners.

The difficulties communicating with Young Person F produced an outcome where Young Person F became more and more isolated from practitioners and friends and family. While the practitioners in the agencies were focussing on the practical aspects of arranging and maintaining placements, there was little scope for work aimed at understanding Young Person F's views and feelings and reasons for 'going missing'.

The Police IMR examined the West Midlands police records in respect of Young Person F and missing episodes that had been reported to them. The report concluded that all policies and procedures at the different times had been followed. However, there were gaps as many 'missing episodes' had taken place in other police force areas where Young Person F had been placed 'out of borough'. It remains unclear just how many times Young Person F was reported as missing by placements.

"*Young Person F was known to the West Midlands Police ( WMP) both as a victim and perpetrator of crime; however the vast majority of contacts were regarding Young Person F being a perpetrator of crime and a regular absent/missing person. Between 17th March 2014 and 1st June 2016, Young Person F was reported as an absent/missing person a total of seventeen times to WMP. Out of those seventeen reports, Young Person F was classified as absent on eleven occasions, and as a missing person six times*".[8]

There were two instances where Safe and Well checks were recorded. These checks were carried out by the police when a person had been recorded as missing , not as absent.

Safe and Well checks are carried out by the police whilst the Return Home interview is usually carried out by the LA social worker or a practitioner from a specific service commissioned for this purpose. There were no records of Return Home interviews having been carried out by Children's Services.

*Learning point*

*"Information from the police's safe and well checks should be shared with children's social care services to inform a follow-up interview by a third party (not the police) to explore the reasons for running away and the action that might be taken to prevent it in the future. Under statutory guidance these 'return' interviews are the responsibility of the local authority but are often undertaken on behalf of local authorities by voluntary agencies who work with missing children or children at risk of sexual exploitation. These interviews are intended to identify longer-term risks or more deep-seated problems. They are particularly important as children are often unwilling to disclose information to the police, but may offer valuable information if the interview is conducted well by a third party who has the trust of the child. Within the scope of inter-agency arrangements, information from these interviews should inform all relevant agencies' practice. The return interviews might provide information for the police about likely suspects in cases of CSE or help agencies develop a trigger plan (an agreed inter-agency plan of the action that will be taken and by whom if a child goes missing)".*[9]

The services provided in Dudley when a child/young person goes missing have been updated and the flowcharts provided to the Panel show that a more robust response should be in place now . The multi-agency meetings include a police intelligence and information sharing input with the intention of picking up vulnerable young people at an early stage to develop preventative strategies diverting them from any gangs or organised activity.

Another issue emerged as the records and the integrated chronology were scrutinised . There was an increase in missing episodes and criminal activity when Young Person F was in

[8] WMP IMR report

[9] HMIC Missing children; who cares? The police response to missing and absent children. March 2016.

one particular local residential placement. The Review Panel queried whether the placement had displayed a more lenient approach to males going missing rather than females thus exposing a culture where practitioner and management attitudes about gender differences and vulnerability determined the decisions made and actions taken . The Review Panel was informed that the residential establishment is no longer open.

*Learning point*

The Panel members were agreed that the responses to Young Person F's behaviour could be viewed as being more flexible and lenient than they had expected on a number of occasions. If the same behaviour had been displayed by a female young person it would in all probability have been responded to with more concern about their safety and with a more protective Placement plan.

Case supervision in all key agencies should reflect on the responses to young people and consider whether the gender of the young person might be influencing the decision making .

In view of the repeat missing episodes, which sometimes covered weeks rather than days, Young Person F was a young person , who should have been considered as vulnerable to child sexual exploitation (CSE). This concern was noted in a multi-agency Missing Strategy Meeting which recommended that the social worker should complete a CSE screening tool . It was not clear from the records if this assessment was completed or if Young Person F was discussed at the Young person Sexual Exploitation Panel (YPSE).

Young Person F's vulnerabilities made him a risk to himself and to other's. A risk assessment was completed by the YOS Case Manager in March 2016 which recorded Young Person F as a 'medium risk'. The level of 'medium risk' had been determined by the fact that Young Person F did not demonstrate suicidal thoughts or actions. The same conclusion was reached by the YOS CPN in August 2016.

There were numerous accounts of abusive and threatening behaviour towards practitioners. Young Person F's continuing hostility and threats led to a significant time in segregation in some establishments. The asset assessment in May 2016 raised the risk level to high. Young Person F's case was discussed at an Integrated Offender Management meeting (IOM) in May 2016. This is a multi-agency meeting convened at the YOS by the Supervising Manager to discuss high risk cases. A decision was made to add ISS as a condition to Young Person F's DTO license.

The overall conclusion from the records and interviews with practitioners was that Young Person F was a rather isolated young person with few close relationships. This left him vulnerable to the influence of others ,who might fill an unmet need to belong to a group. The real difficulty in determining how vulnerable Young Person F was lies in the lack of information about who he spent his time with and what he was doing ,when he was missing from placements.

## *6.5 Criminal activity and links to Gangs*

The first recorded involvement with the police was noted in October 2013. The criminal activities escalated and accumulated to a considerable list of offences by the time of Young Person F's death. There were records in some of the placements of references to involvement in a 'gang' and in particular in relation to the selling of drugs. Young Person F was also thought to have debts which then ensnared him further in the gang activities.

Although there were these pieces of information about gang involvement in the Children's Services records, the YOs records and the police records there was no evidence of any specific follow up or action taken to address this with Young Person F.

There were no records of inter-agency information sharing about this aspect or any action taken to develop a strategy to address the issue and divert Young Person F from this involvement.

*Learning point*

The West Midlands Safeguarding Children Procedures which apply for the Dudley children's workforce have the following useful entry:

*An important feature of gang involvement is that, the more heavily a child is involved with a gang, the less likely they are to talk about it.*

*There are links between gang involvement and young people going missing from home or care. Some of the factors which can draw gang-involved young people away from home or care into going missing can come through the drugs markets and 'drugs lines' activity, There may be gang-associated child sexual exploitation and relationships which can be strong pull factors for girls. Exploitation is at the heart of this activity, with overt coercion taking place alongside the pull factors of money, status, affection and belonging.*[10]

[10] Chapter 2.1. the West Midlands SCB procedures

## *6.6 The statutory requirements and their effectiveness*

The integrated chronology and the Agency reports demonstrate that the statutory requirements such as Looked After Children's Reviews (LAC reviews) took place at the intervals expected. The attendance was not always as multi-agency as required for example the school representation at one point was noted as 'not attended' on three occasions. The review has also revealed that the health assessments, which should be part of the LAC reviews had not followed through after the foster placement breakdown because of the system that was in place at the time as previously noted.

The Independent Reviewing Officer (IRO) had raised concerns with the social worker and their manager in the context of some of the LAC reviews about the placement moves and the services being provided. The Children's Services IMR noted that the IRO's concerns had not had a positive response and this raises a query about the authority of the IRO role and the systems in place to resolve any differences of opinion between managers and the IROs.

Young Person F received more than the required statutory visits by the social worker and the YOS case manager was proactive in visiting and keeping track of Young Person F.

A number of Professionals meetings and Planning meetings took place trying to address the tensions in the foster placement. However , the involvement of all relevant agencies was not always as good as it might have been as the health agencies and school representation was sometimes lacking. The reasons for this gap in multi-agency working was not necessarily that those agencies failed to attend but as the invitations were issued by Children's Services the invitations did not always reach the right practitioner in the agency concerned or with enough time to make arrangements. Where notes from previous meetings had not been provided to the relevant person there was no routine follow through. As there was no formal Placement Breakdown meeting ,because the number of meetings that had been held was judged to be sufficient, it removed a forum for a specific Plan to deal with the breakdown across the agencies. A clear Breakdown Plan should have addressed the health and educational needs as well as the practical placement needs and should have included emotional support to Young Person F.

As the police involvement was restricted to responding to criminal activity and reports of Young Person F 'going missing' the police were not included in any other meetings or discussions about Young Person F other than the YOS meetings. However, if the concerns about Young Person F's vulnerability , substance misuse and possible gang involvement had been recognised and acted on ,the police could have offered some specialist knowledge about these issues and a multi-agency strategy could have been put in place to support Young Person F.

There were a number of services provided to Young Person F over the period of time for this Review and some practitioners were committed in their attempts to reach Young Person F

for example the foster carers and their Agency , the social worker and the YOS case manager as well as some of the practitioners in the placements Young Person F attended. The question ,which was posed, was whether those services, which were provided, were effective in improving the outcomes for Young Person F?

The main stumbling block which emerges from the review is that the services did not succeed in engaging Young Person F to work with them so that he could add his point of view to the Care Plans, which were devised to meet his needs. The outcome for Young Person F would have been more likely to have been positive, if he could have participated in shaping his Care Plans. Participation could also have supported him to develop a more independent and resilient outlook for his own future.

# 7. Findings and Conclusions

The findings of this review in to the death of Young Person F ,who was stabbed in a planned attack to rob him of money and drugs as a part of an organised drug selling activity in the region, have addressed a number of aspects of the services ,which had been provided to Young Person F with a view to learning lessons and improving services where required. Several lessons and opportunities to improve practice and systems in future have been identified and some learning has already been implemented during the course of the review such as the responses by the Children's Services and partner agencies to children going missing.

Some of the findings have been drawn out in Learning points in section 6 of this report and other findings can be set out as follows:

- Where children are placed in a long term placement with a Care Plan, which states the aim as their adoption, any changes to this Plan should be managed with sensitivity. The child must be given adequate time to understand the reasoning for the decisions made. The child's views must be sought and recorded clearly should they request access to records at a later stage.
- When decisions are made by Panels controlling access to resources such as placements and therapeutic services the decisions must be informed not only by the immediate cost but take in to account projected cost if the request is denied as this may incur greater costs in the long run.
- Where a child / young person is persistently abusive or aggressive towards a practitioner there must be a discussion between the supervisor and the practitioner. They must consider whether it is in the child's best interest to continue with the same practitioner by weighing up the positive aspects of stability and consistency of a worker with the negative effect that the practitioner and child are not able to communicate adequately. They must also consider the impact on the practitioner and their ability to deliver a responsive service to the child.

In conclusion the death of Young Person F could not have been predicted but some of the risk and vulnerability factors identified in the HMIC research 2016 ' Missing Children ;Who cares? and some of the case examples are worryingly similar to the issues which affected Young Person F.

The particular concerns raised by this Review is that the multi-agency collaborative working and information sharing had not been as effective as could have been expected. This led to some decision making and actions being taken, which were based on inadequate information or gaps in information ; for example the records demonstrated that it was known by some practitioners that Young Person F was involved in selling drugs around the

 

region sixteen months prior to his death. The information was held but not acted on or shared.

The most concerning conclusion is that the services provided were increasingly unable to engage with Young Person F and although time ,effort and commitment were evident on behalf of the practitioners they were not able to find a way to reach Young Person F.

The skills ,experience and knowledge required to work with children who are hard to reach may be difficult to access in the workforce. If local authorities and their partner agencies who are responsible as Corporate Parents cannot access specialist services some Looked After Children will continue to fall through the gaps.

# 8. Lessons Learnt

This Overview Report has highlighted 'Learning points' which should be used to inform the learning from this review. The learning points can be used as case examples in team sessions or supervision to reflect on practice in the agencies.

The Learning points and recommendations in both this Report and the Agency IMRs must be followed up to ensure that practice and systems are improved and where practice has already been addressed as a result, mechanisms must be in place to embed and maintain the improvements.

The lessons noted in this report and in the individual agency reports will be reflected in the Action Plans and will be monitored regularly by the Serious Case Review Subgroup of the DSCB. Agencies are required to disseminate any learning that is specific to their organisation and the DSCB will facilitate the dissemination of any broader multi-agency learning.

# 9. Implementation of Learning

The learning from this review will be disseminated to all the agencies through the DSCB Learning framework by:

- Publishing the Overview report on the DSCB website and communicating this to all Board members
- Producing a 'Learning and Improvement Information sheet' - which summarises the learning from the review - and publishing it on the website
- Liaising with the training coordinator and the 'Learning and Improvement' subgroup to identify any specific training events required and how the learning can be incorporated into existing training courses/workshops
- Using the SCR as a case study in the annual Learning from SCR event.

# 10. Learning points and Recommendations

The individual Agency review reports, IMRs, have made specific agency recommendations, which will be set out in their Action Plans and progress will be required to be reported to the DSCB Serious Case Review subgroup.

The recommendations of this Overview report will form the DSCB Action Plan and will be monitored regularly by the DSCB Serious Case Review subgroup.

Arising from the main learning points the following are the specific recommendations by the Overview Report author and they have been drawn up in order to ensure that all relevant interagency learning from the Review is addressed:

## *Learning point 1*

The overall learning from this review centres on the 'corporate parenting responsibilities for children and young people looked after by the local authority'. The organisational systems and multi-agency systems that were in place did not reach Young Person F. The systems must ensure that children and young people already by definition vulnerable are detected early enough so that services can be responsive to support them to avoid the drift and pattern of fragmentation of care seen in this review e.g. when one service breaks down all other follow.

There must be a route in the organisational systems where an alert can be channelled from the various levels of the organisation up and down to note when a child is at risk . Multi-agency panels are useful but only if the representatives on the Panels then bring the discussions and decisions back to the relevant members of their own agencies for sharing and implementation. The learning from research projects about costing of services for Looked After Children in the short term and longer term should be part of any discussion with Commissioning services and LA members in the context of the Corporate parenting responsibilities and with a view to the best outcomes to LAC children.

## ***Recommendation 1***

The Dudley Safeguarding Children Board should undertake an urgent review with their Safeguarding Partner agencies e.g. the Local Authority , the Police and the Clinical Commissioning Group (CCG) and any other agencies involved in this case of the current system in place to meet the needs of looked after children and young people to examine, if the decision making about services can made swiftly and be responsive to the needs of the child or young person .

The multi-agency review should report back within three months and set out any actions for improvement to the systems for access by all levels of practitioners and for the child or young person's views to be clearly stated.

### *Learning point 2*

The sibling of Young Person F and the foster carers raised their concerns about the manner in which they had been informed of the death of Young Person F and the subsequent funeral arrangements which they had found distressing. They hoped that learning could flow from this review to ensure that other families and siblings would not encounter a similar experience.

### ***Recommendation 2***

The current policies and procedures in the relevant agencies should be updated to include references to siblings where there are or have recently been siblings placed together and one of them dies or becomes seriously ill.

All multi-agency systems for searching for next of kin for children and young people in the event of a sudden serious illness , serious assault or death should be capable as far as is reasonable of identifying a child who is looked after ,for example the Emergency Duty Service with the local authority.

### *Learning point 3*

The review has identified the need to balance case recording to demonstrate not only times of difficulties such as the need to find placements but to include a full view of the child or young person and most of all to include the views and feelings of the child themselves.

Where there are sibling placements the records and plans must demonstrate their individual needs and plans and information should not be copied across unless relevant.

Access to records should always be born in mind as this is the child's main record , in the case of Young Person F from the age of one years old, and should be a record that can unfold the life events of the child.

The lack of detail or gaps in records as this review has demonstrated can lead to information not being actioned such as referrals for specialist services or information about the drugs and a possible gang involvement.

 

### *Recommendation 3*

All managers, supervisors and practitioners should be reminded promptly of best practice in case recording in all agencies involved in this case and the reasons for compliance with the best practice should be integrated in supervision and training.

### *Learning point 4*

The review noted that the communications between the schools and Children's Services and within schools had not been effective. There was also a confusion about the option of Home Education for a child looked after. In view of the joint responsibilities and corporate parenting principles the collaborative work between schools, whether located in the local authority or the placement area, and the responsible Children's Services must be improved to avoid the fragmentation and eventual loss of education that followed with all the moves.

### *Recommendation 4*

The DSCB must examine ways to improve the systems for Children's Services and all schools and educational units to work together to safeguard a child's educational opportunities . A brief joint research exercise to follow a small number of children and young people through the current system to explore where improvements can be made should be undertaken and reported back to the DSCB.

### *Learning point 5*

The review noted that there was a lack of urgency in responding to Young Person F when there were reports of drug running and gang involvement with increasing missing episodes. The question arose if a female young person would have been responded to more robustly.

There was concern by the Review Panel that the vulnerability and risks to Young Person F were played down partly due to stereotypical notions of male young people.

### *Recommendation 5*

Services involved with young people should reinforce the safeguarding of all children . The services involved in this case must examine their practice and be able to demonstrate to the DSCB that the provision of all services take in to account the needs of the child or young person regardless of gender.

### *Learning point 6*

The Health assessments systems were of concern as outlined and the comprehensive internal agency review report set out the full details.

## *Recommendation 6*

The Agency review report should be followed up by the DSCB in order to improve the current system and embed all improvements so far. The health agencies and local authority must report back to the DSCB about progress regularly.

### *Learning point 7*

The review noted that on a number of occasions the practitioners, in the different agencies, including the Independent Reviewing Officers (IRO) raised concerns or misgivings about the services being provided and the plans proposed. There was no evidence in the records of any challenges to other practitioners or their managers , which is a common thread in Serious Case Reviews nationally. In relation to the role of the IROs this is of particular concern as it is a part of their responsibilities to follow up from Looked After Reviews.

## *Recommendation 7*

The current multi-agency and internal agency policies and procedures for challenging and working together must be revisited. A multi-agency working group of front line practitioners and managers including IROs should be set up to explore the obstacles and how to overcome them . Any learning from this group should be disseminated across the agencies and reported back to the DSCB.

### *Learning point 8*

The lack of a person independent of the direct services to Young Person F after the sudden loss of the Advisor left Young Person F without a support to follow him through the many moves . Although some of the practitioners remained consistent the role of a more independent advocate or advisor could have supported him more constructively.

The overall impression from the records and agency reviews was that there was very little time, if any ,given to talk to Young Person F about his feelings about all that had happened since the move out of the foster placement and the run up to the breakdown. There was a lack of recognition that Young Person F had experienced a number of losses during this time; the hope for adoption, leaving the foster home and his sibling well as the younger children, changing schools and where he was living. Services were not responsive to the accumulation of events and their impact on Young Person F.

## *Recommendation 8*

All looked after children should be provided with the option of an independent advisor or advocate, if declined this option should be repeated at later stages as circumstances can change.

All practitioners must take in to account not only one event at a time but the accumulation of events and the impact on the child or young person and the services provided to them must be capable of responding flexibly.

The DSCB must request a report from the local authority Children's Services to explain the current services of support to looked after children in similar circumstances to Young Person F and to set out any actions that there may be to improve the current services.

Birgitta Lundberg ,

Independent Lead Reviewer and Overview Report Writer

November 2017

# Appendix 1: The full Terms of Reference

## Terms of Reference: Serious Case Review Young Person F

The Serious Case Review will be conducted in accordance with the requirements of the statutory guidance 'Working Together to Safeguard Children' (2015), Chapter 4, and the agreed DSCB multi-agency Safeguarding procedures.

Young Person F was a young man subject of a Care order to Dudley Metropolitan Borough Council and had been since the age of 1. He was placed within a long term foster family until he was 14, when the placement broke down. In more recent years he had been placed in a number of different foster homes and lodgings. He was stabbed at a Cheltenham address on 2nd October 2016 and subsequently died the next morning 3rd October 2017.

As a result the information was considered by the DSCB Serious Case Review Sub-Group and referred to the Independent Chair of DSCB on 9 December 2016 who agreed on 11 December 2016 that the criteria for a Serious Case Review were met under Regulation 5(2)a and b(i).

In accordance with the DSCB Serious Incident Protocol each agency and organisation is required to secure their records and arrange for a formal chronology to be provided in relation to their involvement with the family. They will also need to identify an agency report author as soon as possible.

This Serious Case Review has been commissioned and will be carried out by an Independent Serious Case Review Panel Chair and Report Author and a nominated panel of the DSCB.

The Review will take into account the requirements of the generic terms of reference in Working Together to Safeguard Children 2015 and in order for lessons to be learnt will focus on the young man and his experiences as a Child Looked after with key elements to address:

- Examining how the Local Authority met its responsibilities as a Corporate Parent to Young Person F.
- Considering how Young Person F's needs were met and how his views and wishes were heard?
- Examining the effectiveness of multiagency working to meet his needs by :
- Establishing whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

- Identifying clearly what those lessons are, how they will be acted on, and what is expected to change as a result.
- Whether any other action is needed now within any agency.
- Whether the analysis of the information and the consequent response by all agencies was appropriate.
- Whether appropriate casework and management decisions were made.
- Whether Care Plans and Placement plans were in place and reviewed as required
- Whether appropriate actions were taken with regard to referrals, reports of 'missing' episodes and subsequent placements.

## The scope of the review

- Each agency should provide a factual chronology of the decisions and actions that were taken in the agency.
- Each agency should analyse how the needs of Young Person F were met and how decisions were reached and actions taken
- Agency reports are asked to consider if there were any opportunities within this period for agencies to be alerted to concerns and if those opportunities were missed and why.
- Each agency's report should focus on the practice of its own practitioners and managers and compliance with policies and procedures at the time, making recommendations regarding its own practice and/or internal policies and procedures that arise from the review.
- Each agency should draw out lessons to be learnt and make Recommendations about improvements that should be made.
- Each agency should draw up an Action Plan to demonstrate how their recommendations will be implemented in practice, by whom and when.
- The progress of any Actions arising from the review should be monitored and reported to the DSCB.
- The Independent Lead Reviewer will communicate with family members to support them to contribute to the review, if they wish to.

## Time scale

The time frame to be covered by the review starts on January 1st 2013 up to the time of death. Any significant information that will assist the analysis and learning outside this time frame can be included after discussion with the Review Panel.

# Appendix 2: The Review process

Following the decision to proceed with a Serious Case Review a Briefing and Scoping meeting was convened by the Dudley Safeguarding Children Board Business Unit at the end of January 2017 .The Review Panel and Terms of Reference were drawn up and agencies were requested to identify Agency Review ( IMR) authors .

The Review Panel met five times between March and October 2017 ,which included half a day with the Agency Review authors in preparation for the Review. At a later stage the Agency Review authors participated together with the Review Panel in discussing their reports and findings.

In early June 2017 the Independent Lead Reviewer /Overview Report Writer and the DSCB Business Unit Manager visited the older sibling and the family ,who had been the foster carers to Young Person F and his older sibling for nine years . They had been informed of the Review and its purpose by letters beforehand and had responded positively to the request to participate in the review process. Their contribution was helpful and provided a more rounded picture of Young Person F as a child and young person than had been available from case records in any agency.

Arising from this visit an additional Agency Review Report was requested from the private fostering agency, which they had been part of. The Agency provided a report, which demonstrated that a considerable number of services had been provided to the foster carers and the placement during the period in scope.

The intended Learning and Consultation day with the front line practitioners and managers directly involved in the services with Young Person F was reluctantly cancelled as the practitioners in question across the agencies were in the main no longer in the employment of the same agencies. This does reflect the turnover of practitioners in all agencies. However , some practitioners ,who had moved to other employment, were able to participate in their former agency internal reviews . This was helpful as their comments added to the case records which had been examined . They were able to reflect with the Reviewers on the recording practice and the pressure to deal with practical matters such as placement moves and court appointments . The overall learning for them was how with hindsight this had left very little room for a more rounded picture of Young Person F to be present in the records as well as any evidence that Young Person F had expressed any views or opinions himself about anything other than the moves.

The Overview Report final draft will be presented first to the Sub Group Serious Case Reviews in November 2017 and subsequently as a final report to the full Dudley Safeguarding Children Board in late November 2017.

 

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