Derbyshire Safeguarding Children Board

Serious Case Review Overview Report

in respect of

ADS

Born 15th June 1994

Died 24th January 2012

4th November
2014

Independent Overview Author:

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Contents

Summary

This Serious Case Review (SCR) concerns a young person, ADS, who died on January 24th 2012 following an incident on January 20th 2012. He was found with a ligature around his neck in his cell at HMP Hindley Youth Offender Institute, where he had been detained.

This SCR has focused on the period prior to ADS's detention at HMP Hindley Young Offender Institute. Matters primarily relating to ADS's care and treatment at HMP Hindley YOI were the subject of the Prison and Probation Ombudsman's Review and Clinical Health Review by Wigan Primary Care Trust. The information and learning from these two reviews has been incorporated into this Overview Report.

Learning that has arisen during the Review

The most significant learning that has arisen from the review is the need for a multi-agency approach to the management of ADHD and children with complex needs, the continued importance of all agencies reporting and exploring the impact of domestic abuse on children and the need for **all** agencies to accept responsibility for convening multi-agency meetings for vulnerable children and young people.

Actions already implemented by agencies

Youth Justice Board

1. Since this Serious Case Review began, the Youth Justice Board (YJB) has made significant changes to the documentation required for young people prior to their being sentenced to custody and changes have also been made to the systems in place to monitor transfer of documents to the secure estate. These will be commented upon further within the body of this report.

Youth Offending Service

1. A review was undertaken of all young people within custody to review vulnerability and identify potential friends or acquaintances of ADS, his co-accused and other Derbyshire young people resident at the same establishment. Where relevant, young people were identified to the secure establishment.

2. An immediate management review of practice in courts was undertaken looking at cases where young people are being or are likely to be sentenced to custody (or remanded to custody). As a result of this, interim guidance was issued which details the specific methods to be used for transfer of documents to the Youth Justice Board and the Secure Estate. This also clarified responsibilities, action to be taken and responsibilities of staff and managers outside of normal working hours. The procedure also clarified requirements for management review (gatekeeping) of specific documents. A working group was established comprising a manager and senior Court Officers from each of the teams to examine this area in greater detail and produced a full guidance document.

Chesterfield Royal Hospital NHS Foundation Trust

1. The CAMHS management team have recognised that improvements are necessary in

their care of clients with ADHD. Some of these improvements such as written care plans had already been implemented but only with those who are newly diagnosed. This is being addressed immediately.

Derbyshire Community Health Services

Changes and improvements already implemented are:

1. Major improvements in record keeping have already been made in Derbyshire Community Health Services and now all health visiting records are computerised using Systmone/TPP.

2. More sophisticated tools are used to assess families and their individual circumstances. There is now more focus on the 'Think Family' approach and the importance of early intervention, using the Common Assessment Framework and request for support from the Multi Agency Teams where appropriate. The CAF and pre CAF process may have highlighted any concerns or unmet needs following a more thorough health needs assessment, including the Tynedale assessment and the introduction of the Ages and Stages Questionnaire. Health Visitors assessment is based on the Framework for the Assessment of Children In Need (2000) and includes; Childs Development Needs, Parenting Capacity and Environmental factors.

2. All Health Visitors working for Derbyshire Community Health Services have regular safeguarding training, including yearly updates for the Named Nurses and bi annual training from the safeguarding board. This is monitored and records kept.

4. As mentioned there is a review planned of the School nursing service offered at special schools such as Swanwick School and Sports College. There may be changes in practice that will be implemented.

Conclusions

Overall, the many agencies involved with ADS in the community worked extremely hard to support him, and saw him as a very likeable young person. However, they sometimes failed to communicate effectively with each other and at no point were a multi-agency professionals' meeting or a multi-agency meeting, involving ADS and his family, convened and the responsibility for this failure must be shared. I do not however, believe that it can be evidenced that this failure or the other failures, identified with the benefits of hindsight and the in depth analysis of each agencies' involvement, directly contribute to ADS's untimely and tragic death.

The findings of the Prison and Probation Ombudsman's Review and the Clinical Health Review by Wigan PCT are reflected in this Overview Report and the Executive Summary.

The Prison and Probation Ombudsman's Review and the Clinical Health Review have identified serious concerns about the care of ADS, by some officers, within HMP Hindley Young Offender Institute; their failure to protect him from being bullied; to effectively implement the ACCT process (the suicide prevention process used within prisons) and to provide a holistic approach to his care. In relation to the interface between HMP Hindley Young Offender Institute and the Youth Offending Service, the reviews have commented critically on the lack of effort made by the Mental Health Team, based within HMP Hindley Young Offender Institute, to obtain historical information from the community based Child and Adolescent Mental Health Services to assist in their support of ADS and the failure by the Youth Offending Service to provide a post court report following ADS's third court appearance when he was already detained for a previous

offence. However, the reports do not conclude that these errors directly contributed to ADS's death. The reviews have also found examples of assessments being completed satisfactorily by the Youth Offending Service and some examples of good communication by Youth Offending Service staff with ADS's key worker in HMP Hindley Young Offender Institute.

Recommendations

In addition to those recommendations contained in the Individual Management Reviews Derbyshire Safeguarding Children Board should:

- monitor the implementation of any recommendations made by the Prison and Probation Ombudsman's and the Clinical Health Review in relation to HMP Hindley YOI and should seek assurance from the Governor of the YOI that young people from Derbyshire who are detained in the YOI are safeguarded and protected;
- satisfy itself that assurances are sought from any custodial setting, where Derbyshire young people are detained, that they are safeguarded and protected;
- monitor the implementation of the recommendations contained in the IMRs, particularly the establishment of effective arrangements to provide multi-agency support to children and young people with ADHD;
- ensure that the findings of this review are effectively communicated to staff across the partnership represented on the board;
- ensure that CAF training highlights the importance of identifying offending behavior as an indicator of vulnerability in young people;
- highlight the importance of all professionals pro-actively making contact with other professionals involved in a young person's life and convening multi-agency professionals meetings or CAF meetings involving the young person and his family; and
- highlight the importance of seeing children and young people on their own to gather their views and feelings about their circumstances.

Introduction

1.1 The circumstances that led to the Serious Case Review

1.1.1 This Serious Case Review (SCR) concerns a young person, ADS, who died on January 24th 2012 following an incident on January 20th 2012. He was found with a ligature around his neck in his cell at the HMP Hindley YOI, where he had been detained and later died in hospital.

1.2 Decision to hold the SCR

1.2.1 The Serious Case Review Panel held on February 3rd 2012 unanimously agreed the 'Working Together to Safeguard Children' (2010) criteria were met in the following area:

- When a child dies in custody in a YOI a serious case review should be instigated.

1.2.2 On February 16th 2012 the Derbyshire Safeguarding Children Board (DSCB) Independent Chair ratified the decision to conduct a Serious Case Review in respect of ADS.

1.2.3 The subjects, scope, terms of reference and arrangements to conduct the SCR were ratified by the DSCB on March 3rd 2012.

1.2.4 Ofsted was notified of this decision on March 7th 2012.

1.3 Subjects of the review

ADS - born June 15th 1994, died January 24th 2012

Sister - born August 15th 1991

Mother - born July 29th 1963

Father - born November 8th 1965

Mother's partner - born September 4th 1960. Died December 2nd 2009

1.4 Scope of the review

1.4.1 A detailed chronology of all contact with ADS was provided focusing on three stages of his life.

1. The two year period before ADS became involved with the Youth Justice System in May 2007, identifying why this involvement occurred and factors that could have prevented this from happening.
2. The period prior to custody, including the information that was shared and the factors influencing the decision to place him in custody. The review will examine whether the assessments made were evidence-based, and whether all professionals had full and detailed information to enable them to arrive at the appropriate decision.
3. The period in custody, including assessments undertaken, information shared and preventative measures taken.

1.4.2 It was agreed that if information emerged that is relevant outside the timescales and back to 2004, this should be included, particularly if this related to his additional needs and vulnerability.

1.5 SCR Timescales

1.5.1 The decision to conduct a SCR was made on February 16th 2012 and it was anticipated that it would be concluded and forwarded to Ofsted by September 3rd 2012; this was later amended to October 1st 2012. Following the letter from Mr Tim Laughton MP, Parliamentary under Secretary of State for Children and Families to LSCBs on July 5th 2012 this arrangement has been cancelled. LSCBs are no longer required to send SCR documents to Ofsted at the completion of the SCR but are required to send them to DfE at the completion of the review and to send a copy of the Overview Report, Executive Summary and Action Plan to DfE, one week before publication so that Ministers can be briefed. DfE will not evaluate SCRs but Ofsted will ask for evidence of learning from them at the start of unannounced inspections of arrangements to protect children.

1.6 Purpose

1.6.1 The purpose of the review is to:

- Establish whether the death of ADS was predictable and/or preventable.
- Establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together to safeguard and promote the welfare of ADS.
- Identify clearly what the lessons are, how they will be acted upon, and what is expected to change as a result, and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children and young people.

1.7 Overview report author

7.1 I am the author of this Overview Report. I am an independent social work consultant with considerable experience of safeguarding; I chaired Leicester, Leicestershire and Rutland LSCB for six years, have undertaken a number of SCRs and acted as an Ofsted Additional Inspector in several inspections. I have had no involvement with any operational aspects of the services subject to this review but have previously undertaken an SCR on behalf of DSCB and am currently chairing a Domestic Homicide Review for the council and its partners.

1.8 The SCR panel

1.8.1 Details of Panel members (commissioners)

Agency	Job Title
Derbyshire Constabulary	Head of Public Protection
Derbyshire Children and Younger Adults Social Care	Deputy Strategic Director
Derbyshire Young Offending Service	Head of DYOS
Derbyshire Child and Younger Adults, Schools and Learning	Deputy Assistant Director
Chesterfield College	Principal of Chesterfield College
Derbyshire Children and Younger Adults Locality Services	Locality Manager
Chesterfield Royal Hospital NHS Foundation	Chief Nurse* Trust
NHS Derbyshire County PCT	Assistant Clinical Director
Derbyshire Community Health Services	Executive Director of Nursing*
NHS Derbyshire County PCT	Consultant/Designated Nurse
Youth Justice Board	Head of YJB Business Areas (East Midlands and Eastern)

*Those commissioners marked with an asterix * did not attend panel meetings but were provided with reports and minutes and briefed by their senior managers who attended.*

1.8.2 This SCR process was managed very efficiently and there were no avoidable delays during the process. The Serious Case Review Panel was expertly and independently chaired by Jacqui Jensen, Service Director, Derby City Council and included an appropriate range of agencies. Jacqui Jensen is experienced in SCRs and chaired the Panel as part of a reciprocal arrangement with Derby City Children's Social Care.

1.8.3 Serious Case Review Panel meetings were held on May 9th, July 24th and August 14th 2012 to satisfy the Panel as to the robustness of the process, consider the reports and confirm the recommendations and action plans. DSCB accepted the recommendations and signed off the SCR on September 12th 2012.

1.8.4 The Serious Case Review Panels were regularly attended by most members and those senior managers who did not attend were briefed by their representative. Although Wigan Local Safeguarding Children Board (WSCB), in whose area HMP Hindley YOI is located, has not attended they have contributed directly to the SCR and have been kept fully informed of developments. In addition, WSCB has maintained contact with the Safeguarding Lead within HMP Hindley YOI, regarding the reviews by the Prison and Probation Ombudsman Review and Clinical Health Review by Wigan PCT. The Overview Author attended all meetings. The agenda for each meeting was appropriate, there was a good level of debate and appropriately robust challenges to agencies, themes were identified and recorded as they emerged and the minutes and actions were promptly circulated and the latter closely monitored.

1.8.5 A number of recommendations have been identified and have been incorporated into an integrated action plan. The DSCB Serious Case Review sub-committee will monitor the plan on a monthly basis until they are all implemented and they will then be reviewed annually.

1.9 The involvement of the family

1.9.1 The Serious Case Review Panel agreed that the review would benefit from the involvement of family members which have included:

- Mother
- Father
- Step-mother

1.9.2 Family members have an important perspective to bring to the review to assist DSCB in gaining the best possible understanding of what happened, why, and importantly what, if anything, might have prevented ADS's death. I have interviewed Mother on two occasions; at both meetings her solicitor and ADS's stepmother have been present. Father is now living abroad but he was aware of the interviews and contributed by telephone.

1.9.3 The outcomes of the review will be shared with family members before publication of the Executive Summary.

1.10 The involvement of organisations in other LSCB areas

- HMP Hindley Young Offender Institute
- Wigan Local Safeguarding Children Board
- Greater Manchester Police
- Wigan PCT

1.11 Coroner's Inquiries/Criminal Investigations

- Greater Manchester Police
- Coroner Inquiry (Bolton), this has yet to be undertaken.

1.12 Individual Management Reviews

1.12.1 The following organisations have been involved in the SCR and have submitted chronologies and Individual Management Reviews (IMRs) as part of the SCR process, meeting the requirements set out in Working Together to Safeguard Children (2010). They have been authorised by their agencies and scrutinised and challenged by the Serious Case Review Panel on two occasions.

1.12.2 All agencies formally contributing to the SCR identified an appropriate manager or officer, to be the author of the IMR. These managers or officers had had no direct involvement with the family, or the immediate line management of any of the practitioner(s) involved. Agencies that provided an IMR included:

- Derbyshire Youth Offending Service
- Derbyshire Children and Younger Adults
- Derbyshire Community Health Services
- Derbyshire Constabulary
- Chesterfield Royal Hospital (CAMHS and School Health)
- Whittington Moor GP Practice
- Education (Schools, Out of School Education)
- Chesterfield College

1.13 Expert Opinion

1.13.1 The panel has not identified any features of the case that have indicated the need for an expert opinion.

1.14 Related reviews

1.14.1 Matters primarily relating to ADS's care and treatment once at HMP Hindley YOI are the subject of the Prison and Probation Ombudsman Review and Clinical Health Review by Wigan PCT. These are statutory requirements for young people who have died in custody.

1.14.2 Derbyshire's Serious Case Review Panel has ensured that the information and learning from these two reviews has been incorporated into the Overview Report. To achieve this coordinated approach, key panel members and authors have liaised closely and shared information and DSCB is appreciative of the efforts made by the Prison and Probation Ombudsman's investigators to provide information promptly.

1.14.3 The SCR of the St Helen's Safeguarding Children Board in 2007 recommended that access to the reports provided by the Prison and Ombudsman Review should be made available to LSCB SCRs and this has happened in this review through shared reports and a meeting between the Ombudsman, the author of the Clinical Health Review, the Overview Author of the SCR and senior managers of Derbyshire County Council.

1.15 Public and Media Interest

1.15.1 Public and media interest was, and will be, managed before, during and after the review by the four main agencies on the DSCB. Derbyshire County Council will take the lead in relation to the SCR on behalf of the DSCB. Named public relations representatives for the four main agencies will establish regular and robust communication links.

1.15.2 Information relating to the young person, family members and professionals involved in the case (with the exception of the DSCB Chair, SCR Panel Chair and the overview report author) will be anonymised by DSCB before being submitted to any external organisation or body (including DfE)

1.15.3 The identity of the subject and the family will be anonymised in the final overview report and executive summary report. The terms 'Mother and Father' will be used in the IMRs, Overview Report and Executive Summary report.

1.15.4 This review will be subject to revised Government guidelines in relation to the publication of Overview Reports. Publication of a redacted Overview Report and full Executive Summary are required. These reports will not be published until after the conclusion of the Coroner's inquiry.

1.15.5 Freedom of Information requests relating to this case will be handled in the first instance by the Derbyshire County Council.

1.16 Legal advice

1.16.1 It was agreed that legal advice would be sought from Derbyshire County Council's Legal Services in the first instance.

1.17 Liaison with Ofsted and DfE

1.17.1 The Deputy Strategic Director, Derbyshire County Council or the Deputy Assistant Director, Derbyshire County Council will liaise with Ofsted and DfE if necessary.

2. Terms of Reference

2.1 Key Issues:

2.1.1 In order to reach a view on whether this incident could have been predicted and/or prevented the, following specific issues or questions will be addressed:

Universal Services

- What was the involvement of the agencies with ADS, his mother, his father and his mother's partner during the periods specified?
- Were individual agency and multi-agency procedures and processes followed correctly?
- Was evidence of risk or vulnerability identified by any agency, if so was it responded to in a timely and appropriate way?
- Whether domestic violence or abuse observed or experienced by ADS had an impact on later events?
- Were appropriate actions taken and was information shared with other agencies?
- Was there evidence of good practice?

Specific agency features:

- Education – to address whether earlier assessment in primary school for Special Educational Needs, including diagnosis of ADHD, would have changed the support he received, and thus possibly reducing the risk of later exclusion from mainstream education.

Health

- To review their involvement with ADS during his primary school years including whether earlier diagnosis of ADHD, would have changed the support and treatment he received.
- To consider what impact mother's health needs had on her parenting of ADS.
- Youth Offending Service (YOS) was asked to review whether preventative services provided by YOS may have reduced the likelihood of ADS's offending behaviour and to review the effectiveness of joint work between YOS and CAMHS, both before and during his custodial sentence.

Assessments and Court Reports

- What assessments and reports were conducted?
- Did assessments and reports identify vulnerability and risk?
- Were the views of the young person listened to and taken into account?
- Were any plans or guidance, resulting from assessments/reports, appropriate and were they addressed?
- Were the views of the young person's family taken into account?

ADS Self Harming behavior

- Was there a history of self-harm and/or suicide attempts?
- Were ADS's mental health assessed and what consideration was given to any risks?
- If any assessment of mental health indicated a need for treatment was it provided, monitored and reviewed?

Events during the period of the Youth Offending Institution

- Was ADS's care and supervision in the Youth Offending Institution appropriate given any identification of mental health needs?
- ADS alleged that he was being bullied within the establishment. As identified above, these areas will be examined through the Prison and Probation Ombudsman review. Derbyshire's Serious Case Review role is to ensure that these questions and the extent, to which community based agencies worked together, have been fully addressed:
    - Did the staff act appropriately to respond to identified vulnerability?
    - Were there any indications during his time at the Youth Offending Institution that ADS was intending to take his own life?
    - Were there any incidents that may have triggered a crisis in ADS's emotional wellbeing and if so what actions were taken?
    - Was there an identifiable escalation of risks and were steps taken to mitigate these?
    - On discovery of ADS were actions to preserve his life timely and in line with guidance?

In addition:

In respect of all the issues outlined the authors were asked to consider:

- Whether national and local procedures were followed, intervention was robust, appropriate and reviewed?
- Whether assessment tools were used appropriately?
- Whether the young person was spoken to?
- How information was shared between agencies?
- Whether staff and Managers had received the training and supervision they required to undertake their role?
- Whether, given what was known at the time of their involvement, agencies and individuals acted in a manner that was proportionate and reasonable and significant?
- The over-arching question of whether this incident was either predictable and/or preventable?
- The terms of reference were later extended to include analysis of Mother's health, and what impact this may have had on ADS. Mother's consent to view her medical record was not given but during my interview with her some issues were explored.

2.2 Feedback

2.2.1 It is anticipated that on completion of each IMR, arrangements will be made for feedback to staff involved in the case. There should also be a follow up feedback session once the SCR report has been completed and before publication.

2.3 Issues which relate to ethnicity, disability or faith which may have a bearing on this review

2.3.1 ADS was a White British male, he was diagnosed with ADHD and there are suggestions he had a learning difficulty. It is reported that ADS had caring responsibilities for his mother who suffers with Fibromyalgia.

3. The Subject

3.1 ADS, a Pen Picture

3.1.1 ADS was a white British male; he was born on June 15th 1994 when his Mother was living with her husband, ADS's Father and ADS's sister, who was 2 years 10 months old. There were no further children born to ADS's mother who separated from ADS's Father when ADS was approximately 4 years old. Domestic abuse was known to be a feature in this relationship as far as professionals were concerned but ADS's mother disputes the extent of the abuse. ADS's mother commenced a new relationship with a Partner in 2003 and maintained this relationship until he died in December 2009; this relationship is also thought to have featured domestic abuse, but again this is minimized by ADS's mother.

3.1.2 ADS was always a very tall, well developed, young person for his age. Physically he matured early and his height, build and manner gave the appearance that he was more mature than his psychological or cognitive age. He was often a gentle, kind, young person, he enjoyed finding out how things worked and would often take mechanical and electrical items to pieces and re-build them. He was devoted to his mother and had good relationships with his father, sister, mother's partner, step-mother and latterly his girlfriend and her daughter. He developed good relationships with many adults but often found the company of his peers challenging, preferring the company of much younger children, who were very fond of him. He was susceptible to being teased and could be manipulated by his peers.

3.1.3 Like many young people ADS did not like being told what to do and his mother attempted to develop ways to gain his co-operation without conflict. At times she found it difficult to cope with his behavior which was sometimes aggressive but ADS's mother is clear he was never violent towards her. He could be challenging to adults and there were examples of his swearing at teachers. At times he took part in risky behaviour, playing with fire and hanging out of a window by a rope, he also enjoyed adventurous activities for example free running (Parkour) which involves running across buildings and roof tops and jumping from them.

3.1.4 He had difficulties managing his anger and at times was depressed. Despite his often gentle nature there are reports of his having been physically aggressive to other children from quite a young age and there are reports of his having been assaulted by other young people. He was diagnosed with ADHD in February 2007 having scored highly on the ADHD index and displaying mild features of conduct disorder (to give the reader an indication of the manifestation of his condition it is recorded that when he was 9 he had a reading age of 6).

3.1.5 He was prescribed medication to help him but really disliked people knowing this and in attempts to conceal his embarrassment he sometimes did not take it when away from home. At times he had difficulties sleeping, which he thought was related to his medication. In March 2007 he was also diagnosed with dyslexia and additional support was recommended. He sustained a number of injuries during angry outbursts which were seen as impulsive rather than premeditated behaviour. He was convicted of violence towards others.

3.1.6 There are some indications of a family in which domestic abuse was a feature and as late as 2011 ADS reported difficulties at home when he reported himself as homeless, having fallen out with both his parents. His mother clarified this as being for only a short period of time.

3.2 Interviews with Mother - Summary of Key Issues

3.2.1 I have met ADS's Mother on two occasions, for which I am grateful, as her perception and the information she provided has added considerable insight into ADS's life. She describes him as a kind, loving son who struggled with many aspects of his life. She said that he was never a "mainstream person" and her and ADS's Father's main concern was the decision to send him to a "mainstream" YOI establishment. Many aspects of ADS's life were happy and he enjoyed periods of his education and the loving support of his family but he often felt he did not fit in at school and in some aspects of his community. He was often hurt by the behaviour of his peers but enjoyed the company of younger children to whom he was very caring.

3.2.2 Mother was of the view that, to her knowledge, the children were not affected by the disharmony in her relationships with Father and her Partner.

3.2.3 She also told me that her ill health, whilst painful and difficult to manage did not affect ADS and although he was always willing to help and often worried about her, the main support came from her daughter.

3.2.4 Throughout ADS's life she was a supportive mother.

3.3 Genogram showing membership of family, extended family and household.

Please see Appendix 1

3.4 Explanation of Medical Terminology

Please see Appendix 2

3.5 Integrated chronology of agency involvement with ADS and his family.

Please see Appendix 3

4. Analysis

4.1 Scope of the review

4.1.1 It was agreed at the outset that the review would focus on three distinct periods of ADS's life and these are considered in turn.

1. The two year period before ADS became involved with the Youth Justice System in May 2007 identifying why this occurred and factors that could have prevented this from happening. (May 2005 – May 2007)
2. The period prior to custody on December 6th 2012, including the information that was shared and the factors influencing the decision to place him in custody. The review will examine whether the assessments made were evidence based and whether all professionals had full and detailed information to enable them to arrive at the appropriate decision.
3. The time in custody, including assessments undertaken, information shared and preventative measures taken.

4.1.2 It was agreed that should there be information that was relevant outside the timescales, and back to 2004, this should be included, particularly in relation to his additional needs and vulnerability.

4.2 Summary of key events

4.2.1 The two year period before ADS became involved with the Youth Justice System in May 2007 identifying why this occurred and factors that could have prevented this from happening. (May 2005 – May 2007)

4.2.2 This period has been extended to review ADS's early life and events that occurred in June 2004.

4.2.3 1994 ADS's birth was normal and he thrived in infancy. Health visiting assessments identified nothing unusual. When delays in speech and language and queries about his vision were identified they were referred for specialist investigations. There is record in the GP notes of notification that ADS failed to attend follow-up orthoptic clinic reviews and speech and language therapy assessments.

4.2.4 It is recorded that in February 1998 ADS was attending nursery two days a week.

4.2.5 After his birth ADS was registered with a GP at Whittington Moor Surgery. He had routine child health surveillance contact with the practice in his early years and routine childhood immunisations. In the pre-school period ADS had 12 consultations with the general practice for minor childhood ailments. None of these consultations were unusual or caused concern.

4.2.6 On 5th January 1999 (aged 4 ½), ADS began his formal education at Christ Church, Church of England Primary School.

4.2.7 In March 1999 ADS was seen with his mother by a school community specialist nurse for his school entry interview and passed both vision and hearing tests. It is recorded that Mother stated that he did not have any behavioural issues.

4.2.8 In June 1999 Mother consulted her GP as she was concerned ADS had been falling asleep in class for the previous two weeks. She thought this was because the weather was hot and ADS was young in his year, only just 5 years old. No mention was made by Mother of any circumstances at home that could be affecting ADS's sleep, and no further information was sought by the GP.

4.2.9 In June 2000 ADS (aged 6) was seen by a Senior Educational Psychologist who acknowledged the concerns that had been raised by the school but suggested that ADS's difficulties could well stem from issues relating to maturation, rather than specific special needs, and the gap in his learning could be addressed by support.

4.2.10 In August 2000 the man who later became Mother's partner was charged with Attempted Murder (but was later convicted with Grievous Bodily Harm with Intent); against a previous partner.

4.2.11 In 2001 ADS's Mother and Father separated.

4.2.12 Input from the Senior Educational Psychologist continued with formal assessments in February 2001, (ADS 6 years 9 months),

4.2.13 In 2001 ADS fractured his right wrist having fallen. When followed up in the fracture clinic, ADS had destroyed his plaster cast

4.2.14 ADS was periodically re-assessed by the Senior Educational Psychologist, November 2001, (ADS was 7 years 6 months) January 2003, (ADS was 8 years 8 months) and again in March 2004, (ADS was 9 years 9 months).

4.2.15 In May 2002 Christ Church, Church of England Primary School applied to Derbyshire County Council for a statutory assessment of ADS's needs. The Panel of experts considered the application and came to the view that ADS did not meet the criteria that existed at the time. An extract from the letter to the head teacher states "*The panel considered your presentation against the criteria set down and found that it did not meet the criteria that exist for assessment. The panel suggested advice should be sought from the Local Inclusion Officer or Educational Psychologist which could be incorporated into the IEP's".*

4.2.16 In 2003 Mother met her Partner.

4.2.17 In June 2003, just prior to ADS's Mother becoming involved with her Partner he committed a domestic violence incident against his previous partner.

4.2.18 In March 2004 ADS (aged 10) was again assessed by the Senior Educational Psychologist.

4.2.19 In June 2004 ADS arrived at school with a sick note as he had been absent from school for two days that week. The note said ADS had been off due to sickness but he then told his class teacher and head teacher that his mother, sister and he had been in a Safe House over the previous couple of days, due to domestic violence involving mother's partner who had hit Mother over the head with a metal dust bin lid. The Children's Social Care (CSC) records state that at this time school described ADS as a 'happy child', they had previously had no concerns other than thinking that Mother's relationship was turbulent due to other comments ADS had previously made and they felt that ADS was 'worried'.

4.2.20 In response to the referral from the school, CSC carried out an Initial Assessment promptly, the police were contacted for any relevant information and Mother was interviewed though not until later, following instructions from a manager were ADS and his sister interviewed. Mother said the children had not witnessed any violence and that ADS was at his Father's at the time whilst ADS's sister was in the house listening to music. Mother also told social workers that ADS's Father had been violent to her and she would not take further domestic abuse from a partner. Mother was warned that should she resume a relationship with her partner a Child Protection Conference would be held.

4.2.21 Schools were asked to monitor for any signs of Mother's partner having returned but there is no evidence that there was any further discussion or follow up between schools and CSC following the initial referral and the case being closed.

4.2.22 Although ADS made small steps of progress at school, he struggled with the basics of English and Mathematics, the school made contact with Educational Psychology and strategies were put into place to support him but over time he fell behind. Staff interviewed as part of this SCR remembered ADS clearly; they described him as a "lovable rogue". They had had experience of working with children with ADHD but at the time, and on reflection they did not feel he demonstrated difficulties that would have suggested this condition.

4.2.23 Although in interview as part of the Education IMR, school staff have said that his inappropriate behaviour during his primary years was not particularly significant it is of note that in November and December 2004 when he was 10 ½, he was excluded. On the 10th November he was excluded for his "increasingly disruptive behaviour over the last eight days". On the 6th December 2004, he was again excluded (for 4 days), the decision related to the theft of a SIM card from a mobile phone that was in a handbag belonging to a staff member. Police were involved in the school's investigation of the incident.

4.2.24 In 2004 he again fractured a limb, this time his left wrist, reportedly from a fall, once again destroyed his plaster cast within 1-2 days.

4.2.25 On Christmas Eve 2004 the police were called to a verbal dispute between Mother's Partner, and Mother when they were in bed at her home, this incident was not referred to CSC and no police action was taken.

4.2.26 The next contact with CSC took place on July 29th 2005 when an anonymous referral was received alleging that mother's partner was again living in the household. CSC undertook an Initial Assessment which included contact with the Domestic Abuse Unit who informed them of the verbal incident in December 2004. Mother told social workers that her partner had never hit her; the arguments remained verbal but that following the incident in 2004 she had gone straight to a refuge.

4.2.27 In September 2005 ADS transferred to his first secondary school, The Meadows Community School.

4.2.28 There were a significant amount of behavioural incidents recorded during his time at The Meadows. From September 2005 to February 2007 there were 143 separate incidents. The behaviours ranged from low level disruption; work or homework not being completed; not having the right equipment; verbal abuse of staff and an attack on a vulnerable pupil with hearing impairment.

4.2.29 In March 2006 the first contact with the police was made in relation to ADS, aged 11 years and 9 months), after a minor anti-social behaviour incident; the witness did not press charges.

4.2.30 In May 2006 ADS was involved in anti-social behaviour and the police were involved.

4.2.31 Between September 27th 2006 and March 2007 information was shared with Connexions by the Meadows Extended Schools Group that indicated ADS may require support from a personal advisor when he moved to Year 9.

4.2.32 On 16th November 2006 ADS's GP referred ADS to CAMHS following a consultation with Mother and ADS at which it was reported that ADS was having increasing difficulties at school and at home. He was reported to have dangerously impulsive behaviour, playing with fire and dangling himself out of the window on ropes. Mother said she was "at the end of her tether". The GP recognised the concerns about possible ADHD and appropriately referred ADS for assessment.

4.2.33 In November 2006 Mother received support from the Parent Partnership following her concerns that ADS had issues with the academic curriculum at The Meadows and the organisational skills this required.

4.2.34 In November 2006 another minor anti-social incident was reported to the police.

4.2.35 On January 5th 2007 and 2nd February 2007 CSC received routine notifications of consideration to carry out assessment of Special Educational Need on ADS.

4.2.36 On January 8th 2007 Chesterfield Borough Council Housing wrote to Mother to ask her to attend a meeting at the Town Hall in relation to ADS's anti-social behaviour from November 2006.

4.2.37 In February 2007, (aged 12 years and 8 months) he was permanently excluded for 'extreme violence towards a pupil'. I can see no evidence that these issues were raised with CSC. During the exclusion process Mother stated ADS had been violent towards her when at primary school and she could not cope, wanted him taken away and special education provided. This issue of violence to her was previously unknown by agencies.

4.2.38 In February 2007 ADS's mother reported to the police that Father had been to her address and been verbally abusive. He had left prior to the arrival of the police.

4.2.39 In February 2007 ADS was diagnosed with ADHD and conduct disorder and was prescribed medication.

4.2.40 In February 2007 a locum Consultant Psychiatrist (CAMHS) supported Mother in referring ADS to the YISP due to concerns that ADS was becoming involved in anti-social behaviour. This referral was eventually declined for a service in October 2007.

4.2.41 In March 2007 ADS transferred to Creswell Support Centre and appeared to settle well in the smaller, nurturing unit.

4.2.42 On March 8th 2007 ADS had a medical by the School Doctor as part of the statement process and this identified that ADS had ADHD and required as much 1:1 support as possible to modify his behaviour and to enhance his learning.

4.2.43 Despite having settled well at first, within a few months difficulties began to emerge at the Creswell Support Centre. On May 9th 2007 ADS was excluded following a second violent attack.

4.2.44 On March 27th 2007 records identify that ADS had a diagnosis of Dyslexia and the need for increased support in school.

4.3 Analysis

4.3.1 The information gathered during this SCR demonstrates that during his pre-school years ADS's behaviour did not indicate grounds for concern, he had unremarkable childhood illnesses apart from early assessments that identified possible problems with speech and language and eye-sight. He received appropriate support from his GP and health visitor and his Mother ensured he attended all his routine immunisations and health assessments, although some follow up appointments for speech and language and ophthalmics were not kept; perhaps Mother felt any difficulties had improved and when he started school these issues are not reported to have been of concern, nor was his behaviour.

4.3.2 In the background however, circumstances at home included some difficulties although these were not known to professionals at the time. ADS's parents separated when he was two, his Father abused alcohol but saw his children regularly even though he worked away from home. In interview Mother has told me that in the early years of her marriage to ADS's Father there were many verbal arguments prompted by the tensions of young children and Father working away from home. She said professional agencies were never involved and the arguments were usually settled by her mother and never affected the children, nevertheless children are very sensitive to tensions at home and ADS may have had some sense of what was happening.

4.3.3 After Mother and Father separated Mother began a relationship with her Partner, a man with a violent criminal past, the details of which were not known to Mother, although she knew he had been in prison. Mother maintained and continued to maintain that he never lived with her and the children however, the exact position is unclear for example there is evidence that he stayed overnight at her home and gave her address as his home address during several visits to the hospital. It was difficult to obtain the fullest information from the family as to the situation at home and the extent of difficulties.

4.3.4 Once ADS began school his difficulties in coping with learning soon began to emerge and, in his first year, he was appropriately seen by a Senior Educational Psychologist who continued to provide regular re-assessments for several years. I support the Education IMR author's view that ADS was happy at Christ Church, Church of England Primary School and although his behaviour was at times difficult, school was a supportive, nurturing environment where he felt secure and his early learning difficulties were appropriately managed by using appropriate strategies and timely intervention and provision. The application for a statutory assessment of ADS's needs in 2002 was appropriately presented to panel and considered against set criteria. The finding of the panel was clear that ADS did not meet the criteria that existed at the time for the initiation of a statutory assessment to be considered.

4.3.5 In 2004 ADS (aged 10) was quick to tell his teachers that he had been to a refuge as his Mother had been hit by a dustbin lid during an argument with Mother's Partner, he seemed worried that his Mother would not want him to talk about this. The school promptly and appropriately referred to CSC who carried out an Initial Assessment. Mother made light of this incident but appeared to understand CSC's concern that if she co-habited with her Partner again concerns would lead to a Child Protection Conference. When the Initial Assessment was undertaken the children were not interviewed but effective management oversight and instruction re-dressed this and the children were seen. Despite Mother being warned that if her Partner resided in the house a Child Protection Conference would be convened she knowingly allowed this, but CSC were never informed.

4.3.6 The second domestic abuse incident of July 29th 2005 was again appropriately reported by Christ Church, Church of England Primary School to CSC who gathered information and undertook an Initial Assessment. I support the CSC IMR author that there was insufficient exploration of the fact that the incident took place when Mother's Partner was in her bed. When this Initial Assessment was undertaken the children were again not interviewed but effective management oversight and instruction once again re-dressed this and the children were seen.

4.3.7 It is difficult to determine whether the background of domestic arguments and the incident that led to ADS, his sister and mother spending a short period in a refuge had any impact on later events. One can conjecture that the separation of his parents following years of domestic arguments and the introduction of a new father figure, with continuing domestic difficulties, may have created a level of anxiety and learned aggression but against this ADS continued to see his Father on an almost daily basis and it is said that he had a good relationship with Mother's Partner. His Mother was immensely supportive of the efforts made by school and of ADS, never failing to attend meetings and be accessible to professionals. He also had the support of his sister who was able to calm him down and reason with him when he became stressed.

4.3.8 Towards the end of his primary education ADS's difficulties increased and he was excluded twice but there was no consideration of his having ADHD. It is regrettable that an earlier diagnosis of ADHD was not made, though this is not due to deliberate failings by education staff. From an early stage considerable efforts were made by Christ Church, Church of England Primary School to support ADS's learning. Over time, the Senior Education Psychologist commented that the gap between ADS and his peers was not narrowing but there does not appear to have been a holistic consideration as to why this might have been.

4.3.9 Although ADS was referred for an educational assessment of his special educational needs, he did not meet the assessment criteria and his increasingly difficult behaviour in November and December 2004 when he was 10 ½ and was excluded, does not appear to have been considered alongside his learning difficulties. I support the view of the health overview author that "It is of concern that ADS apparently went through the whole of his primary school education without anyone bringing his behaviour problems to the attention of a healthcare professional. Delay in diagnosis of ADHD and learning disability would have had a detrimental impact on his ability to learn and to be provided with a Statement of Educational Need" and that school health professionals were also not aware, or did not act, and that they and school education staff "need to be aware of the appropriate route by which to channel children and families when behaviour problems emerge to ensure that early

diagnosis is achieved and effective management can be provided to improve behaviour and learning outcome in school".

4.3.10 If ADS had been diagnosed as having ADHD at an earlier stage it would have informed the choice of school, the support necessary and his transition from primary to secondary education, and thus avoiding the difficulties he experienced and which led to his exclusion.

4.3.11 When ADS transferred to secondary education in September 2005 (aged 11 years and 3 months) his behavioural difficulties quickly become apparent and increasingly serious, but it was not until November 2006, when, prompted by his Mother who shared her concern with her GP, that there was consideration of ADHD which is then confirmed in 2007 when ADS was 12½. At this point, although unknown to health and education, ADS first became involved in more serious anti-social behaviour, which were handled appropriately and benignly by the police.

4.3.12 Like many immature or vulnerable boys who are born in the summer and therefore are very young in their school year throughout their education (Research material - DfE Research report Month of Birth and Education July 2010), ADS clearly found the move to his secondary school very difficult and his behaviour deteriorated over time although there were good periods and the school made every effort to support him, his needs were not fully met.

4.3.13 In March 2007, when ADS was almost 13, he was permanently excluded for 'extreme violence towards a pupil' however, this does not appear to have been referred to CSC by The Meadows, which would have been appropriate and may have led to a more holistic assessment of his needs.

4.3.14 In Interview Mother was very critical of The Meadows and told me how much better things were when he transferred to the Creswell Support Centre and later The Delves Special School.

4.3.15 Overall, agency policies, with the exception of the lack of referral to CSC following ADS's very aggressive act on a pupil and CSC's failure to interview the children at the time of the Initial Assessments, were followed correctly and information was shared with other agencies.

4.3.16 There was good recognition of the domestic abuse incidents. However, at no point during this period did any professional convene a Common Assessment Framework meeting. Information which indicated increasingly serious concerns was being gathered by separate agencies but there is no evidence that this information was brought together.

4.3.17 Worthy of comment is the tremendous efforts made by Christ Church, Church of England Primary School to support him over his entire primary education. In interview his Mother told me that she had no criticisms to make of the school, she has subsequently written to state that the school did not raise their concerns about ADS with her although this cannot be substantiated from correspondence seen. The Meadows also made good efforts to support ADS although in interview Mother told me of her severe criticism of his time there. The support provided by the Creswell Support Centre and The Delves was also good.

4.3.18 During the period covered in this section there was no indication of ADS harming himself or of him being a carer to his Mother.

4.4 May 2007 to January 2012

4.4.1 The period prior to custody, including the information that was shared and the factors influencing the decision to place him in custody. The review will examine whether the assessments made were evidence-based, and whether all professionals had full and detailed information to enable them to arrive at the appropriate decision.

Summary of involvement

4.4.2 The combined chronology produced for this SCR evidences that between March 2007 and January 2012 there was an enormous amount of involvement and activity by health, education, youth services and the police. In order to reduce this extensive information, which is covered in detail by the individual IMRs of these agencies, this section summarises agency involvement and then adds dates of significance to the analysis.

Education

4.4.3 At the beginning of the period covered in this section ADS was already at the Creswell Support Centre where he remained until July 2008.

4.4.4 Between September 2008 and July 2010 ADS attended The Delves Special School (now Swanwick Special School & Sports College).

4.4.5 On September 1st 2010 ADS commenced at Chesterfield College.

Health

4.4.6 Throughout this period ADS and his Mother were seen regularly by CAMHS at quarterly meetings to monitor his medication for ADHD. From December 2008 his care was taken over by a psychiatrist who remained his CAMHS clinician until his death.

4.4.7 ADS was also seen periodically by his GP during this period, for prescriptions for his ADHD medication and for health issues.

4.4.8 On occasions ADS was seen at Accident and Emergency for minor injuries, some were accidental, none were considered to be deliberate. The occasions when he hurt himself, for example by punching a wall, were seen as impulsive acts, born out of his frustration.

Connexions and Youth Service

4.4.9 There are a total of 16 recorded contacts made by Connexions service staff to ADS and his mother as well as a further 20 interventions relating to advocacy work carried out by Connexions Advisers.

4.4.10 ADS attended 38 Youth Service activities between September 2009 and January 2011 which covered a range of issues in a number of locations.

The Police

4.4.11 Between May 2006 and April 2010, ADS was named in police incidents of Anti-Social Behaviour on at least 16 occasions. Most of this behaviour was relatively minor but it escalated over the years and in separate incidents in 2009 he was involved in the taking and damaging of cranes at a local business premises, taking and damaging golf buggies and also damaging windows at the local college. Between May 2010 and early 2011 there were a number of incidents involving ADS. In some he was the person reporting a dangerous dog or reporting a disturbance in a public house, in others he was the 'victim' for example he had been chased by his girlfriend's ex-boyfriend's friends.

4.4.12 Things changed in May 2011 when ADS (aged almost 17), in company with some associates, assaulted a man who was out having a meal with his wife. The assault was apparently unprovoked and the victim sustained a fractured skull and a fractured eye socket.

4.4.13 Finally, on 12 October 2011 ADS assaulted his girlfriend whilst on bail following the previous incident, during which he throttled her and held a knife to his own and then her throat.

4.4.14 The YOS was involved with ADS from June 2009 until January 20th 2012. Their involvement included supervision and activities in connection with ADS's offending behaviour. They had contact with ADS whilst supervising Court Orders, a Referral Order and two Detention and Training Orders and a Final Warning which was administered by the Police rather than the Courts.

4.5 Significant Events in chronological order

4.5.1 On September 21st 2007 ADS attended the Emergency Department with a "punch fracture". He reported to have punched a wall and feeling 'fed up with everyone'.

4.5.2 On 16th October 2007 a letter to the Locum Consultant Psychiatrist at CAMHS stated that Derbyshire Youth Offending Service were refusing the request for support as there was a lack of evidence that ADS has been or is likely to become involved in anti-social behaviour. This response comes eight months following the request from ADS's Mother.

4.5.3 In January and February 2008 a number of exclusions were implemented by Creswell Support Centre, due to persistent disruptive behaviour; verbal abuse toward adults and damage to property, (letters dated 25th January / 1st February / 14th February 2008).

4.5.4 In February 4th 2008 Mother reported great improvement in ADS's behaviour since he started attending Creswell Support Centre.

4.5.5 On May 21st 2008 ADS first attended a youth service activity in the evening located in the St Helens Street area of Chesterfield attendance at these activities which were provided to reduce anti-social behaviour by groups of young people in a specific area, continued until July 7th 2010.

4.5.6 In July 2008 ADS and his associates were issued with an Acceptable Behaviour Contract (ABC). An ABC is an agreement between an individual who has been responsible for ASB and one or more agencies responsible for its prevention. It is seen as good practice by the Home Office.

4.5.7 In September 2008 ADS transferred to The Delves (Swanwick Special School & Sports College), following the publication of a final Statement of Special Educational Needs.

4.5.8 In September 2008 The National Institute for Health and Clinical Excellence (NICE) published guidance "Attention deficit hyperactivity disorder – Diagnosis and management of ADHD in children, young people and adults.

4.5.9 On April 18th 2009 ADS with two other youths broke into a compound and drove mobile lifting cranes causing damage. ADS jumped into the canal to avoid the police but was later traced and issued with a Final Warning which was managed by the police.

4.5.10 July 10th 2009 ADS committed an offence of Criminal Damage.

4.5.11 On November 17th 2009 ADS was sentenced to a six Month Referral Order, and was fined for the criminal damage committed in July 2009.

4.5.12 On November 23rd 2009 ADS became involved with the YOS following the Referral Order.

4.5.13 On December 2nd 2009 Mother's Partner died of a heart attack at Mother's home, ADS helped his Mother to try and resuscitate him but they were unable to do so.

4.5.14 On January 18th 2010 The Delves made an application for the Essential Skills Course at Chesterfield College.

4.5.15 June 1st 2010 it was identified that ADS had completed all objectives that had been set in the Referral Order Contract and the Intervention Plan; this resulted in the Referral Order being closed.

4.5.16 On September 1st 2010 ADS commenced at Chesterfield College.

4.5.17 On November 3rd 2010 ADS was accused in college of poking another learner in the eye with a stencil brush. When approached, ADS left college, punching a wall, it was later agreed he would only attend on Fridays until Christmas.

4.5.18 On March 8th 2011 Information was given to the CAMHS Psychiatrist by ADS that his girlfriend at the time had had a termination. She was said to be 14 years old and to have ADHD and learning difficulties. There is nothing documented that the Psychiatrist considered any safeguarding issues in respect of this young person.

4.5.19 On March 14th 2011 ADS contacted CSC seeking accommodation saying he had left home following an argument with his Mother and did not want to return to live with her and she would lose all his benefits. He said he had also fallen out with his Father previously. Advice was provided and contact made with ADS's Mother to establish the facts and whether ADS was really homeless. Mother said he could return home and the argument was over nothing. ADS was resistant to CSC contacting his Mother saying she would hit him. ADS later returned home.

4.5.20 In May 2011 ADS's attendance at college was obviously deteriorating as the Curriculum Manager visited ADS at home on two successive days to encourage him to attend college to complete his Functional Skills course.

4.5.21 On May 21st 2011 ADS, in company with some associates, assaulted a man who was out having a meal with his wife. The assault was apparently unprovoked and the victim sustained a fractured skull and a fractured eye socket. ADS was charged with Wounding with Intent.

4.5.22 In September 2011 Chesterfield College referred ADS12 to Connexions for support in finding alternative training as he was unable to carry on attending college due to his behaviour. Connexions arranged a meeting with NLT and a potential taster session was arranged with BTCV.

4.5.23 On October 12th 2011 ADS assaulted his girlfriend of the time, during which he throttled her and she reported that he had held a knife to his own, and then her throat.

4.5.24 On November 22nd 2011 ADS appeared in North East Derbyshire Dales Youth Court for the offence of Assault by Beating committed on 10th November 2011, to which he pleaded 'Guilty'.

4.5.25 On November 30th 2011 ADS's solicitors requested information from CAMHS about ADHD and ADS's needs when appearing in court.

4.5.26 On December 1st 2011 a Case Manager from the YOS telephoned CAMHS to gather information about ADS's ADHD and Conduct Disorder. Information was provided and the impact of these upon his behaviour. The fact that he had thoughts about killing himself, feelings of worthlessness and depression was also discussed. The Case Manager records that the Psychiatrist was aware of these issues, that she stated she was supporting ADS with them and that no further action was required by the Case Manager. The record of the discussion does not show if the issues of bereavement (arising from the death of mother's partner or the later bereavement resulting from the termination of the pregnancy of his girlfriend) or domestic violence were discussed. The Case Manager was advised to contact ADS's Educational Psychologist, regarding his learning difficulties.

4.5.27 On December 2nd 2011, the Case Manager undertook a Vulnerability Management Plan & Risk Management Plan and recorded that ADS was at medium risk vulnerability and medium risk to harming others. On the same date she also completed a mental health assessment (SQIFA) on which she records that ADS gave varying responses to the following questions:

- Do you feel really miserable or sad? - *Yes, often*
- Do you dislike yourself or your life? - *Sometimes*
- Do you have powerful memories of past upsetting events which make you feel unwell, scared or angry? - *Sometimes*
- Do you have panic attacks i.e. overwhelming fear, heart pounding, breathing fast and stomach churning? - *Sometimes*
- Do you feel worried/scared for long periods of time? - *Yes, often*
- Do you harm yourself e.g. cut yourself or take overdoses? - *No*
- Do you think about harming or killing yourself? *Yes, Often*

4.5.28 The score on the SQIFA indicated concerns that warranted a full mental health assessment. The Case Manager discussed the case with the YOS CAMHS worker who informed her that as ADS was already open to the main CAMHS team his care would remain their responsibility.

4.5.29 On December 6th 2011 ADS received a four month Detention and Training Order.

4.5.30 The Post Court Report assessment on 6 December 2011 was completed by a Court Officer who was not ADS's usual caseworker. She identified self harming behaviour and the fact that although ADS stated he did not intend to harm himself again, he had been very upset in the cells and that the YOS were concerned regarding his vulnerability. The Post Court Report also highlighted that this was new information to that already provided by the YOS.

4.5.31 On December 6th 2011 the Case Manager recorded that ADS was vulnerable and Mother reported that he had thoughts of suicide. The recommendation on the 6 December 2011 was for Hindley YOI which was the normal placement for young people from Derbyshire. This was reflected in the placement alert form.

4.6 Analysis

4.6.1 This period evidences an escalation in ADS's difficulties and his increasingly serious aggressive and offending behaviour with additional difficulties in his family and personal life.

4.6.2 His GP continued to provide good support to ADS and his Mother who was provided with counselling after the death of her partner. ADS's medication continued to be managed responsively, but there was a failure by CAMHS to identify and report the vulnerability of ADS's 14 year old girlfriend when she has a termination. There was little communication between CAMHS, the GP and School Health. CAMHS assured the YOS that they were dealing with ADS's suicidal thoughts but CAMHs response to a request from the court for information about issues that might affect ADS when he appeared before the court was not sufficiently descriptive about ADS's individual needs.

4.6.3 Strenuous efforts to retain him in suitable education and training continued and he was eventually moved to a college that worked with Connexions to meet his needs and keep him engaged in education.

4.6.4 ADS engaged in youth service activities intended to divert him and his peers from anti- social behaviour and the approach of the police was supportive rather than punitive.

4.6.5 Connexions were advised of the possible need for their support in good time and provided sensitive individual support that was highlighted to me by ADS's Mother.

4.6.6 The YOS delivered an effective Referral Order and engaged well with ADS. They identified ADS as being vulnerable and consulted CAMHS and other services appropriately especially prior to his detention in HMP Hindley YOI. They carried out a number of vulnerability assessments and provided sufficient information to HMP Hindley YOI to make them aware of the risks to ADS. However the Ombudsman has commented that the concerns identified by the Court Officer on 6th December 2011 were not conveyed via a suicide self harm warning form or verbally to escort staff. Escort staff do not read the post court reports as standard, so this was an omission as it alerts all staff to **current** concerns. The induction staff at HMP Hindley YOI did say they read the post court report but were not concerned.

4.6.7 Despite the fact that Mother continued to engage well with all agencies and to be seen by them her increasing ill-health appears not to have been identified by agencies other than her GP. ADS was rarely seen alone by health agencies and no agency thoroughly addressed the two bereavements he suffered or the impact of his Mother's health which in my view increased his anxieties and feelings of responsibility for her.

4.6.8 In terms of ethnicity, religion and disability there is good evidence that ADS's disability was identified and appropriately supported. There were no specific mental health assessments but his emotional and psychological difficulties were identified appropriately.

4.6.9 ADS continued to be supported by his family during this difficult period.

4.7 The period in custody including assessments undertaken, information shared and preventative measures taken.

4.7.1 The actions of YOI staff and health during the period that ADS was detained in YOI are the subject of reports by the Prison and Probation Ombudsman Review and Clinical Health Review by Wigan PCT. This brief section therefore considers the actions of community based staff during this period.

4.7.2 On December 6th 2011 the Case Manager created an ASSET for the start of the Detention and Training Order, imposed on December 6th 2011. The ASSET highlighted the following areas as being most problematic in ADS's life; emotional and mental health issues, perception and others, vulnerability and his harm to others.

4.7.3 On December 6th 2011 the Youth Offending Information Service had a record of the documents being sent to the Youth Justice Board Placement Team, providing details of ADS's risk and vulnerability. The placement alert form requested HMP Hindley YOI as a placement, as its location would enable ADS's family to visit, and this was the normal placement for young people from Derbyshire.

4.7.4 On December 8th 2012 there are records of several phone calls and an email from the YOS to Connexions as ADS had been given a custodial sentence. They wanted his Assessment of Learning and information on his attainments so he could access support in custody and details of courses he could access when he was released from custody. Connexions agreed to obtain the information and contact college regarding the qualifications ADS had gained and NLT about a start date following his release.

4.7.5 On December 8th 2011 the Case Manager telephoned HMP Hindley YOI and was told that ADS had completed his induction, no ACCT had been opened, and HMP Hindley YOI was not sure whether ADS had his ADHD medication, but they would contact her about this. They later contacted the Case Manager and explained that ADS was being given his medication correctly.

4.7.6 On December 9th 2011 the CAMHS Psychiatrist wrote to the solicitors, giving general advice on how to support someone with ADHD during a trial, but information on how to support ADS, or his specific vulnerabilities, was not included.

4.7.7 On December 12th 2011 YOS inform HMP Hindley YOI of ADS's educational achievements and confirmed that a place at NTL would be offered to ADS on his release.

4.7.8 On December 20th 2011 the Case Manager took Mother to the initial DTO meeting at HMP Hindley YOI. During the meeting ADS reported issues about the time that he was being given his ADHD medication. The Case Manager recorded that both she and the HMP Hindley YOI Key Worker would to look into this with Health/CAMHS.

4.7.9 On December 21st 2011 HMP Hindley YOI confirmed that following information from YOS, ADS would be given his medication at the correct time.

4.7.10 On December 29th 2011 the Case Manager visited ADS in the YOI to undertake a pre-sentence interview. She reported that during the interview ADS became agitated and in the end refused to talk, he disclosed that he was being bullied. The Case Manager recorded her concerns, and the name of a person ADS said was bullying him, on a safeguarding form and handed it to a HMP Hindley Prison Officer who was working in Visits, but she could not recall who. The form asked if there were any immediate concerns regarding the young person and the Case Manager ticked yes. This form was eventually located on 11 September 2012. Staff from the visiting hall did telephone the wing where ADS was detained to say that they were concerned about comments he had made following the visit, although these did not relate to the bullying reported to the Case Manager.

4.7.11 On January 4th 2012, following a request from ADS's Mother, ADS's GP wrote a letter addressed "To Whom It May Concern". It is not clear from the letter for whom it was intended but it appears it was intended to be used to support ADS in his sentencing. It states that "ADS is a 17 year old gentleman who acts as a carer to his mother who suffers from post-traumatic stress disorder, fibromyalgia and sciatica. She requires her children to prepare food for her, see to her toileting needs, dressing, assisting with stairs and getting in and out of bed and on and off the sofa. Her 19 year old daughter is the main carer however; ADS not only assists but completes the above caring tasks whenever his sister is away from home".

4.7.12 This letter contains information that has not been mentioned previously in any of ADS's records, no one appeared to have been previously aware that ADS was a young carer.

4.7.13 On January 8th 2012 the Case Manager created an ASSET for the purpose of the Pre-Sentence report that was due in Crown Court on the 13 January 2012. The ASSET highlighted the following areas as being most problematic in ADS's life; emotional and mental health issues, perception and others, vulnerability and his harm to others. It is not known whether it included any risks to him.

4.7.14 On January 12th 2012 a Vulnerability Management Plan & Risk Management Plan was created by the Case Manager who recorded that ADS was at medium risk due to his vulnerability and medium risk to others.

4.7.15 On January 13th 2012 ADS was interviewed by the Case Manager for the Post Court Report interview for the second Detention and Training Order sentence. The Post Court Report form was not completed nor sent to the YJB Placement Team or custodial establishment. Whilst this is not in line with procedures I share the view of the YOS IMR author that HMP Hindley YOI were aware of ADS's vulnerability as the Placement Confirmation Form sent at 2.41 p.m. by the YJB Placements Team to HMP Hindley YOI and copied to Derbyshire YOS clearly indicates that ADS was to be treated as a suicide and self-harm risk. It also indicates welfare concerns regarding risk of bullying and learning difficulties and mental health concerns including ADHD and the fact ADS was on medication.

4.7.16 On January 13th 2012 a Placement Alert form was sent by the Case Manager to the YJB Placement Team requesting that ADS be placed in a Secure Training Centre or the Keppel Unit at HMP Wetherby YOI, in view of his vulnerabilities. The Ombudsman has found that on receipt of this form the YJB Placement Team explained to the Case Manager that she needed to complete a specific referral form for the Keppel Unit however the form was still being worked on when Jake fatally self harmed.

4.7.17 On January 13th 2012 ADS received a six month Detention and Training Order for the assault of May 21st 2011. The same day, the Case Manager visited ADS in the Crown Court Cells before and after the court hearing. There was a failure to send a completed Post Court Report (PCR) to the custodial establishment.

4.7.18 On January 16th 2012 ADS was sentenced to detention until April 2012.

4.7.19 On January 18th 2012 the Case Manager was informed that ADS had been placed on an ACCT document by HMP Hindley YOI due to an incident where he had smashed up his room and had tried to cut his wrists. The Case Manager also recorded that she spoke to ADS's mother and explained what the ACCT document was for, and agreed to transport her to the next planning meeting at HMP Hindley YOI on January 20th 2012.

4.7.20 On January 18th 2012 following his attempt to cut his wrists ADS was placed on "suicide watch" at HMP Hindley YOI.

4.7.21 On January 20th 2012 the Case Manager was unable to attend the agreed planning meeting but telephoned HMP Hindley YOI to ensure that ADS was OK, and to ensure that he was told that his planning meeting had been re-arranged and that his family would be visiting him on the following day (January 21st 2012).

4.7.22 On January 20th 2012 ADS hanged himself. He later died in hospital on January 24th 2012.

4.8 Analysis

4.8.1 This period during which ADS was detained in HMP Hindley YOI was clearly very hard for him. Separated from his Mother and girlfriend he found the environment difficult.

4.8.2 Whist the issue of where ADS was placed in detention is the most significant of ADS's parents' concerns; this review focuses on what was made known to the Youth Justice Placement Service, which decides where young people are detained, and whether this assisted them in their decision. The view of the Ombudsman is that it was apparent from the placement alert, following his appearance at Derby Crown Court for sentencing on 13th January 2012, that a request for a Secure Training Centre or the specialist Keppel Unit at HMYOI Wetherby was being made. An additional referral form is normally required for Keppel but not for a Secure Training Centre and the Ombudsman appears to accept that the Case Manager was in the process of completing a referral to Keppel when ADS fatally self-harmed. Despite the parents' concerns regarding the placement, there was a failure to complete a post court report for HMP Hindley YOI, however, there are also examples of appropriate information being shared by the YOS with HMP Hindley YOI.

4.8.3 There was sufficient evidence to indicate that ADS was vulnerable to self-harm and although this was not always considered to put him at a high level of risk, the information was appropriately conveyed by the YOS to Hindley.

4.8.4 When ADS was detained in HMP Hindley YOI there was no formal handover of the management of ADS's care by CAMHS at Chesterfield Royal Hospital to CAMHS at HMP Hindley YOI and I support the Health Overview author's view that this was a missed opportunity to share information between the two services and ensure effective continuity of care.

4.8.5 There were good plans to enable ADS to return to education after his release from HMP Hindley YOI.

4.8.6 ADS's family continued to support him by visiting whenever they could. His Father moved abroad as previously planned, whilst he was in HMP Hindley YOI and this distressed him.

4.9 Summary of agency involvement and agency IMRs

4.9.1 The IMRs have all been quality assured by the responsible agency, by me and the SCR Panel which has challenged findings appropriately. There has been an appropriate willingness to reconsider the reports and make amendments where these were accepted. Following challenges, authors have tried to address the reasons **why** failings or omissions occurred - they have achieved this with varying degree of success and overall, this remains a challenging part of SCRs. Overall, the findings are based on good evidence and I concur with them. The recommendations are sound and follow from areas of weakness identified in the reports and I concur with them. Action plans have been completed and their implementation will be monitored by the individual agencies, senior management boards and DSCB.

4.9.2 Feedback to staff involved in the SCR will commence when the review is completed, staff will be seen individually and will be provided with appropriate support. Not all authors have specifically indicated which of the key issues they did not address and why but overall their reports have covered the issues of relevance to their agency.

4.10 Learning from previous SCRs

4.10.1 I have reviewed the executive summaries of two serious case reviews that pertain to young people in HMP Hindley YOI. They are:

The SCR conducted by Manchester LSC in 2006 in respect of SE.

4.10.2 This review had significant similarities to ADS, S E died, age 17, on December 15th 2005 in the Juvenile Wing of HMP Hindley YOI apparently as a result of hanging using torn bed sheets as a ligature. The main similarities between his death and that of ADS is their both having reported being bullied.

4.11 The SCR conducted by St Helen's LSCB in 2009 in respect of Child L.

4.11.1 This review also concerned a young person who was found hanged in his cell at HMP Lancaster Farms YOI.

4.11.2 It appears that many of the community based recommendations from both reviews have been implemented in Derbyshire or by youth justice processes; it is not possible from this review to determine the extent to which recommendations in relation to HMP Hindley YOI have been implemented.

4.11.3 Both SCRs identify the demanding nature of working with young people with multiple complex needs and the responsibility of all agencies to be aware of the need to communicate, consult and meet, to share information and ensure effective planning whether this be through Child in Need processes or the Common Assessment Framework.

5. Learning from this Review and Conclusions

5.1 Learning from this Review

5.1.1 The most significant learning that has arisen from the review is the need for a multi- agency approach to the management of ADHD and children with complex needs that involve several agencies, the continued importance of all agencies reporting and exploring the impact of domestic abuse on children and the need for **all** agencies to accept responsibility for convening multi-agency meetings for vulnerable children and young people and pro- actively sharing information about risk.

5.2 Conclusions

5.2.1 The death of any child or young person is appalling. ADS's family are understandably deeply traumatised by their loss and are seeking answers as to the reasons why it happened. Their contribution to this review has been enormously helpful and the issues they raised added to the terms of reference and were shared with the Prison and Probation Ombudsman for her consideration.

5.2.2 Overall, the many agencies involved with ADS worked extremely hard to support him; almost without exception they had a very benign view of him and saw him as a very likeable young person. However, although they all wanted the very best for him they sometimes failed to communicate effectively with each other and at no point was a multi-agency professionals meeting or a multi-agency meeting, involving ADS and his family, convened by anyone; the responsibility for this failure must be shared. I do not however believe that it can be evidenced that this failure or the other failures identified with the benefits of hindsight and the in depth analysis of each agencies' involvement, could have been predicted or prevented and did not directly contribute to ADS's untimely and tragic death.

5.2.3 The findings of the Prison and Probation Ombudsman's Review and the Clinical Health Review by Wigan PCT, are reflected in this serious case review Overview Report and the Executive Summary.

5.2.4 The Prison and Probation Ombudsman's Review and the Clinical Health Review have identified serious concerns about the care of ADS, by some officers, within HMP Hindley Young Offender Institute, their failure to protect him from being bullied, to effectively implement the ACCT process (the suicide prevention process used within prisons) and to provide a holistic approach to his care. In relation to the interface between HMP Hindley Young Offender Institute and the Youth Offending Service, the reviews have commented critically on the lack of effort made by the Mental Health Team, based within HMP Hindley Young Offender Institute, to obtain historical information from the community based Child and Adolescent Mental Health Services to assist in their support of ADS during his time in HMP Hindley Young Offender Institute and the failure by the Youth Offending Service to provide a post court report following ADS's third court appearance when he was already detained for a previous offence.

5.2.5 However, the reports do not conclude that these errors directly contributed to ADS's death. The reviews have also found examples of assessments being completed satisfactorily by the Youth Offending Service and some examples of good communication by Youth Offending Service staff with ADS's key worker in HMP Hindley Young Offender Institute.

6. Actions already implemented by agencies

6.1 Youth Offending Service

a. A review was undertaken of all young people within custody to review vulnerability and identify potential friends or acquaintances of ADS, his co-accused and other Derbyshire young people resident at the same establishment. Where relevant, young people were identified to the secure establishment.
b. An immediate management review of practice in courts was undertaken looking at cases where young people are being or are likely to be sentenced to custody (or remanded to custody). As a result of this, interim guidance was issued which details the specific methods to be used for transfer of documents to the Youth Justice Board and the Secure Estate. This also clarified responsibilities, action to be taken and responsibilities of staff and managers outside of normal working hours. The procedure also clarified requirements for management review (gatekeeping) of specific documents. A working group was established comprising a manager and senior Court Officers from each of the teams to examine this area in greater detail and produced a full guidance document.
c. Since this Serious Case Review began, the Youth Justice Board (YJB) has made significant changes to the documentation required for young people prior to their being sentenced to custody and changes have also been made to the systems in place to monitor transfer of documents to the secure estate.

6.2 Chesterfield Royal Hospital NHS Foundation Trust

a. The CAMHS management team have recognised that improvements are necessary in their care of clients with ADHD. Some of these improvements such as written care plans had already been implemented but only with those who are newly diagnosed. This is being addressed immediately.

6.3 Derbyshire Community Health Services

a. Major improvements in record keeping have already been made in Derbyshire Community Health Services and now all health visiting records are computerised using Systmone/TPP.
b. More sophisticated tools are used to assess families and their individual circumstances. There is now more focus on the 'Think Family' approach and the importance of early intervention, using the Common Assessment Framework and request for support from the Multi Agency Teams where appropriate. The CAF and pre CAF process may have highlighted any concerns or unmet needs following a more thorough health needs assessment, including the Tynedale assessment and the introduction of the Ages and Stages Questionnaire. Health Visitors assessment is based on the Framework for the Assessment of Children In Need (2000) and so includes; Childs Development Needs, Parenting Capacity and Environmental factors.
c. All Health Visitors working for Derbyshire Community Health Services have regular safeguarding training, including yearly updates for the Named Nurses and bi annual training from the safeguarding board. This is monitored and records kept.
d. As mentioned there is a review planned of the School Nursing Service of services offered at special schools such as Swanwick School and Sports College. There may be changes in practice that will be implemented.

7. Recommendations

7.1 There are few recommendations to be made in addition to those contained in the IMRs.

7.1.1 DSCB should:

1. Monitor the implementation of any recommendations made by the Prison and Probation Ombudsman's and the Clinical Health Review in relation to HMP Hindley YOI and should seek assurance from the Governor of the YOI that young people from Derbyshire who are detained in the YOI are safeguarded and protected;
2. Satisfy itself that assurances are sought from any custodial setting where Derbyshire young people are detained that they are safeguarded and protected;
3. Monitor the implementation of the recommendations contained in the IMRs provided as part of this review. Particularly the establishment of effective arrangements to provide multi-agency support to children and young people with ADHD;
4. Ensure that the findings of this review are effectively communicated to staff across the partnership represented on the board;
5. Ensure that CAF training highlights the importance of identifying offending behaviour as an indicator of vulnerability in young people;
6. Highlight the importance of all professionals pro-actively making contact with other professionals involved in a young person's life and convening multi-agency professionals meetings or CAF meetings involving the young person and his family; and
7. Highlight the importance of seeing children and young people on their own to gather their views and feelings about their circumstances.

8.0 Updated position at time of publication

8.1 The recommendations of the serious case review were fully implemented by the Youth Offending Service within the timescales outlined in the review. In addition to the recommendations identified at the time a number of changes to practice have taken place since the incident. These include:

- A greater use of Secure Training Centres and Children's Homes for young people in custody. These are smaller establishments than the Young Offender Institutions where ADS was placed and provide a more supportive environment. This has been achieved by improving communication with the Youth Justice Placement Team who make decisions about where young people in custody are placed.
- The Service has begun to provide independent advocates for young people in custody. These advocates will provide an additional opportunity for young people to express their concerns about their experience in custody. The advocates will also be able to convey any concerns to the agencies responsible for the care of the young person.
- Management oversight processes have been updated to ensure that managers have a clear framework for quality checking assessments and the transfer of information to secure establishments. This ensures that all possible relevant information about young people in custody is passed to the establishment.

8.2 Health organizations in Derbyshire are committed to providing a high quality of care for children in the services that they deliver, and to learning from serious case reviews.

- Chesterfield Royal Hospital, in conjunction with commissioners, has audited services for children with ADHD against NICE guidelines, and has put changes in place to ensure compliance with national recommendations. This includes evidence of multi-agency involvement in the assessment and management of children and young people with ADHD.
- Information sharing has been strengthened with parents, general practitioners and school nurses, and, where relevant, with other agencies. Documentation clearly indicates which other professionals are involved with the child, to improve coordination of care and young people are regularly offered time to be seen alone without their parents or carers present. These changes have been evidenced through audit which has demonstrated a very high level of compliance.
- Reassurance has been given by the Youth Justice Board that the new healthcare standards in respect of children in secure settings will facilitate appropriate information sharing in respect of the health of children in those settings.
- GP practices across Derbyshire have reviewed their repeat prescribing procedures to ensure that appropriate prescribing controls are in place.

9.0 Signing Off

Glenys Johnston OBE ……G.Johnston……05.11.14……..

Overview Author

Christine Cassell……C.Cassell….05.11.14……

Independent Chair - Derbyshire Safeguarding Children Board