Executive Summary

REPORT TO

DERBYSHIRE SAFEGUARDING CHILDREN BOARD CONCERNING

Child P

In order to preserve anonymity substitute initials have been used in this summary.

March 2007

INTRODUCTION

Summary of circumstances that led to a review being undertaken in this case

1. P, aged 15, was a child in care at the time of his death in 2006. He was a young man who had had his problems, but also had many positive qualities.
2. He was found dead on an open space one morning in June. The cause of death was ingestion of vomit and a drugs overdose. The coroner's verdict was one of accidental death.
3. It is important to say, that, very sadly, the teenage years can be dangerous ones, and that death by overdose from a cocktail of drugs is an increasing hazard for young people at the start of the 21st century. However, as the recent DCSF Interim Report of 161 child deaths or serious incidents in 2003-5 makes clear[1], being in care as an adolescent increases vulnerability. It is essential that lessons are learned so that these risks can be diminished for the children and young people for whom being looked after away from home becomes necessary.
4. The other introductory point to be made is that the members of Derbyshire LSCB are to be commended for recognising that, to fully understand how, as a young person looked after by Derbyshire County Council since the age of 8, P came to be in a position of vulnerability, it was necessary to track back over his life, and look at the circumstances that led to his being looked after and the care provided whilst he was looked after, and not to focus narrowly on the immediate period before his death.
5. P had a geographically mobile and troubled early life before he became accommodated at the age of 8. Evidence from the school, and from both his parents, indicated that he already had serious behavioural and emotional problems. Prior to being looked after, he had lived with his

[1] Brandon, M et al, 2007

parents for the first three and a half years of his life but when his parents separated he moved between his mother and her new partner, his paternal grandmother and his father. P has a half brother and two sisters who remained cared for within the family.

6. Between 1999 and his death P had 16 moves and lived in 15 different placements as well as having short stays with his parents. Most of these were in the first 3 years after he started to be looked after.
7. Between the ages of 11 and 14 he had a period of stability in a small independent sector children's home. This placement was initially intended to be a short term bridging placement prior to another attempt to enable him to settle in a long-term foster family. However, somewhat against the odds, P settled well and made progress at home and in school. With assistance from the Children's Rights section, he successfully resisted earlier attempts to move him to foster placements nearer to his family.
8. When he was almost 15, still clearly against his better judgement and expressed wishes, he moved to a foster family with the intention that this would provide him with a good experience of family life up to the age of 18. This foster family was recruited and supported by a private sector fostering agency registered with CSCI and provided under a contractual arrangement with Derbyshire Children and Younger Adults Service.
9. The move to the first placement was carefully planned, but did not work out, and P moved at short notice into a second foster home just before his 15th birthday.
10. In Spring 2006 a 15 year old boy in the care of another authority who had a serious drug habit and had recently spent a period of weeks in Secure Accommodation, joined him in the foster home. The two boys did not appear to develop a peer relationship and did not spend social time together. P's placement was not going well and he was again challenging limits and engaging in confrontational behaviour in college and in the foster home. His problems were essentially emotional and relational and he was only minimally involved in criminal behaviour. Following disagreements with his carer, P did not return home at the

expected time on the evening prior to his death. The carer reported him missing and he was returned home by the police in the early hours. P told the police that he did not want to return and that he would run away. The police officer contacted the local Children's Services duty system but was told that no alternative placement was available. Unsuccessful attempts were made by the Duty worker to contact the fostering agency duty worker. No attempt was made to contact the emergency duty system.

11. In the early afternoon of the following day, after another disagreement with his carer, P accepted a lift in a taxi. The circumstances resulting in his death in the early hours of the following morning are still unclear. It is not known whether, when P took the cocktail of drugs, he was aware of the risks or was encouraged to take the drugs and was unaware of what he was doing and the possible risks. If the former, this risk-taking behaviour was out of character, and therefore could not have been predicted.

Summary of information known to the relevant organisations and professionals at the time of P's death

12. There was nothing in P's history or recent behaviour which would suggest that his death could have been predicted, and specific steps taken by individuals or agencies to prevent it. It is not possible to point to specific pieces of information which, had they been known would have prevented P's death.
13. On the other hand there are stages in the 8 years between P's father first seeking assistance and P's death when, had information known to the different services been shared and carefully appraised, different decisions should have been taken and the circumstances and events leading up to his death would not have occurred.
14. As in other reviews of child deaths, there are weaknesses of communication, but there are also examples of social workers, children's rights workers, teachers and other school staff and carers working diligently together to try to meet his needs. What was missing

at key points in his life is a careful, knowledge-informed multi-agency assessment and analysis of P's needs.

15. The schools and involved agencies all had sufficient information to know, that P had serious emotional and behavioural difficulties, accompanied by physical symptoms.
16. P had made considerable progress in recent years, and social workers should have known from his history that the chances of being successfully placed in foster care were poor and that his foster placements should be treated as at very high risk of disruption. Given his many previous experiences of loss and disruption, it should also have been clear that further placement breakdowns would be significantly harmful to his future well-being and life chances. It had also become clear that P had many positive qualities and could make warm and mutually beneficial relationships when he was with people who valued him, and that, with loving and skilled care he had the potential to do well.
17. There are some, specific examples of miscommunication towards the end of his life, particularly between the social worker, team manager and Independent Reviewing Officer principally responsible for the service provided to him and to his parents; the social worker and manager accountable for the service provided to the other child in the placement and the fostering agency workers responsible for the identification and support of the foster carer with whom P was placed at the time of his death.
18. It appears that details of the other child's problems and needs were never provided to P's social workers and managers – the individuals and agencies who held this information each seem to be of the opinion that this was the responsibility of the other, or of Derbyshire to ask for the information. Once the other child had been placed, this information is unlikely to have led to any action that could have prevented P's death, but this knowledge provided before the placement of the other young person might have stopped him from being placed in what was meant to be P's long term home. Given that the regular use of illicit drugs was not a part of P's lifestyle, it is unlikely that he would have

found himself with ready access to the quantity of drugs that led to his death had he not been in the same household as a known drug user.

19. Poor communication resulted in lack of clarity about respective roles in the matching, supervision and support of the foster carer and the two boys placed there. This was aggravated by a lack of Looked After Children (LAC) foster placement agreement documentation for either child. Face to face meetings or planned telephone calls between the agencies who knew these three people best, may have informed decisions of the impact they might have on each other. The result was a lack of clarity between the social workers and their managers about how to ensure that the work with these two highly vulnerable teenagers should be divided up to ensure maximum support of each of them and of the carer.

21 One result of this was that there appeared to be no contingency planning for what should happen when the entirely predictable event occurred of P refusing (outside office hours) to return to the foster home.

RECOMMENDATIONS

My recommendations are broadly in line with those made in the individual Management reports, but diverge in places and these will be pointed out. Some of the recommendations have already been taken forward or are implicit in some recent policy documents of Derbyshire Children and Younger Adults Department, especially 'Supporting Families, Kinship Care and Permanence Policy'.

Children's Social Care

1 There is a need to review the procedures for decisions about accommodating children to ensure that they are based, as much as possible, on the principle of partnership with parents, and recognise the important role parents continue to play in children's emotional lives. In particular, there

needs to be a consideration of when it is appropriate to use formal child protection systems when entry to care is being considered and when these procedures will be counter-productive

2. There should be a multi-disciplinary case analysis as soon as the possibility of entering care being of benefit to a child emerges as a serious possibility. A multi-agency child in need conference, a 'core group' meeting including parents (strengthened by the attendance of additional specialists) or a Family Group Conference should usually be held.

3. There should be consideration of whether more 'shared care' 'support foster care' type placements should be available for parents struggling with children and young people with challenging behaviour.

4. Whilst there is an important role for support workers / assistant social workers to work alongside the child's accountable social worker, the social worker should continue to play a key role in working with the looked after child, parents, and carers. If moves between placements become necessary, the social worker should normally be the person who moves the child on to a new placement, and if this is not possible prepares the child for the move or spends time with him/her immediately afterwards to help him/her to understand the reasons for the move and provides emotional support.

5. All relevant agencies should be involved in regular updates of the care plan. The role of the CAMHS service with looked after children needs to be looked at to ensure that the portfolio of services available meets the special needs of these children. If the 'no services till in permanent placement' policy is still a basis for CAMHS work, this should be seriously looked at. Schools, school nurse service, SENCOs etc need to be consulted prior to LAC reviews (not necessarily to attend unless the young person wants that) and relevant parts of the review recode sent to them.

6. The LAC review should be seen as a process and not just a single meeting. Parents, as well as young people and carers, should be consulted

about the most convenient timing and venue for LAC reviews and be given adequate notice so that the chances of their attending are maximised. If they cannot attend, or there are reasons why they should not attend, the social worker and possibly in some cases the IRO should meet with them beforehand. The LAC questionnaire to parents should be taken seriously and could be the agenda for such a pre-review meeting. This applies to all looked after children, but especially to accommodated children. The IRO should check that this has happened. If the clearly expressed wishes of a child or parent about significant decisions are not being followed, especially if the child is accommodated and they have no recourse to court, parents and young people, and significant carers should have the possibility of speaking directly to those making the decision.

7. Parents and those with parental responsibility should always be consulted before a looked after child changes placements unless this happens in an emergency. They should be formally notified when a looked after child changes placements, and of the address, unless there are sound reasons why this should not happen. It should not be left to a young person under the age of 16 to do this for themselves, and even for those over 16 it should be the exception rather than the rule for this to happen.

8. The respective roles of the child's social worker and team leader, the IRO responsible for the drawing up the conclusions to LAC reviews, (and, if they become involved, the ADEPT panel) should be clarified. The procedure should be strengthened to scrutinise any case where the consistently held wishes of a child or young person are being over-ruled. The role of the IRO in considering whether the court should be alerted in such cases should be reviewed, in cases of accommodation as well as for children on care orders.

9 Children's social workers, their managers and IROs should be encouraged to be more assertive in putting their views across to senior managers if they consider that a child's well-being may be harmed by a decision that is being considered.

10 Contingency plans should be built into all care plans. Especially for children whose placements are known to be 'high risk' in terms of breakdown, contingency plans should consider how crises should be handled by emergency duty teams, and guidance notes provided to the Emergency Duty system, these should be considered at each review.

11. There should be a review of practice when working with parents of looked after children so as to maximise the possibility of safe, appropriate and comfortable contact arrangements being achieved. Discussions should take place with trainers and providers of post-qualifying training to ensure that the skills and knowledge base for working with parents of looked after children is strengthened.

12. Managers in local authorities and independent foster care agencies should consider how to ensure that workers and team leaders are familiar with the basic and up-dated knowledge for practice in the area in which they are working. This needs to be at greater depth than can be acquired by 'one-off' training events. The Children's Services Departments in the East Midlands area should work with their local Universities to ensure that the post-qualifying social work programmes, and those for other professionals, provide and assess learning which leads to knowledge-informed practice. These should link in with in-service programmes to update knowledge and skills for all children's social workers and other professionals and their managers. In complex cases, time and information resources must be made available for children's social workers', team leaders and senior mangers to 'research' the knowledge they need to assist them in the decision making processes.

13. Children's Services should write procedures to the effect that there should be a professionals' meeting when it is proposed that another child joins a foster family intended to be a long term placement for another looked after child. This should be followed by discussions with the child already in placement and the carers, and usually the parents. In some cases it may be relevant to have the IRO for the child already in placement to chair this

meeting. This is especially relevant if there are 2 different local authorities and/ or an IFP involved.

The Independent Fostering Agency

1. The Independent Fostering Agency should ensure that its supervising social workers are not geographically over-stretched and are able to attend, if necessary at short notice, scheduled or emergency matching and planning meetings with social workers of the placing agency, statutory reviews and case discussions.

2. The Independent Fostering Agency should ensure that there is always an out-of-hours duty worker available to be contacted in emergencies.

3. The Independent Fostering Agency should review its processes to ensure better written and verbal communication with the child's social worker at the matching stage and that their supervising social worker contributes to the foster placement agreement, the statement about the match between the carer and the needs of the child, the placement plan and the LAC reviews.

4. The East Midlands Fostering Policy on Purchasing Placements from Independent Agencies appears comprehensive on first reading, but this case has revealed that more work needs to be done specifically around emergency placements, matching procedures, emergency duty procedures and especially the decision making processes when a second child is to be placed by a different local authority.

5. There should be consideration by the commissioning section as to how a general contract with an Independent Foster Care Provider (IFP) can be adapted for an individual child. In particular, the contracting agreement should not be regarded as a substitute for the foster placement agreement which is the responsibility of the child's social worker, in collaboration with the IFP supervising social worker.

6. It should be made clear in formal contracts and in placement agreements for individual children that the decision about matching of a child with a foster carer is the responsibility of the local authority looking after the child. The contract and agreement should spell out who is accountable for what in terms of the monitoring of the placement, support for the carers and child, and arrangements should an unforeseen placement breakdown occur.

7. If there has not been a multi-disciplinary analysis of the needs of a child before he or she enters care or accommodation, when a child is past infancy and has already been identified as having complex needs a full assessment should follow before a care plan is arrived at. It may be that specialist assessment foster carers should be part of the contract carer scheme.

8. Within three month of starting to be looked after, there should be a full child and family history on file, which has a section recording the history of earlier social work and other interventions to support the family. This can be incorporated as part of the process of analysing and reflecting on the data collected through other recording systems but should 'stand out' as a key document to be consulted, and added to/ amended as appropriate, when important decisions are being made.

CSCI

1. CSCI (OFSTED) should consider how their inspections can get a full picture of how the fostering service provided by a local authority ensures that there is joined up practice between the child's worker and the foster care team supervisor. This is especially important when an independent agency is providing the foster care service.

2. When inspecting Independent Foster Care Providers CSCI/OFSTED should focus on arrangements to ensure good communication with the local authority social workers, and particularly on matching arrangements when

another child is to join a placement intended to be the long or medium-term home of a child already in the family

3. In their inspections of the foster care service, CSCI / OFSTED should pay attention to the aspect of qualification and training concerning relevant professional knowledge- at the moment the emphasis tends to be on management training for those managing foster care teams.

CAMH's

1. The CAMHs service should review its practice with looked after children to ensure that psychiatric and psychological assessments are available to looked after children and that appropriate services are available to children in temporary as well as long-term placements, and their parents and carers.