Derbyshire
Safeguarding
Children
Board

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Everybody's Business

SERIOUS CASE REVIEW

Executive Summary

CHILD D

October 2009

In order to preserve anonymity substitute initials have been used to refer to individual family members mentioned in this summary.

1 Agencies Involved

- Derbyshire Connexions Service
- Derbyshire County Primary Care Trust
- Derbyshire Children and Younger Adults Department
- Derbyshire Police
- Derbyshire Youth Offending Service
- Derbyshire Connexions Service

This executive summary has been produced following the resubmission of the serious case review. This report reflects the discussions and conclusions of the resubmitted review

2 Membership of the Re-submission Panel

Rachel Dickinson Assistant Director Derby City Council (Independent Chair)

Ian Johnson, Assistant Director, Derbyshire County Council

Rachel Walker, Detective Inspector, Derbyshire Police

Dona Womack, Strategy Officer, Derbyshire Safeguarding Children Board

Kathy Webster, Consultant / Designated Nurse, Safeguarding Children

Patricia Field, Consultant Paediatrician/ Designated Doctor

Jonathon Holland, Service Manager, Youth Offending Service

Simon Caines, Head of IAG and Development Connexions Derbyshire

Miles Dent, Operations Manager (Safeguarding) Derbyshire County Council

3 Reason for the Report

This is the Executive Summary of a Serious Case Overview Report as required under Chapter 8 of Working Together to Safeguarding Children (HMSO 2006) and commissioned by Derbyshire Safeguarding Children Board. It follows the death by suicide of a young person (D) in June 2006.

This report is based upon information provided by the various agencies involved in providing services to D and his family, on discussion within the Serious Case Review panel meetings and on relevant background material for agency policy and practice guidance.

The conclusions and recommendations are based on analysis of the information provided, and from available research papers. They are intended to assist in the application of ‘best practice’ in the future for all agencies.

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

4 Purpose of the Serious Case Review

As stated in Chapter 8 of Working Together to Safeguard Children (HMSO 2006) a Serious Case Review is required when a child dies and abuse or neglect is known or suspected to be a factor on that child’s death. The objectives of a Serious Case Review are to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children

- Identify clearly what those lessons are, how they will be acted on. And what is expected to change as a result

- As a consequence, improve inter agency working and better promote and safeguard the welfare of children

This report examines the actions of the agencies involved with D and his family members. It considers individual agency policies, procedures and decision making and looks at how the agencies interacted and communicated with each other. The recommendations reflect the lessons to be learnt and are intended to improve services for other young people and their families in the future.

This report also takes into account the views of D’s maternal grandmother who was interviewed as part of the Serious Case Review.

5 Summary of the Case and Background to the Report

D was just one month short of his eighteenth birthday when he took his own life. He had led a troubled life and had been known to several universal and specialist services. It was because of his history and the involvement of services that a decision was taken to undertake a serious case review. The review was to consider what lessons could be learnt for future inter agency practice, to understand why some young people choose to take their own lives and what, if anything, could have been done to prevent this incident and similar future tragedies.

D had been known to Social Care Services throughout his life. His mother had herself been a child in care at the time of D's birth. She had been ambivalent about caring for him and he had an unsettled period during the first years of his life during which there were no clear plans for him and he did not have a primary care giver with whom to make a good attachment.

Arrangements were made and agreed when D was three years old that he should live with his grandmother and should maintain contact with his mother. Social Care Services had concerns about the ability of the grandmother to meet his needs but had no further contact with D until he was seven years old by which time he was displaying very challenging behaviour at home and at school.

Concerns about D increased over the following months and years, his behaviour became increasingly difficult and he was known to be living in a violent household. It was difficult to work with him and his family as his grandmother was reluctant to admit that she was finding him hard to care for and was unwilling to accept help. D was taken into care and placed with foster carers when he was nine years old. There was a history of broken placements and finally, when he was 12 years old, a decision was taken to return him back to his grandmother's care. Social Care had very little further contact with him, even though he was known to be living in a household where there were serious occurrences of domestic violence.

From the time that he returned home D became known to other service providers, primarily Police, Youth Offending Services and Connexions. In the months leading up to his death, and following his release from a period in a Youth Offenders Institution, D was in regular touch with the Connexions Service, they were given no indicators that he was considering taking his own life. No other services were involved with him at that time.

Whilst the review concluded that no-one outside the family had the evidence to regard D as at risk of suicide it must be acknowledged that he had complex needs and that he was very vulnerable. He did not receive the co-ordinated multi agency response that his needs warranted; had he done so this might have helped him. However D had a good relationship with Connexions advisors and had given them no indication that he had suicidal thoughts. It cannot be concluded that a co-ordinated multi-agency service response would have prevented his death. None the less Derbyshire Safeguarding Children Board acknowledges that teenagers can be very vulnerable and that a better co-ordinated approach with improved facilities for sharing information may improve their outcomes.

6 Recommendations from the review include:

- A review of current training provision for front line staff and managers to ensure that sufficient emphasis is placed on:

  - Attachment and permanence for children
  - Working with hostile and difficult families
  - Safeguarding teenagers

- More effective use of chronologies in assessments and decision making process

- Multiple moves of children in care will be brought to the attention of the assistant director (safeguarding and specialist services)

- Establishment of an Adolescent Suicide and Self Harm working group to learn lessons from local and national incidents and to implement structured change

- Additional training for front line police officers and supervisors including the Safer Neighbourhood Teams on the impact of domestic incidents on children and teenagers

- That Youth Offending Service Social Workers are given access to the electronic recording system and trained in its use

- Connexions will improve information requests made to other agencies and put greater focus on early interventions in school