HARROW LSCB

Serious Case Review

Overview Report and Executive Summary

Services provided for Child R
October 2011 – November 2013

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Introduction

Between December 2013 and January 2015 Harrow Safeguarding Children Board conducted a Serious Case Review about a young man, who died as a result of taking a combination of drugs after he had gone missing from a care placement. He is referred to in this report as Child R. Deborah Lightfoot, who was my predecessor as the safeguarding children board chair decided that there should be a Serious Case Review in order to ensure that agencies had an opportunity to learn lessons from this very sad death. This report presents the full findings of the review.

The functions of the Serious Case Review are to provide a rigorous analysis of the actions and decisions of professionals and to identify ways in which services for other young people can be improved.

This Serious Case Review has been unusually challenging because many Harrow services had been involved with Child R and he had also lived in eight different care placements, seven of which were outside London. I am grateful for the cooperation of everyone who has supported the work of this review over the last year, including colleagues in a number of LSCBs in other parts of England and Wales who have contributed and current and former members of staff who have participated. I am particularly grateful to the members of Child R's family.

In order to make the learning from the Serious Case Review as accessible as possible the findings of the overview report are presented in the following way.

- Part 1 of the report is an Executive Summary which provides an overview of the key events and findings
- Part 2 contains the recommendations made for individual agencies and the Harrow Safeguarding Children Board
- Part 3 draws on recent research to ask some important questions about how professionals are working with very difficult adolescents.
- Parts 4 and 5 provide a full explanation of the most important findings of the review for local agencies.

The appendices to the report contain very detailed information about the key events in Child R's time in the care of Harrow Council, the services that were provided, his views (which were expressed in letters that he wrote before he died), the views of his family and further information about how the review was carried out.

I hope that by setting out the report in this way it will be possible for readers with different objectives to find the information that they need.

Alongside this report the Harrow Safeguarding Children Board has published a formal response to the findings of the Serious Case Review and a plan setting out in detail the actions that agencies and the board will now take to implement the learning from the review. The review has also been circulated to the safeguarding children boards in parts of the country where Child R was placed as a looked after child so that agencies in those areas can consider whether they too need to take action to improve services.

Chris Hogan

Independent Chair

Harrow Safeguarding Children Board

Services provided for Child R

1. EXECUTIVE SUMMARY

1.1. Between December 2013 and December 2014 Harrow Safeguarding Children Board (the LSCB) conducted a Serious Case Review under the guidance *Working Together to Safeguard Children 2013* in relation to the services provided for a young person, referred to as Child R. The purpose of the review is to undertake a '*rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1]

1.2. This document sets out the Serious Case Review findings which, in keeping with the statutory guidance, are published in full.

Reasons for conducting the Serious Case Review

1.3. Child R was of Eastern European descent and came to live in the UK in 2006 when he was nine, following his mother who had moved here the previous year. Child R was 16 when he died in November 2013 while missing from an open residential children's home in Sussex. Child R caused his own death by taking a combination of drugs. Two were proscribed Class A drugs and the other was a prescription medication. Individually the drugs were found to be present at levels likely to be toxic, but not normally fatal.[2]

1.4. From 2008 onwards Child R and other members of his family had received services from agencies in Harrow, including the mental health service, youth offending services, children's social care and early intervention services, the pupil referral unit (for children excluded from mainstream school) and the substance misuse service. Between 2010 and early 2012 he and other children in his family were subject to a child protection plan. Child R was accommodated by the local authority in late October 2011. In January 2013 the Family Court made Child R the subject of the first of a series of Interim Care Orders, which continued until November 2013.

1.5. Between October 2011 and May 2012 Child R lived in a residential unit in London. Between May 2012 and his death he lived in a series of residential units that were all were some distance from Harrow. The only exception was a period of two months in mid-2013, when he lived with his family in Harrow. Eleven months of the period in residential care were spent in secure accommodation as a result of orders made under Section 25 Children Act 1989 (i.e. because he was judged by the

[1] *Working Together to Safeguard Children* (2013), 4.1 and 4.6

[2] The post mortem examination finding was that the combination was fatal. In addition Child R's tolerance would have been reduced because he had been in secure accommodation for some months and is not believed to have taken any illicit drugs during this time. The prescription medication was a pain-killer that had not been prescribed to Child R.

local authority and the courts to be a risk to himself or others if not placed in secure accommodation). He had repeatedly absconded from open residential units.

1.6. Less than a week before his death the Family Court made a Care Order and endorsed the local authority's plan that Child R should live in an open residential unit in Sussex. Child R absconded from the unit 48 hours after his admission.

1.7. Taking full account of the long period that he had spent looked after by the local authority, the lengthy periods in secure accommodation, the large number of agencies involved, the high level of risk managed by agencies and the high level of difficulty that professionals experienced in working with Child R and his family, it was clear that important lessons could be learnt by the agencies involved and that a Serious Case Review would be the best mechanism to do this. Deborah Lightfoot, who was at that point the Independent Chair of Harrow Safeguarding Children Board, made the decision to conduct the Serious Case Review on 2 December 2013.

<u>The focus and scope of the Serious Case Review</u>

1.8. In its initial discussions the team conducting the review agreed comprehensive terms of reference. These are set out in Appendix 3 of the report.

1.9. As it progressed the team carrying out the review determined that it should most usefully focus its work on three areas:

- the difficulties faced by agencies (both individually and collectively) in working with older adolescents who have multiple and serious problems
- the difficulties faced by young people, family members and agencies when a young person repeatedly absconds and behave in a way which poses a risk to themselves and to others
- the impact of decisions to place a looked after young person at some distance from his home and the home local authority.

These are difficult areas of practice which are the subject of much wider national professional debate, which the Serious Case Review has sought to draw on. The review also considers in detail the local factors that have affected the provision of services in Harrow.

1.10. The Serious Case Review has evaluated in detail services provided in the period between October 2011 (when Child R was first looked after by Harrow Council) and his death in November 2013. This allowed for a manageable and proportionate review with a focus on current and recent practice. Even taking just this specific period, the review has had to consider a very large amount of material. The review received background reports from agencies that knew Child R before October 2011 so that it could place recent events in context.

Agencies involved

1.11. The Serious Case Review considered the work of the following agencies and contracted professionals:

Services in Harrow and neighbouring local authorities

- Local authority social care and early intervention services
- Virtual school and other education services
- Residential unit
- Vocational educational project
- Metropolitan Police Service
- Youth justice services
- Community and acute health services and Child and Adolescent Mental Health Service (CAMHS)
- Substance misuse service

North Wales

- Residential unit
- Police
- Youth justice
- Health and mental health services

Two unitary authorities in the Midlands

- Residential unit
- Police
- Youth justice

Essex

- Secure unit, attached health and mental health service
- Local health providers

West Sussex

- Residential unit and Sussex Police

Northumberland

- Secure unit
- Forensic psychiatric service attached to secure unit
- Substance misuse service
- Northumbria Police

1.12. Full details of the involvement of agencies are set out in the narrative in Appendix 1.

1.13. As the work of the Serious Case Review developed it became clear that it would not be feasible to examine in detail every aspect of practice in all of the areas where Child R had lived. The review has focused its work in the main on the decisions and actions of agencies in Harrow, including the local authority which had overall responsibility for

planning and coordinating the provision of care for Child R. However a considerable amount of information has been gathered from agencies in the areas in which Child R lived and one of the lead reviewers made visits to meet staff in two localities.

1.14. The findings of the review will be shared in full with the local safeguarding boards in the areas where Child R lived to enable them to consider whether there is additional learning for their local services. A number are areas that host significant numbers of looked after children placed by other authorities.

How the review was undertaken

1.15. Details of the steps taken to carry out the review are set out in Appendix 3.

1.16. The Serious Case Review has taken into consideration evidence from Child R giving his views on the services that he received and also the views of members of his family.

1.17. At a number of points in his life Child R wrote letters and statements which set out his wishes and feelings and his views about the way that he felt professionals worked with him. Two in particular have been considered by the review. One was submitted to the judge in the Family Court at the hearing which made the Care Order, less than a week before his death; the second was an earlier document submitted to a secure accommodation review. The contents of these statements are set out and discussed in Appendix 2 and have influenced the findings of the review at a number of points.

1.18. In December 2014 Child R's mother (and two other family members) met independent members of the review team and gave their views about the provision that had been made for Child R and the decisions and actions of professionals. These are also summarised in Appendix 2 and are referred to at a number of other points in this report.

Key events

1.19. Appendix 1 contains a detailed narrative of key events and professional involvement with Child R. This is summarised briefly here, along with a table showing the details of Child R's care placements.

Family background

1.20. Agencies working with Child R had little specific information about his life before he came to live in the UK. His mother was very reticent about discussing the family's life in their country of origin and gave some misleading information to professionals about the relationships between family members. Her view was that his problems only began when he moved to the UK. Section 3.3 of this report considers further the specific difficulties that professionals encountered in working with a young person whose early history was unknown.

Early difficulties and help

1.21. Child R lived in the care of his mother in Harrow between 2006 and 2011. Over this period professionals became increasingly concerned about Child R's behaviour problems at school (which led to his permanent exclusion), his offending and substance misuse. He was diagnosed with ADHD and had medication for this and later also tablets to help him sleep. In 2010 he and the younger children in the family were made the subject of child protection plans because of neglect. There are now clear accounts of his contact with members of a gang, which were a source of significant stress and anxiety for Child R and his family, though at the time not all the professionals involved had the same knowledge of this or understanding of its significance.

Local authority care

1.22. In late 2011, after he had committed a number of offences and taken an overdose, Child R became looked after by the local authority. An arrangement made with an extended family member to care for him had broken down and he was perceived by all of the professionals involved to be at a very high level of risk.

1.23. Initially he lived for six months in a residential unit in a borough neighbouring Harrow. During this time he stopped attending his vocational educational placement which, whilst he was being taken to the project each day, he had participated in well.

1.24. In May 2012, following a period in which he ran away and tested positive several times for a range of drugs, Harrow social care placed Child R (who by that time was 16) in a residential unit in North Wales. This was in part an attempt to remove him from criminal associates and the direct influence of substance misuse. But it was also a reflection of the shortage of good quality residential provision in and

around London. During the following 11 months he lived in three different residential units, all some distance from London. When living in open units he absconded frequently and overdosed several times. A seven month period was spent in secure accommodation.

1.25. In January 2013 the local authority obtained an Interim Care Order from the Family Court, the first of a series that led in November 2013 to the making of a Care Order. An unusual step for a child of this age, the application reflected the very high level of concern that there was about Child R's safety.

Living at home with his family

1.26. During April and May 2013 Child R lived at home with his mother and other family members. This placement broke down as a result of further serious concerns about substance misuse. Child R was closely monitored while he was living at home and his family received regular visits, though his perception was that his timetable of activities consisted of a lot of checking and monitoring by professionals and little that was constructive or enjoyable for him. No comprehensive plan was made for education or vocational training during this period. Neither his mother nor professionals arranged an appointment with the Harrow CAMHS service (which knew Child R well) for some weeks after his return home.

1.27. The period of care at home broke down when professionals decided that while he was living in the community they could not safely manage the risks caused by Child R going missing from home and repeatedly testing positive for a range of drugs.

Final period in care and placement

1.28. Between June and November 2013 Child R was again accommodated in residential care, including a further period of 10 weeks in secure accommodation.

1.29. At the beginning of November 2013 he moved under a care plan agreed by the Family Court to an open residential unit in Sussex. The following day he absconded from the unit, though he had showed no sign of being unsettled or planning to leave. Four days later Child R was found dead a few miles from his family home.

Care placements of Child R

Date	Type of placement	Location	Length of stay	Reason for placement ending
October 2011	Open residential unit	Borough neighbouring Harrow	6½ months	Broke down due to going missing, substance misuse and level of risk to self and others. Plan to remove Child R from contact with associates and access to drugs
May 2012	Open residential unit	Midlands	3 weeks	Planned as a temporary move
June 2012	Open residential unit	North Wales	4½ months	Broke down due to going missing, substance misuse and level of risk to self and others
October 2012	Secure accommodation *	Northumberland	6 months	Planned placement at home with family
April 2013	Placement home subject to Interim Care Order	Harrow	2 months	Broke down due to going missing, substance misuse and level of risk to self and others
June 2013	Secure accommodation *	Northumberland	10 days	Placement in open residential unit with experience in substance misuse
June 2013	Open residential unit	Midlands	5 weeks	Broke down due to going missing, substance misuse and level of risk to self and others
July 2013	Secure accommodation *	North West	1 week	Family objected because accommodation was being shared with young people who had committed serious offences
August 2013	Secure accommodation *	Essex	3 months	Care plan sanctioned by Family Court to move to open residential unit
November 2013	Open residential unit	West Sussex	2 days	Went missing

* All secure episodes are under Section 25 Children Act 1989

Efforts made to safeguard Child R and promote his wellbeing

1.30. In order to concentrate on current and recent practice, the Serious Case Review did not consider in detail the provision that was made for Child R and other family members before 2011.

1.31. Child R's mother and a number of professionals believe that the involvement of a number of early help services made before 2011 was not well coordinated. A number of professionals have also said that they believe that Child R should have become looked after (possibly through an application for a Care Order) much sooner.

1.32. Throughout the period under review Child R received a very high level of input from the local authority social care and early intervention service, substance misuse services, youth offending services and mental health services and funding of a number of costly residential placements.

1.33. Staff in all agencies were strongly committed to doing the best they could for Child R. Managers across the agencies involved tried very hard to coordinate the provision made and respond to the difficulties faced by staff. The level of resources and effort applied to the work have made it extremely difficult for the professionals involved to come to terms with the fact that Child R died in exactly the way that many feared and predicted he might, having run away and taken a drug overdose.

1.34. Child R was – for reasons that all of the professionals involved appreciated but no one was able to fully understand – a young person who repeatedly put himself at risk. Whilst his longstanding pattern of behaviour meant that his death was always a very real possibility, it is far more difficult to determine whether it could have been prevented. The review has identified shortcomings and gaps in services, as well as very diligent work. However it is not possible to identify specific points where a different course of action would have guaranteed a different outcome.

1.35. The Serious Case Review has recognised that there are important lessons that can be drawn from the review of professional involvement with Child R and his family. In the main these are complex problems that professionals working in many local authority areas find equally challenging. They are not necessarily amenable to easy solutions.

Wider lessons about work with very troubled adolescents

Work with the most troubled adolescents

1.36. The efforts of professionals to work with Child R and his family highlight difficulties often encountered by professionals working with very troubled adolescents. This review has found it very useful to draw on the findings of the recently published summary of research findings by the Association of Directors of Children's Services (ADCS).[3]

1.37. Child R was at risk due to involvement in gang activity, substance misuse, mental health problems and parental neglect. Adolescence is a time of rapid personal and social change so it is not unusual for young people to experience risks arising from a number of sources and to take risks.

1.38. The multi-faceted nature of his difficulties meant that a large number of services became involved, each offering different interventions, focused on specific objectives linked to the mitigation of a particular risk. Although meetings were held there is little evidence of effective coordination of activities with Child R when he was receiving early help services (prior to 2011). Later all of the children in his family were made the subject of a child protection plan and regular core group meetings were held, but at this point the focus of a lot of the activity was on the younger children. During the period covered by the review there were numerous meetings to coordinate activities, but they were almost always convened to deal with a crisis. Sometimes key professionals were not involved.

1.39. The ADCS research highlights how in cases with such a high level of complexity professionals often miss opportunities to work as a team, especially when they offer different definitions of the problem or view a different problem as being the most important or underpinning one. Work with very difficult young people inevitably generates anxiety and conflict which needs to be managed, both within agencies and across the professional network.

Young people in care who are placed at a distance from their homes

1.40. Lack of funding never constrained the provision made by the local authority for Child R. Between October 2011 and November 2013 spending on residential placements for Child R's care amounted to some £380,000 (equating to approximately £4,000 per week for the period when he was in residential care). It is not unusual for an authority to spend a large amount of money on very troubled adolescents because the option of not intervening or making an

[3] Elly Hanson and Dez Holmes, (2014) That difficult age: developing a more effective response to risks in adolescence; Association of Directors of Children's Services / Research in Practice. Further references to research in this part of the report are to this document

intervention that allows for greater immediate risk is seen as being unacceptable. However it is extremely difficult to make an effective intervention if a child is moved repeatedly or placed far from family and community. Consequently such placements often achieve very poor outcomes.

1.41. Everyone involved with Child R would have preferred, if it had been possible, to spend this money (or a smaller amount) on earlier and better coordinated help, or if it was necessary, fostering and residential placements that were much nearer to Child R's own community and able to work more closely with his family and local services.

1.42. There are substantial additional risks associated with the placement of children at a distance from their home area:

- Social workers and other professionals from the home authority are required to work with networks of professionals and services that they do not know
- It is more difficult to plan, coordinate provision and respond quickly to developments and emergencies
- Information sharing and service planning become more complex, particularly if records (such as GP records) move slowly between professionals in different areas
- Commissioning arrangements can be hard for social workers to understand and vary between different services and different localities.
- Professionals from the home authority are likely to have less contact with the young person because of the additional time that it takes to make visits and to liaise with other professionals.

Specific findings on service provision

<u>Shortcomings in health and education services for looked after children</u>

1.43. During the period under review there were significant shortcomings in Harrow's looked after children's health service and in the provision for education of looked after children. Neither offered an adequate response to Child R, who had complex needs, moved placement on several occasions and spent much of his time in care living at a distance from Harrow. A well-functioning service might have made a significant difference in coordinating the complex health provision (from mental health services, GP and substance misuse services) that Child R received. The health services for looked after children in Harrow have failed to meet adequate standards since at least 2012, but weaknesses identified by external inspections have not been rectified.

1.44. Until 2014 concerning personnel and operational difficulties had affected the Harrow Virtual School (which is responsible for coordinating educational provision for looked after children) for a

considerable period. The evidence is that it has now been placed on a firmer footing.

1.45. These services constitute only a tiny fraction of overall children's health and education provision, but for important groups of the most vulnerable children they are critical. There is a need for senior leaders in all local agencies to reflect on these shortcomings in a constructive, collaborative way and rectify them.

Mental health and substance misuse services

1.46. In theory there is a well-coordinated network of substance misuse services for young people in different parts of the country. In practice Child R received variable standards of provision because different services are commissioned in different areas to meet local needs. These do not always take account of the needs of looked after children placed by other local authorities.

1.47. There were radical differences in the diagnosis of mental disorders and the treatment approach between the two main psychiatrists involved with Child R, based on different views on the primacy of substance misuse in his difficulties. One believed that he met the diagnostic criteria for ADHD and required treatment for anxiety and depression which she believed drove his substance misuse. The other decided that – having closely monitored him - Child R did not meet the diagnostic criteria for ADHD or for depression and believed that his problems were rooted in his history of extensive substance misuse which had begun in early adolescence. These differences, which were never discussed or resolved, underpinned very different treatment approaches.

1.48. On three occasions when Child R moved there was no arrangement to provide for continuity of mental health services care. It was left for the new carer or placement to refer him as they thought necessary for his needs to be assessed. This meant that assessments were started from scratch with little or no access to information from previous services. This contributed to differences in the provision made – some of which was focused on the use of medication and some on the use of counselling.

1.49. There is no coherent national child and adolescent mental health system with agreed standards and protocols for transfer of cases which would guarantee (or at least strive to achieve) continuity of service. Handover relies on clinicians (who may have imperfect information and different views) recognising that it would be useful to seek or provide information about the patient.

1.50. The evidence is that working arrangements between staff in Harrow social care and the specialist CAMHS service need to be improved so as to ensure that there is:

- Agreement between the local authority and CAMHS providers on how the services should be working together in relation to looked after children, covering issues such as how CAMHS clinicians are notified of significant changes in children's lives and consulted about important decisions
- Agreement on common expectations as to how professionals should be working when looked after children are placed away from Harrow covering issues such as whether cases remain open to the CAMHS service and for how long, how information is transferred between different areas and
- Effective monitoring and challenge by the Corporate Parenting Board and the LSCB in relation to provision made for the mental health of looked after children.

Young people leaving secure accommodation

1.51. When he left secure accommodation in April 2013 no comprehensive provision was made for Child R's education or mental health. The Serious Case Review findings match the national picture. In 2010 Ofsted found that the level of support provided after discharge did not match the needs of young people, particularly when there had been limited opportunities to plan.

1.52. The Ofsted report made two recommendations to local authorities which the Serious Case Review has recommended should be implemented in Harrow. (See recommendation 4) These were that local authorities should:

- ensure that young people moving out of secure settings have a guaranteed education or training place arranged for them
- ensure that firm discharge plans, based on the assessed need of the individual young person, are in place sufficiently early to enable transitional work with any new placement or facilities.

Children missing or absent from care placements

1.53. A distinction is made between children who leave care placements without authorisation who are judged to be at risk and are defined as being 'missing' and those categorised as 'absent'. If a child is categorised as 'missing' the police will actively seek to find the child and coordinate the actions of other agencies. If categorised as 'absent' the police will alert local police teams of basic details of the child and keep the child's circumstances under periodic review. This poses three challenges:

- ensuring that the risk assessment is informed by all of the relevant information
- making judgements which match the response to the circumstances of the child and are consistent and

- ensuring that all of the professionals involved have a shared understanding of the arrangements so that they know what action will be taken and can challenge judgements.

1.54. When Child R left his placement shortly before his death not all of relevant information about risk to him was shared with the police. Considering carefully all of the material that should have informed the decision making there is a strong case that he should have been classified as being missing, rather than absent.

1.55. It is not possible to draw the conclusion that Child R would have been located before his death if he had been treated as 'missing' sooner, as it is apparent that he was not at an address or in an area that he was known to frequent. It is not possible to say with certainty that he would have come to police notice even if he were being actively sought. There is however important learning about the need to make the best informed risk assessment at the earliest possible point when a child is absent or missing from a care placement.

<u>The quality of local authority early intervention services and targeted social work needed</u>

1.56. The complexity of Child R's case and the range and difficulty of tasks required would have challenged the most experienced, able social worker. However Harrow was only able to allocate his case to an experienced social worker two months before his death. This was a cause for concern both for his family and some other professionals.

1.57. Throughout the period under review, staff and managers very rarely had the time and capacity to reflect calmly on the work with Child R without being subject to the anxiety of having to manage an immediate risk or make a difficult decision. Such 'thinking time' would have been extremely beneficial and might have allowed more reflective consideration of Child R's needs, which in turn is likely to have impacted positively on the work undertaken with Child R and between agencies.

1.58. The pressure to react to events was generated by the behaviour of Child R but exacerbated by the fact that once he became looked after there was no overall re-assessment of his needs. Throughout the case history, assessment activity was triggered by immediate events, or focused on specific aspects of care (the youth offending assessment or ASSET, substance misuse assessments, immediate risk assessments). These narrower, task-focused assessments had their place but they did not provide the basis for planning an effective way to think about how Child R's needs would be best met by agencies collectively in the medium to long term.

1.59. Linked to this, insufficient work was carried out to establish a care plan during the first few months when Child R became looked after. After

this the options as to where he would live and be educated became increasingly narrow and negative and led the local authority to place him in a number of residential placements at some distance from Harrow.

1.60. This underlines the need for there to be a period of intensive and focused activity in the months after a child has become looked after in order to establish a care plan and improve the chances of a child achieving a positive plan for permanency, either within their family network, in substitute care or living independently. This is established professional knowledge, though it is not always easy to achieve.

1.61. Each time the local authority sought a placement for Child R only one potentially suitable residential unit could be identified. As a result he was often placed at a great distance from London. The nature and distribution of residential provision for children is currently largely shaped by market forces leaving a very limited number of placements offering specialist services in and around London. The fact that placements were always made in response to a crisis reduced the likelihood of their success.

Recommendations and action to implement them

1.62. Section 2 of the report sets out the recommendations made by the Serious Case Review on these topics. Harrow LSCB has separately published a response to the findings and recommendations of this review.

2. RECOMMENDATIONS

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
Care planning for looked after children				
1.	4.6	Child R had no plan for permanency by the time of his second LAC review. Research demonstrates the negative impact on long term outcomes of lack of planning in the early weeks and months in care. The local authority needs to identify whether this is a wider problem and if so take action to remedy it. Key factors were: • the quality of LAC reviews and the care plan made for the child; • the implementation of key actions identified at the first review and • the level and quality of social worker's involvement in the case	A very high proportion of children who become looked after will have a plan for permanency or return to the safe care of their family network by the time of the second LAC review. Those who don't will be the subject of senior management scrutiny	The local authority should review the effectiveness of its work with children to the point of the second LAC review (four months after a child is looked after) in order to maximise the proportion of children who become looked after who have a plan for permanency by the time of the second LAC review
2.	4.6	Looked after children living at some distance from the local authority area (and therefore unable to access local services) are more likely to achieve poor outcomes because of the difficulty of obtaining and coordinating provision and responding effectively to concerning developments	The local authority and partner agencies will monitor the outcomes achieved by looked after children living at some distance from the local authority area and achieve continual improvements in services and outcomes for	Harrow LSCB should seek assurance from the local authority and other member agencies about the quality of provision and outcomes achieved by children and young people placed at a distance from Harrow, paying particular attention to: • the effectiveness of the local authority sufficiency strategy in reducing the

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
			this group.	number of children placed out of the area • the extent to which specialist services are available • the sufficiency of education and health resources • the risks to children missing from care • effective information sharing between Harrow agencies and partners in other local authority areas
3.	4.6	Once Child R became looked after there was no overall reassessment of his needs because this was not required by local procedures, although the Children Act guidance requires an up to date core assessment when a child who has not previously had an assessment becomes looked after.	The local authority will coordinate a full single assessment of needs of looked after children when professional judgement is that it will assist in achieving good outcomes, such as when a child becomes looked after and there is no recent comprehensive assessment of their individual needs.	The local authority should ensure that the greater professional discretion available following the introduction of single assessment is used to enable comprehensive assessments of the needs of looked after children when this will be of benefit
4.	4.6	There were gaps in service planning for Child R when he left secure accommodation in April 2013. Ofsted thematic inspection has identified the vulnerability of children leaving secure accommodation	Every Harrow child leaving secure accommodation (either in the secure estate or welfare secure provision) will have a comprehensive plan and arrangements will be in place to ensure transition to	The local authority and the YOT should ensure that • young people moving out of secure settings have a guaranteed education or training place • discharge plans, based on the assessed need of the individual young person,

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
			the next placement	are in place sufficiently early to enable transitional work with any new placement or facilities, or with the family
Health of looked after children				
5.	4.1	There have been long-standing shortcomings in the provision and coordination of health services for looked after children in Harrow. Those placed away from the borough are particularly vulnerable to poor information sharing and provision	The quality of health services for children who are looked after by Harrow will match best national standards. Specific arrangements will be made to meet the needs of those who live at some distance from Harrow	The local authority and Harrow Clinical Commissioning Group should ensure that all looked after children have access to timely, comprehensive health assessments leading to quality assured health care. Commissioners of services should ensure that monitoring arrangements are robust enough to ensure that if standards fall below the expected level rapid remedial action is taken by all parties.
6.	4.1	Health issues were regularly addressed in Child R's LAC reviews but the reviews had no effective means of ensuring progress. Health agencies and professionals were not represented at LAC reviews, although some health professionals were playing a key role in Child R's life	LAC reviews are attended by health professionals (including CAMHS) when it is the right thing to do for the child and the meetings will be more effective in accessing health provision for looked after children	The local authority should review the way in which health matters are addressed and health professionals are involved in LAC reviews, taking advantage of the greater professional discretion now available.
7.	4.1	Child R's GP records were not transferred consistently or in a timely fashion. This led to fragmentation of records which impaired the quality and safety of the	When a looked after child moves to a placement out of the area there will be timely transfer of key information	The local authority, health commissioners and health providers (including Harrow GPs) should collaborate to devise a safe and effective local system for the transfer

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
		service provided for him in different localities. Pending any national improvement in arrangements the local authority and local health providers need to develop a practical local solution that meets the needs of vulnerable children	from health records to clinicians (including the GP) in the area to which the child has moved	of key health information about looked after children and other vulnerable groups of children
Education of looked after children				
8.	4.2	The Virtual School service for looked after children did not function effectively for most of the period under review	Harrow's looked after children, including those who are placed at a distance from the local authority, will benefit from a high quality service from the Virtual School	Harrow LSCB should provide regular monitoring and challenge to the local authority in relation to the functioning of the Virtual School and the outcomes achieved by all Harrow's school-aged looked after children
LSCB scrutiny of services				
9.	4.1 and 4.2	Neither the LSCB nor the Corporate Parenting Panel has been effective in monitoring or challenging the poor provision being made in relation to the health and education of looked after children.	Bodies with oversight and governance roles will work together effectively to hold the local authority and other agencies to account for the quality of provision for looked after children. This should include provision for health (including mental health); education and outcomes in relation to youth offending.	Harrow LSCB should clarify governance arrangements in relation to the monitoring of services for looked after children so that 1) the roles of the LSCB, the Corporate Parenting Panel and the Health and Wellbeing Board are clear 2) monitoring and challenge in relation to provision for health (including mental health); education and youth offending is effective.

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
Youth Justice services				
10.	5.3	Youth justice provision for Child R was sometimes poorly coordinated when he was placed at a distance from Harrow	Youth justice provision for children placed at a distance from Harrow will comply with national YJB standards and be well coordinated	Harrow YOT should provide the LSCB with assurance about the quality of provision made for looked after young people who are placed at a distance from Harrow in order to ensure that it is as effective as possible and complies with national standards
11.	3.1 and 5.3	Child R became affiliated to a gang in Harrow at an early age, but the response to this by agencies was limited and not well coordinated	The local authority and its partners will offer an effective response to the needs of younger people, including those of primary school age who are at risk of becoming involved in gang activity	The LSCB should seek assurance from the local authority and relevant partnership bodies as to the effectiveness of its work in relation to gang affiliation of young people in Harrow, especially primary school aged children and young adolescents.
Partnership working between the local authority, health commissioners and CAMHS				
12.	4.3	The Harrow specialist CAMHS service played an important role in Child R's life. However coordination of work with the local authority social care service and coordination of provision with services in different part of the country was below the standard required to meet his needs	There will be more effective collaboration between the local authority and the specialist CAMHS provider	The local authority and the provider of the local CAMHS service should ensure that there is a clear agreement about the way in which services work together in relation to looked after children, covering issues such as: • attendance of specialist CAMHS at LAC reviews and other meetings • how CAMHS clinicians are notified of significant changes in children's lives

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
				and consulted about important decisions • common expectations as to how professionals should be working when looked after children are placed away from Harrow • whether cases remain open to the CAMHS service and for how long when a child is placed at a distance from Harrow • how information is transferred between different areas when a child is placed at a distance from Harrow
13.	4.3	Referral arrangements for specialist CAMHS services prevented direct referral of children to specialist CAMHS by professionals and agencies other than GPs	Referral arrangements for specialist CAMHS services will meet the needs of the most vulnerable children	Commissioners of specialist CAMHS services should review current referral arrangements so as to enable a wider group of professionals and services to make referrals
Work with minority ethnic groups				
14.	3.3	Agencies did not consistently use interpreters when working with Child R's mother, limiting her participation. There may be a pattern whereby professional thresholds for the use of interpreters have become too high, particularly when dealing with complex matters	Interpreters and translators will be used when service users need this service to deal with complex matters and participate fully in decision making	Harrow LSCB should monitor and challenge the use that member agencies are making of interpreters in safeguarding work and seek assurance that it is appropriate to the needs of those families whose first language is not English

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
15.	3.3	Professionals were not able to explore aspects of Child R's needs arising from his experience in his country of origin	The needs of children who have recently arrived in the UK will be met	Harrow LSCB should agree how in future it will be provided with assurance from member agencies as to the effectiveness of their work with children from minority ethnic groups and families who have recently arrived in the UK
Creating a culture to enable professionals to manage very challenging work				
16.	4.6	Within and between agencies there was often no scope, or an effective mechanism, to contain the level of anxiety that staff experienced and to channel it into a constructive discussion.	Staff will have mechanisms for reflective discussion on cases – both within and between agencies - in order to constructively manage risks associated with complex safeguarding work	Harrow LSCB should seek assurance that all member agencies provide staff with effective mechanisms for reflective discussion on cases in order to constructively manage risks associated with complex safeguarding work, and that such mechanisms exist across agencies and disciplines
Developing a more effective strategy to meet the needs of very troubled adolescents				
17.	3.1	Significant amounts of money were spent on residential and secure accommodation for Child R. There is a growing recognition supported by research evidence that the outcomes from such care for very troubled adolescents are very poor and that there is a need for agencies to consider whether their current range of provision for adolescents is reflects the best current thinking about how to meet	Harrow Council and partner agencies make the most effective use of resources available to assist very troubled adolescents	LSCB should engage member agencies and other bodies such as the Corporate Parenting Panel in a discussion about the most effective sort of provision for very troubled adolescents, taking account of recent discussion documents published by the Association of Directors of Children's Services.

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
		the needs of very troubled adolescents. Consideration of the balance between resources committed to early help as opposed to residential care and other forms of care and consideration of the need for care placements near the home authority should form part of that discussion		
Responses to children who are absent or go missing				
18.	4.5	The vulnerability assessment made by Sussex Police did not fully reflect Child R's circumstances and the nature of risks for two reasons: 1. Not all the information that was known to the children's home was shared with the police 2. Sussex Police risk assessment checklist identified risk factors but was insufficiently sensitive in differentiating the level of risk	Risk assessment of children who leave care placements without authorisation will properly reflect their needs	Sussex Police should review its risk assessment framework for missing and absent children to ensure that call handlers are able to obtain information about the severity of risk factors and are not limited to a checklist
19.	4.5	Research indicates that there is significant variation in the effectiveness of placements in responding to incidents in which young people go missing of placements for looked after children	Pre-placement discussions and placement agreements for looked after children will set specific expectations as to the action that will be taken by a placement if the child leaves it without	The local authority's commissioning service should ensure that all placements considered for looked after children will deal effectively with children who abscond, including having an understanding of the distinction between reporting a child as 'absent' and 'missing'.

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
			authorisation	
20.	4.5	Harrow's Emergency Duty Team (EDT) was not informed about Child R going missing on the final occasion due to a computer system malfunction. It is not possible to be certain how actively the EDT becomes engaged in responding to children who are reported missing or absent	The local authority EDT will play an active role in relation to children who abscond from a care placement or are missing from home and challenge the police categorisation of the episode if necessary.	The local authority should review the current practice of services working out of hours in relation to children reported missing and absent so as to ensure that there is an effective response to risk and vulnerability
21.	4.5	Once Child R went missing further delay occurred because Harrow social care could not provide the police with a recent photograph. Members of the looked after children social work service told the Serious Case Review that this was a long-standing issue that had not been resolved because of technical difficulties and concerns about data protection and the security of photographs being held and transferred	The local authority will act as a good parent to children who are looked after who go missing i.e. the looked after service and EDT can immediately provide the police with all relevant details (including photographs and details of associates, and addresses frequented by the child) when a child leaves a placement without authorisation	The local authority should ensure that systems are in place that allow full details of every looked after child (including a recent photograph) to be made available to the police in the event that the child goes missing
22.	4.5	Harrow LSCB has an extremely comprehensive protocol and guidance document on children who are missing. However there is no evidence that it was ever referred to or used in relation to Child R. The document had been	All staff who work with vulnerable children in Harrow will have a good understanding of their responsibilities in relation to children who are missing	Harrow LSCB should establish how widely disseminated and understood its June 2013 policy and protocol on children who go missing is and take whatever steps are necessary to ensure that the document is now properly understood by key groups of

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
		published in July 2013 and senior managers say that at the time of Child R's disappearance work was still underway to ensure that all relevant staff knew about it and were able to understand and implement it.		staff and is being implemented.
Management of allegations in a child centred way				
23.	5.3	Two incidents arose in a residential care placement (an allegation of physical assault against a member of staff and a sexual allegation against Child R) which took a considerable time to resolve and where the evidence is that the impact on the young person concerned were not fully considered.	When allegations involving young people and professionals arise (including allegations against the young person) the focus will always include the needs of the young person and procedural issues will be addressed in a way that is consistent with the best interests of children.	Harrow LSCB should confirm that training programmes for those who undertake investigations into allegations against staff stress the need for the conduct and management of the investigation to be consistent with the needs of the young person / people involved. This should be included in the training for the Local Authority Designated Officer (LADO), police officers, social worker managers, reviewing officers and staff in HR departments.
Collaborative working between local authority services				
24.	4.6	Differences in working methods and organisational and professional culture between the local authority's early intervention service (EIS) and targeted services contributed to tension between services and impaired the effectiveness of work with Child R and his family	The EIS and Targeted Services of the local authority will collaborate effectively, drawing on the respective skills and knowledge of both services, so that the local authority as a whole can optimise its contribution for	The local authority should review working arrangements between EIS and Targeted Services, drawing on the respective skills and knowledge of staff in both services, so as to optimise the contribution that council services as a whole make for vulnerable children

	Section in the report	Learning	Required outcome	Recommendation for member agency or LSCB
			vulnerable children.	
Transfer of GP records				
25.	4.1	In common with a number of Serious Case Reviews, this review established that the system for transfer of patient records between GPs served a vulnerable patient very poorly. The evidence is that this is a recurring issue that should be addressed at the national level in the NHS, as well as through the development of a local protocol	Key information from medical records (particularly those of vulnerable patients) will be transferred between GP surgeries in a timely and accurate way so as to enable continuity of care and risk management.	Harrow LSCB should bring this issue to the attention of NHS England and ask it to provide a mechanism for the safe and timely transfer of key information from patient records between GPs which meets the needs of vulnerable patients including children who are at risk of in care
Discharge arrangements				
26.	4.4	Child R was discharged from his final secure placement on a Friday. Experience in other services – particularly substance misuse – is that this is to be avoided in the grounds that it is more difficult to put packages of care in place and respond effectively to likely stresses in placements and treatment plans	Agencies making discharge and treatment arrangements – including Cafcass, magistrates, local authorities and health trusts - will reflect more carefully on when they are arranged.	Harrow LSCB will ask agencies to consider more carefully when during the course of the working week vulnerable service users are discharged or subject to significant changes in treatment plans.

3. THE CONTEXT

The circumstances of every child and family have distinctive features. However the review of services for Child R highlights three frequently recurring patterns in service provision:

- Difficulties in managing risk and personal choices when working with very troubled adolescents
- Additional difficulties which arise in working with children who have spent a significant part of their childhood outside of the UK
- Risks and challenges associated with the placement of looked after children at a distance from their home authority area.

These are described briefly in the following paragraphs in order to place the work with Child R and his family in a wider context. Describing these recurring difficulties does not diminish the responsibility of professionals to address them, but it helps explain why this can be so difficult to do.

3.1. The difficulties of managing risk and personal choice when working with very troubled adolescents

3.1.1. The evaluation of services provided for Child R illustrates very well many of the difficulties faced by professionals in working with very troubled adolescents. The vulnerability of older adolescents has been identified through the number and nature of Serious Case Reviews triggered by the young people's deaths, sexual exploitation and other forms of serious harm.[4] Wider research has highlighted a number of specific difficulties that face professionals in understanding and working with adolescents who are at a high level of risk. [5]

<u>The nature of adolescent behaviour</u>

3.1.2. Risk taking is part of normal adolescence, but professionals often find it difficult to judge the extent to which it stems from choices freely made and developmentally healthy or is the product of negative earlier experience and exposure to abusive behaviour by adults or other young people. Professionals have been strongly criticised when they are found to have underestimated the vulnerability of adolescents or viewed abusive experiences as a

[4] Ofsted, Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011;

[5] Elly Hanson and Dez Holmes, (2014) *That difficult age: developing a more effective response to risks in adolescence*; Association of Directors of Children's Services / Research in Practice.

result of personal choices.[6] This may have sometimes made professionals risk-averse.

3.1.3. As adolescents have a considerable degree of personal and social autonomy (reflected in a very complex framework of legal rights and responsibilities). It can be difficult to engage them in interventions, sometimes leaving them to experience harm without adequate help or being offered help that is too heavy handed or comes too late.

Complexity of problems and solutions

3.1.4. Child R was at risk due to involvement in gang activity, substance misuse, mental health problems and parental neglect. Adolescence is a time of rapid personal and social change when young people often experience risks arising from a number of sources at the same time.

3.1.5. The multi-faceted nature of his difficulties meant that a large number of services became involved with Child R, each offering different interventions, focused on specific objectives linked to the mitigation of a particular risk. Although there were meetings held, there is little evidence of effective coordination of activities with Child R when he was receiving early help services (prior to 2010). Later all of the children in his family were made the subject of a child protection plan and there were regular core group meetings, but at this point a lot of the focus of activity was on the younger children. During the period covered by the review there were numerous meetings to coordinate activities, but they were almost always convened to deal with a crisis and sometimes key professionals were not involved (such as the CAMHS service).

3.1.6. Research highlights how in cases with such a high level of complexity professionals often miss opportunities to work as a team and this is fertile territory for conflict between professionals involved, especially when they offer different definitions of the problem or view a different problem as being the most important or underpinning one.

Reliance on resources which have poor outcomes

3.1.7. Many authorities spend a large amount of money on very troubled adolescents because the option of not intervening or making an intervention that does not actively address immediate risks is seen as being unacceptable.

[6] For example, Alexis Jay (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997 – 2013*, Rotherham Council

3.1.8. Lack of funding never constrained the provision made by the local authority for Child R. Between October 2011 and November 2013 spending on residential placements for Child R's care amounted to some £380,000 (equating to approximately £4,000 per week for the period when he was in residential care).[7]

3.1.9. It is extremely difficult to make effective interventions if a child is moved repeatedly or placed far from family and community. Everyone involved with Child R would have preferred, if it had been possible, to spend this money (or a smaller amount) on earlier and better coordinated help, or if it was necessary, fostering and residential placements that were much nearer to Child R's own community and able to work more closely with his family and local services.

3.1.10. This concern to make more effective use of resources is reflected in the thinking set out in recent policy statements such as those made by the Association of Directors of Children's Services, noting that the outcomes achieved by (for example) residential care homes located far from the home authority are not good, so poor in fact that '*a significant amount of residential care would be decommissioned if it were judged more carefully on outcomes*'. [8]

3.1.11. Successful interventions with troubled young people are characterised by

- Building relationships based on a degree of trust
- Re-establishing authoritative (firm but fair) parenting which is able to respect the need for
- Interventions that 'go with the grain' that is seek to channel positive aspects of adolescent values, interests and aspirations.

3.1.12. It is very difficult to balance management and control of risk, some of which stems from adolescent behaviour and choice, with an approach which respects and builds on aspirations. It is very difficult to sustain such interventions in the face of risky behaviour for which the professionals will to some degree feel that they will be held to account if a young person is seriously harmed or harms others.

3.1.13. The Association of Directors of Children's Services has recently begun to promote a series of principles which should underpin the

[7] Overwhelmingly this represents the cost of residential placements. A very small amount of money was spent on commissioned family and individual support services during mid-2013 when he lived at home. The figure takes no account of the ordinary staffing and other organisational costs for provision made by health, education, social care, youth offending and substance misuse services.

[8] Elly Hanson and Dez Holmes, (2014) *That difficult age: developing a more effective response to risks in adolescence*

provision of services for difficult adolescents. See Appendix 7. The Serious Case Review has recommended that Harrow's Local Safeguarding Children Board initiates a debate about how these can be adopted in Harrow and staff can be offered the support necessary to implement them. (See recommendation 17)

3.2. Working with children who have spent part of their childhood outside of the UK

Lack of knowledge of Child R's early years and background

3.2.1. Child R moved to the UK at the age of nine. Records and interviews show that professionals working with him had almost no useful knowledge of his family background, events that had occurred before he came to live in the UK or of his family's life as part of the wider community.

3.2.2. Much of his observed behaviour was disorganised and chaotic, which some professionals believed must be suggestive of difficult early experiences. However professionals were unable to obtain anything more than minimal information about Child R's early life, health and development, or wider events in the family. The little knowledge that was held about the family background was not universally shared between the professionals involved. This would have happened if there had been an updated, comprehensive assessment of Child R's needs (see Section 4.6).

3.2.3. When he came to the UK, Child R very quickly became drawn into gang activity. It remained unclear to professionals how this happened and whether it related to his family circumstances, current or past. Gang affiliation may have offered Child R a degree of friendship and social connection but it soon became a source of threats of violence, fear of the police and very considerable anxiety to him. It led Child R to put himself at considerable risk. It would be very useful to develop a better understanding about whether the pressures on families that have recently migrated to the UK make young people who do not have strong peer and community networks more vulnerable to pressures of gang affiliation.[9]

[9] A recent SCR report describes a young person who, though he was from a different cultural and ethnic background come to the UK at a similar stage in his development and had very similar negative experiences. Agencies were also able to obtain very little information about his background or offer effective help. See Brent LSCB (2013) Serious Case review in relation to Child H.
http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=668B77D0-5C93-4CF4-B93E-E3054D80EBD1&LabelText=Brent&SearchTerm0=%7E%5B%40BRENT%5D%7E&SearchPrecision=20&SortOrder=Y1&Offset=3&Direction=%2E&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

3.2.4. Child R's mother was very reticent about discussing any of these topics. She admitted giving deliberately misleading information about family relationships because she did not trust professionals and she believed that telling the truth would lead to the family losing welfare benefits. She told the SCR that members of her extended family and the wider community strongly advised her not to trust professionals but that she now regretted not trusting some professionals sooner.

3.2.5. Cultural differences may have shaped the mother's understanding of systems and arrangements in the UK, to the disadvantage of Child R. It is clear for example that, despite having a solicitor from her country of origin representing her in the care proceedings and her child's age, Child R's mother wrongly understood the making of a Care Order as entailing a complete transfer of parental rights and duties to the state.

3.2.6. In October 2011, when Child R became looked after and when care proceedings were initiated, the local authority had a responsibility, to find out much more about Child R's early years and background. In particular efforts could have been made to consider whether there were extended family members in his country of origin who could have looked after him (as they had done before he came to the UK). These could have been linked to the completion of a fuller assessment of his needs, which is discussed further in section 4.6 below.

Wider learning

3.2.7. There has been some recent attention focused on the difficulty of working with families that have recently migrated to the UK where information about past history is not readily available, including lessons from other Serious Case Reviews.[10] This offers useful basic guidance, leaving professionals to deal with the complexity of individual circumstances and to develop services that meet local needs.

3.2.8. Given the successive waves of migration to the UK of families with children since the 1950s, there should within agencies be a strong collective understanding of the way in which services need to respond to the changing ethnic and religious make up of communities. This means engaging families and not missing

[10] Department for Education (2014) *Working with foreign authorities: child protection cases and care orders: Departmental advice for local authorities, social workers, service managers and children's services lawyers*. NSPCC (2014) *First generation immigrants, asylum seekers and refugees: learning from case reviews* http://www.nspcc.org.uk/globalassets/documents/information-service/case-reviews-immigrants-asylum-seekers-refugees.pdf

important aspects of need. It also means not offering insensitive services that led to the over-representation of children from minority ethnic groups on child protection plans or looked after by the local authority. The findings of the Serious Case Review offer Harrow's LSCB an opportunity to consider how effectively agencies are meeting the needs of children from minority ethnic groups and families who have recently arrived in the UK and the review has made a recommendation in relation to this. (See recommendation 15)

Use of interpreters and translators

3.2.9. Child R's mother would not have been able to contribute fully to the Serious Case Review without the involvement of an interpreter and translation of letters. Agency records show that she very often attended meetings without the assistance of an interpreter and that the approach taken by agencies to this was inconsistent. Bearing in mind her account that her use of English has improved considerably over the past four years, it is very likely that at key points she could not have understood or have and participated fully in meetings and discussions.

3.2.10. There is a concern that in all agencies and services professional thresholds for the use of interpreters may have become too high, limiting the participation of some families in discussion of complex matters. It is beyond the scope of the review to investigate this more widely, however it is an area that Harrow LSCB and its member agencies should discuss and monitor in future. The review has made a recommendation in relation to this. (See recommendation 14)

3.3. Risks and challenges associated with the placement of looked after children at a distance from their home authority area

3.3.1. Child R was looked after for 24 months. He spent 13 months in placements at a substantial distance from Harrow. The secure placements were successful in protecting Child R from immediate harm, but created their own difficulties for the young person, family and for professionals, particularly at the point when he had to leave them. The use of secure accommodation is discussed in more detail in Section 4.4.

3.3.2. The open residential placements were not successful. In each of them there were – sometimes after a honeymoon period when Child R seemed more settled – difficulties with his behaviour towards staff, absconding, heightened mental health difficulties and substance misuse, including associated risks of offending. With

one exception (which lasted 4½ months) they all broke down before any effective work could be done.

3.3.3. Research, the findings of Serious Case Reviews and thematic inspections have highlighted the additional difficulties that arise for local authorities and other agencies when young people in care are placed outside the local authority area, particularly if the placement is at some distance, and the poor outcomes that many such young people experience.[11]

3.3.4. Typically provision may suffer for a number of reasons:

- Information sharing and service planning become more complex, particularly if records move slowly between professionals in different areas
- Social workers and other professionals from the home authority are required to work with networks of professionals and services that they do not know
- It is more difficult to plan, coordinate provision and respond quickly to developments and emergencies
- Commissioning arrangements can be hard for social workers to understand and vary between different services and different localities. Sometimes the rate of organisational change and re-commissioning of services means that even local staff struggle to know how to obtain a service
- Professionals from the home authority may have less contact with the young person because of the additional time that it takes to make visits and to liaise with other professionals
- In many cases the level of social work contact defaults to visits at the statutory minimum level, i.e. every six weeks, and may not be in keeping with the needs of the young person.

3.3.5. These sorts of difficulties and the poor outcomes experienced by some young people led the Parliamentary Under-Secretary of State at the Department for Education to conclude that a negligent '*out of sight, out of mind'* culture had developed among local authority staff. [12] There is absolutely no evidence that this applied in relation to Child R. While there is a case that some mistakes were made there is no doubt that staff in all the agencies that dealt with Child R were very mindful of him and tried very hard to promote his welfare and keep him safe.

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[11] HMI Probation, Ofsted and Estyn (2012), *Looked After Children: An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home.* Ofsted (2014) *From a distance: looked after children living away from their home area*

[12] Edward Timpson, *Daily Telegraph*, 24 April 2013; www.telegraph.co.uk/news/politics/conservative/10013169/Time-for-radical-changes-to-our-shameful-system-of-child-protection.html .

3.3.6. Rather than offer a broad condemnation of professionals it is much more useful to examine in detail how the placement of Child R at a distance from Harrow adversely affected the services he received so that agencies required to work with other children can respond better in future. The following sections of the report deal with health services (including mental health services) and education. Often the difficulties caused by placing a child at a distance from Harrow highlighted existing weaknesses in services.

3.3.7. Harrow Council usually has in the region of 170 looked after children, or which typically about half are placed outside of the local authority area.[13] The majority of these are placed in neighbouring authority areas leaving 18-20% (some 30 children) living more than 20 miles from Harrow.[14] Some will be in established permanent placements where services are well coordinated and others (such as those awaiting adoption) will not be in local authority care in the long term. However a percentage of these children will be in less stable placements where the coordination of a range of complex services is key to achieving a good outcome for the child.

3.3.8. There has been considerable national discussion about how to address this problem.[15] Staff from Harrow's commissioning services participate in regional initiatives but the Serious Case Review has been told that neither regional nor national initiatives have produced positive results. Recent research by the National Audit Office for the Department for Education has confirmed that at a national level '*there has been no improvement in getting children into the right placement first time and close to home'* as the overall numbers of children placed more than 20 miles from their home '*have not improved in the last four years'*.[16]

3.3.9. The 2012 Ofsted thematic inspection report confirmed the important role that LSCBs should play in monitoring and challenging agencies in relation to outcomes for this group of children and young people. It recommended that each LSCB should monitor the performance of the local authority and partners in

[13] Children looked after at 31 March by placement in or out of local authority's area at 31 March by Local Authority (Table LAA9)

[14] Figures provided by Harrow Council to the SCR and to the local authority's Corporate Parenting Panel

[15] See for example *Report of the Expert Group on the Quality of children's homes, presented to DfE Ministers – December 2012,* http://webarchive.nationalarchives.gov.uk/20131027134109/http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a00224323/quality-child-homes-report

[16] Report by the Comptroller and Auditor General - Children in care, HC 787 session 2014-15 27 November 2014 Department for Education (page 9). Local authorities are required to report on children placed more than 20 miles from their home so this is the only national indicator available.

meeting the needs of all looked after children living in and out of the local authority area, paying particular attention to:

- the extent to which specialist services are available
- the sufficiency of education and health resources
- the risks to children missing from care
- the effectiveness of the local authority sufficiency strategy in reducing the number of children placed out of the area.

3.3.10. There is no need to add to this recommendation, and Harrow LSCB should implement it. (See Recommendation 2)

4. KEY FINDINGS FOR HARROW LSCB AND MEMBER AGENCIES

4.1. Coordination of health provision for looked after children

Introduction

4.1.1. Child R had complex health needs. When he became looked after he had been a patient of the CAMHS service for three years. He had been diagnosed with ADHD and had difficulties sleeping and was prescribed medication for both. He had not been taken to the three most recent CAMHS review appointments. Two months after becoming looked after he was prescribed an anti-depressant. Child R was known to substance misuse services and had taken at least one serious overdose.

4.1.2. It could reasonably have been expected that the local authority, care placements and health providers would collaborate to ensure that professionals had a good overview of his health needs and a coordinated plan as to how different aspects of his health needs should be met. Records and interviews with staff show that this did not happen and that although a number of professionals made efforts to arrange health care, over the course of the next two years the provision made fell substantially short of the level that an ordinary parent would want for their child.

Significant episodes when the coordination of health provision was poor

4.1.3. There is no record that the treating CAMHS clinician, Child R's GP or the looked after health service were notified that he had become looked after until several weeks after the event. At this point the local authority relied on individual social workers remembering to complete notifications when a child became looked after, which were often overlooked. As a result compliance with this requirement was poor.

4.1.4. The notification requesting a looked after health assessment for Child R was sent by the residential unit to the GP seven weeks after he became looked after. An appointment was offered which Child R failed to attend. The GP wrote to the LAC health service nurse with responsibility for coordinating health assessments to say that Child R had missed the appointment, asking if another appointment should be offered and noting from review of the records that the surgery had no immunisation history for Child R.

4.1.5. The LAC nurse told the review that the GP offered the assessment but Child R did not attend and that given his age (nearly 15) she felt that he was making an informed choice. There is no evidence that this thinking was shared with the local authority so that it could consider the implications, or tested with the GP who knew the family. The nurse said she was aware that Child R was receiving CAMHS input, though this would not ensure that other health needs were understood or met. As there are no LAC health service records on Child R it is impossible to

know whether the nurse knew about Child R's substance misuse problems. Given the complexity of Child R's health needs this was clearly not an adequate response.

Significant episodes – prescribing anti-depressant medication and sharing of information about potential side effects

4.1.6. On 4 January 2012 the CAMHS psychiatrist decided to prescribe Child R anti-depressant medication. After he had been taking it for about a week Child R reported physical symptoms to residential staff, who in turn reported them to the psychiatrist. She felt that they might be side effects of the new medication. Two weeks later she saw Child R, determined that he was experiencing what might have been a serious side effect and changed his medication.

4.1.7. The psychiatrist wrote to Child R's GP with a summary of the appointment. However this information has not been found in any of the later GP notes or summaries that were created when Child R moved to different placements.

4.1.8. The psychiatrist said that she was going to write to the residential unit but there is no evidence that she did. She did not communicate with the allocated social worker though she may have believed that the fact that the EIS worker had brought Child R to the appointment obviated the need for that. There is no evidence that anyone in the local authority understood the potential implications of the drug reaction.

4.1.9. This together with the fragmentation of the GP records as Child R moved to different placements meant that clinicians who might have considered prescribing the same medication later during Child R's time in care would not have known that it might have serious side effects.

Subsequent GP records and treatment

4.1.10. In May 2012 Child R was placed away from Harrow. It has been impossible for the Serious Case Review to reconstruct a coherent set of GP records covering the period May 2012 – November 2013 because of the number of moves that Child R experienced and the delay in transferring GP records that is built into the NHS arrangements.[17]

4.1.11. In relation to most of his placements it is possible to trace from residential unit or local authority records that Child R was registered at a GP surgery shortly after moving into a placement. Each GP would

[17] Commonly it can take several weeks and sometimes some months for full GP records to be transferred to the new GP. This will happen more quickly if the GPs are in the same locality and happen to share the same electronic record system. Once the record arrives there may be a further delay while key points are summarised. Summaries tend to highlight major conditions but (based on cases that have been subject to Serious Case Reviews) not social background factors or indicators of risk.

have then created a temporary record and requested the existing records from the previous GP using the normal NHS arrangements. The lack of records in some locations suggests that he did not stay long enough in the placement to register.

4.1.12. It is impossible to be certain how many times different records were transferred and to what extent any GP ever saw a coherent or near-complete record. Given the short time that Child R spent in some placements it is reasonable to conclude that most GPs who saw Child R did so without being able to refer to anything like a full health history. Given the complexity and potential gravity of his problems this is a serious shortcoming. It is clear that for a child such as Child R additional steps are required to ensure the continuity of health care (including GP care) which may be outside the normal NHS arrangements. The review has made a recommendation in relation to this. (See recommendation 7).

4.1.13. It has been previously recognised in Serious Case Reviews that the existing GP record transfer arrangements serve vulnerable children very poorly. The review has therefore repeated a recommendation made previously by SCRs to the national leadership of the NHS in relation to this. (See recommendation 25)

The role of the Looked After Children's Health Service

4.1.14. It has long been recognised that the health needs of looked after children are often poorly met.[18] As a result, each local authority is required to commission a looked after children's (LAC) health service. This is usually done in collaboration with local health commissioners (now Harrow Clinical Commissioning Group but for most of the period under review here Harrow Primary Care Trust and NHS Harrow).

4.1.15. As an absolute minimum the LAC health service should ensure that an assessment of health needs is arranged when a child becomes looked after and that it is reviewed and updated annually. However the 90 pages of statutory guidance envisage a much wider coordination and development of provision.[19]

4.1.16. When a child lives in a stable placement and has relatively straightforward health needs, the GP may be able to coordinate provision. When a child moves repeatedly and has complex health

[18] Beginning with the Quality Protects initiative in November 1998 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH_4004387

[19] Department for Education and Department of Health (2009) *Promoting the health and wellbeing of looked-after children.* https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children First published: Part of:Children's social care, Children's services and Improving the adoption system and services for looked-after children

needs the LAC health service will have a vital role if the sorts of difficulties described in relation to Child R above are to be avoided.

4.1.17. Later, on a number of occasions (and particularly when Child R was in the secure unit in Northumberland) the LAC review recognised that Child R had never had a health assessment and tasked the social worker with arranging an assessment through the local health provision, which the secure unit would have facilitated. This did not happen. At the secure unit in Essex the unit took it on itself to arrange an initial health assessment shortly after Child R's admission (presumably with his consent).

4.1.18. In effect Harrow's LAC health service played no role at all in either providing or coordinating health assessments and no role in sharing information with placements and health providers when Child R moved to placements outside the borough. The responsibility fell entirely to his social workers.

History of the Harrow LAC health service

4.1.19. The lack of input in this individual case is not unexpected as published inspection reports have identified long-standing and very serious concerns about the Harrow LAC health service.

4.1.20. In July 2010 Harrow Council's Corporate Parenting Panel was told that 91 out of 97 looked after children had received a health check in the previous year and that *'each child received an annual health assessment as well as optician appointments and vaccinations when required'*.[20] After the nurse who provided this service was promoted the standard of service deteriorated.

4.1.21. In June 2012 the joint Care Quality Commission and Ofsted inspection report described services to promote the health of Harrow's looked after children as 'inadequate'.[21] At that point there was *'no effective strategic level clinical perspective and practice oversight within the health and social care arrangements*'. The local authority was also at fault because '*the system by which social care notifies the responsible heath agencies of those young people coming into, or leaving, the care system and any changes of placement is not robust'*. Performance on undertaking initial health assessments within the expected 28 day timescale was unsatisfactory but was not being monitored by either health or social care and the quality of assessments and the resulting recommendations for health plans were described as being '*variable and unsatisfactory overall'*.

[20] Harrow's Independent Reviewing Officer Service Annual Report 2008/2009, Minutes of the Corporate Parenting Panel July 2010.

[21] Ofsted (2012) *Inspection of safeguarding and looked after children services: Harrow June 2012*

4.1.22. One of the three priority actions identified in this report in relation to looked after children was that '*the local authority, NHS Harrow, North West London Hospital NHS Trust and Ealing Integrated Care Organisation should ensure that all looked after children have access to timely, comprehensive health assessments leading to quality assured health care'.*[22]

4.1.23. It is therefore of concern that many of these problems persisted in 2013 (when it was identified that there was a backlog of between 60 and 90 health assessments awaiting to be undertaken).[23] The former Director of Children's Services told the Serious Case Review that at that point consideration had been given to commissioning a private contractor to assist in clearing the backlog.

4.1.24. The CQC carried out a further inspection in January 2014.[24] Whilst it identified some improvements the inspection report noted that '*in all cases of looked-after children which we sampled, there were delays in both initial and review health assessments being undertaken*'. Assessments remained of '*highly variable quality'*. Most of the strengths in service identified in the 2014 inspection relate to the role of local health visitors in promoting the health of looked after children aged 0-5.

4.1.25. It is also important to note that (apart from mentioning the needs of asylum seekers) neither of the inspection reports specifically comment on the standards of service provided to looked after children with complex health needs (such as mental health and substance misuse problems) or those such as Child R who are placed outside of the local authority area where problems of service coordination are likely to be greater.

4.1.26. The Serious Case Review has sought to understand why it is that the service has been and remains ineffective. The following contributory factors have been cited:

- Over the last four years the Harrow LAC health service has been catching up from a very low baseline (i.e. for many years it was not adequately commissioned and resourced and lacked proper clinical leadership)
- Over the same period the number of looked after children has increased significantly without any consistent increase in resources

[22] Ibid page 19

[23] The original figure was 90, but audit and closer review suggested that the real figure was closer to 60. These figures are cited in correspondence between the Serious Case Review and the provider health trust which refers to a contract dispute between the health commissioner and provider. The figures are not in dispute

[24] Care Quality Commission (May 2014) *Review of Health services for Children Looked After and Safeguarding in Harrow*

- Historically the nursing and paediatric medical elements of the service were commissioned from different health trusts, making it difficult to provide a coherent service
- At the time of the publication of the Ofsted / CQC inspection of 2012 there remained a considerable lack of capacity
- At one point a key part of the service was based in the local authority leaving health staff with no proper access to health records. The LAC nurse is said to have made paper records on some cases, many of which cannot be found
- From 2012 there were shortcomings in the performance of key staff and periods when staff were absent, leading to critical backlogs
- The local authority system for providing notifications of children who became looked after was unreliable and inefficient because it depended on individual social workers notifying health colleagues when children became looked after with no system in place to check that they had done so
- Duplicate and inaccurate notifications were commonplace
- The local authority's monitoring of its own performance was poor for long periods
- Monitoring of the effectiveness of the service by the provider health trust was poor so that it was only when the local authority and the commissioner identified concerns over the backlog that action was taken
- Health commissioner monitoring of the contract performance was also poor, so that there were delays in challenging backlogs in the service
- There were differences in the understanding of the staff roles in the commissioning arm of the health service and how actively they should manage the problems.

4.1.27. Given the limited resources available to the review it has not been possible independently to verify every aspect of the evidence; but no one has suggested that any of these explanations are not true.

4.1.28. The rapid rate of change in the NHS and the need to make financial savings also had a direct impact. A report from the provider trust describes how …'*management capacity within* (the service) *has significantly reduced over a period of time and therefore the temporary acting* (title of post-holder) *was overburdened with workload pressures and was trying to operationally manage across a multitude of adult and children service lines whilst also implementing large transformation projects'.*

4.1.29. It was notable that the health trust providing the main LAC health assessment service went through several mergers during the period under review and has experienced further substantial organisational

change and merger while the Serious Case Review was being conducted.

4.1.30. In comparison to many local authority areas there has been limited multi-agency planning and coordination of this service. Oversight of services for looked after children in Harrow is the responsibility of the council's Corporate Parenting Panel.[25] Records of meetings show that although the health of looked after children has been discussed by that group since 2010, it was not until July 2012 that representatives of health commissioners attended the meeting to present and discuss detailed reports. As far as can be established, health providers have never attended. There was not until recently a multi-agency, officer-level group on corporate parenting with health representation. In the experience of the reviewers this is unusual and likely to have been counter-productive.

4.1.31. Harrow's Health and Wellbeing Board has been in existence in some form since 2011, though it is only in 2014 that the health needs of looked after children were first discussed.

4.1.32. Perhaps most concerning is the evidence that since the negative external inspection report of 2012 discussions among the commissioners and the provider of the service seem to have focused more on shifting blame for the problem onto the shoulders of others than recognition of shared responsibility and a common interest in providing a good health service for a group of very vulnerable children. This has been evident even in reports and correspondence submitted to the Serious Case Review.

The impact of failings

4.1.33. If the LAC health service had been functioning effectively it might have made the health care for Child R safer and more effective. For a young person with such complex health needs who moves so often, there is a strong case that to make well-coordinated provision someone with a good working knowledge of health services should keep an overview of his health needs and the services that he had accessed, ensuring that when he moved placement, information moved quickly with him so that the clinicians who saw him had access to his health history. This can only be done through developing a close working relationship between the LAC health service, social care staff in the local authority and other health professionals so that expertise in health matters is complemented by up to date information about developments in the child's life and the care plan.

[25] http://www.harrow.gov.uk/www2/ieListMeetings.aspx?CommitteeId=788

4.1.34. Such provision might be needed for a small percentage of the looked after children, whereas others (while still vulnerable) have less complex health needs. The current local protocol envisages the looked after children nurse undertaking this role. It is not clear whether that is feasible. If the problem is one of capacity it must be clear to commissioners that the problems caused by unmet health needs will be substantially more expensive in the long term than any short term saving.

4.1.35. The Serious Case Review has been told that the LAC health service is shortly to be re-commissioned from another provider. This will not in itself solve the problems. Newly commissioned services always take some time to function effectively and often experience teething problems. Delivery of a good service requires proper collaborative working between health staff and the local authority, which is often difficult to develop and sustain. It is particularly difficult in the climate of rapid and unpredictable change in the NHS.

4.1.36. The recommendation made by Ofsted and CQC in 2012 was straightforward and specific but has not so far been implemented. The Serious Case Review has repeated it. (See recommendation 5)

4.1.37. There is no evidence that at any point in this process the LSCB has been effective in monitoring or challenging the poor provision being made in relation to the health of looked after children. In this it is probably no different to most LSCBs. The Serious Case Review has made a recommendation in relation to this. (See recommendation 9)

<u>The role of looked after reviews in monitoring health provision</u>

4.1.38. It is part of the responsibility of the LAC review to monitor the extent to which the care plan is meeting the health needs of the child or young person. At each of the LAC reviews on Child R the Independent Reviewing Officer (IRO) properly made sure that this was placed on the agenda and fully discussed on every occasion. However without the assistance of a health colleague with a good oversight of provision and the capacity to make sure that actions were implemented between meetings, the LAC review could do little more than note gaps in provision or unsuccessful attempts by social workers and others to arrange health services. As a result many of the reviews note the same concerns and identify the same actions

4.1.39. The Serious Case Review will recommend that the local authority reviews the way in which health issues are addressed in LAC reviews, considering carefully how they can be made more effective and linking this arrangement to its commissioned LAC health service. Because there has historically been a concern to ensure that LAC reviews are not too large and attended only by people who know the child well, it has become normal for health professionals not to attend LAC reviews.

In some cases this may have disadvantaged looked after children with complex needs and it is hoped that the local authority will be able to take advantage of the greater professional discretion in relation to the conduct of LAC reviews contained in recent government guidance to adopt a more flexible approach. [26] (See recommendation 6)

4.2. Services to promote the education of looked after children

Overview of provision

4.2.1. Child R had been permanently excluded from mainstream school in 2009 and subsequently attended the Harrow Tuition Centre. From then it became the responsibility of the local authority to make provision for his education. There is no suggestion in any of the records seen of a plan for him to return to mainstream education. In 2011 Child R joined a motor mechanics project but after he became looked after by the local authority his attendance declined and he was often late. In early 2012 he ceased attending altogether.

4.2.2. The profile documents prepared by social care to identify placements for Child R mostly contain only the very limited information set out in the preceding paragraph. The final one (completed in October 2013) contains the details of education attainment levels provided by the secure placement in Essex. Educational needs were never a significant factor in placement searches or choice. Once Child R was placed out of London arrangements for education were always dictated by the approach and facilities available in placements that had been chosen for other reasons.

4.2.3. As a result educational provision varied from one placement to another and records offer no sense of continuity or a long term plan. In Harrow (2011-12) Child R attended a vocational training programme. In North Wales (2012) the residential unit had a school where he worked towards GCSEs, impressing teachers with his intelligence.

4.2.4. Records from the Northumberland secure unit (2012-13) indicate that it provided an adult education curriculum, though there are also references to Child R taking qualifications in Personal and Social Education and Information Technology awarded by ASDAN. [27]

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[26] Department for Education, (October 2014) *Consultation on looked-after children: improving permanence Government response* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365091/Looked-after_children_improving_permanence_consultation_response.pdf

[27] Certificate of Personal Effectiveness (CoPE), is a nationally recognised qualification. It can be studied in Years 10 and 11 or in post-16 education. It aims to develop skills and knowledge in areas such as communication, citizenship and community, beliefs and values, the environment, health and fitness, and independent living, among other things. Level 1 and 2 CoPE are equivalent to a GCSE at grade E/F and B respectively.

4.2.5. Arrangements made for Child R's education during April – June 2013 when he lived with his family in Harrow are considered in more detail below.

4.2.6. In Staffordshire (mid 2013) the curriculum appears to have focused on 'independent living skills', such as budgeting and cooking, with no obvious academic or vocational content. At the Essex secure unit (2013) there was a much more structured educational approach which resulted in assessments being provided for Child R's potential and attainment in a range of academic and vocational subjects.

4.2.7. Documents from Child R's final placement in Sussex indicate that 'after some assessment' he would be following a 'planned independence programme'. This suggests a similar approach to the Staffordshire unit.

Public policy in relation to the education of looked after children

4.2.8. Recognising that the educational needs of looked after children have often been poorly met, local authorities have been encouraged to promote better outcomes through the creation of a dedicated service (often referred to as a virtual school).[28] As an absolute minimum the virtual school is expected to ensure that the child has a PEP setting out educational targets and actions to meet the objectives. The virtual school usually has a 'virtual head', most often an experienced teacher and school leader.

Personal Education Plans

4.2.9. Coherence in the education of each looked after child should be achieved through the development of a Personal Education Plan (PEP) which is reviewed and updated in parallel with the LAC review. The Serious Case Review has found four PEPs for Child R, completed in December 2011; February 2012; December 2012 and September 2013 (though the final one seems not to have been written up before Child R's death). They provide very little information and it is not clear whether they were produced as a result of specific meetings between the local authority social worker and staff providing education to Child R.

Looked after review meetings

4.2.10. The six-monthly LAC reviews offer more information about the specific provision that was being made for Child R's education. The June 2012 review contains a specific reference to Child R needing to take his

[28] https://www.gov.uk/government/publications/promoting-the-achievement-of-looked-after-children This guidance published in 2010 has now been superseded by Department for Education (2014) *Promoting the education of looked after children* https://www.gov.uk/government/publications/promoting-the-education-of-looked-after-children

ADHD medication in order to be able to get the most out of education sessions. Reference is also made to a planned visit by the virtual head to the residential unit in North Wales.

4.2.11. In November 2012 the IRO specifically asked the allocated social worker to liaise closely with the virtual head to ensure that she was satisfied with the educational provision in the secure unit and to ensure that she is involved in identifying appropriate courses that Child R will engage in when he returns to the community. However there is no subsequent evidence that either of these actions was taken.

Role of the virtual school and virtual head teacher

4.2.12. The history of the virtual school in Harrow is complex. Until late 2011 the role of virtual school head was shared by three local head teachers, each focusing on a specific group of schools (primary, secondary and special needs) to seek to promote the education of looked after children.

4.2.13. During 2011 the local authority came to the view that while this arrangement had many advantages, particularly the strong links that the three individuals were able to make with local education services, it would be better to create a dedicated role of a virtual head teacher. This person would be able to provide better leadership to the two staff who made up the virtual school (one dealing with PEPs and one monitoring attendance) and provide better data on the effectiveness of the service in improving the attendance, behaviour and attainment of looked after children.

4.2.14. The local authority then made a part time appointment to the post of virtual school head. Initially this appeared to be a successful development: in May 2012 Ofsted's inspection reported positively on the work of the virtual school (albeit without mention of children placed at a distance outside Harrow) and in July 2012the new head presented a thorough report and development plan to the Corporate Parenting Panel.

4.2.15. Subsequently, the evidence is that the person appointed as virtual head did not function effectively in the post, with little visible activity and periods when she was absent from work. A review of arrangements in March 2013 led to the appointment of two interim heads, who remain in post.

4.2.16. It has been impossible to establish whether – beyond the notes of LAC review meetings referred to above - Child R was referred to the virtual school during his time in care.

4.2.17. The current heads began work in April 2013 and so were not in post when plans were being made to return Child R to Harrow. On coming into post their priority was to work with children living and being

educated in or close to Harrow. They were able to turn their attention to children who were placed some distance away from the borough in Autumn 2013, by which time Child R was in secure accommodation and above school leaving age.

4.2.18. The Serious Case Review has not been able to establish how effective current arrangements are, particularly for children placed at a distance from Harrow. It is clear that the governance arrangements for the virtual school need to be put on a proper basis, including the formation of a proper governing body bringing it into line with arrangements in ordinary schools and offering a comparable degree of scrutiny and support.

Child R's education when he was in the residential unit in London November 2011 – May 2012

4.2.19. Apart from keeping Child R safer than he would have been if he had been living with his family, the most important intended purpose of the residential placement was to enable Child R to maintain his attendance at the mechanics project which – at the point when he became looked after and for some time after – was the only constructive activity in which he engaged. There was disagreement between professionals as to whether Child R could and should travel on his own from the residential unit to the project. Evidence and opinion remain divided on this.

4.2.20. When Child R's attendance started to fail insufficient was done to address the problem. Debate focused on whether it was right or wrong for one particular professional to take Child R to the project and lost sight of the overall significance of making sure that – however it happened – he did continue to attend.

4.2.21. The school attendance service acknowledges that at the time the Pupil Referral Unit made administrative errors in the way Child R's attendance was recorded and coded so that it appeared that he was attending the project when he wasn't. However it is clear that a range of professionals who were involved knew that he was not attending and were slow to recognise that non-attendance significantly increased the risk of substance misuse and offending.

Plans for education when Child R returned to live with his family in Harrow in April 2013

4.2.22. In January 2013 the local authority began to formulate a plan to rehabilitate Child R to live with his mother. Child R moved back to Harrow on 15 April 2013. Prior to this staff from Harrow's education services had not been involved in detailed discussions about the education Child R would receive when he returned to Harrow, except

that it would be arranged through the Pupil Referral Unit or PRU (Harrow Tuition Service). As a result there was no firm plan in place. On his return it was established quickly that it would not be beneficial for Child R to attend the PRU itself because of the potential for conflict with other young people.

4.2.23. Subsequently the tuition service made arrangements for Child R to attend courses at a local college while steps were taken to arrange a motor mechanics course. The college course was not satisfactory as Child R had already covered the curriculum. However there appears to have been no immediate alternative. Efforts to arrange the motor mechanics course failed because the potential provider could only run the programme if there was a sufficiently large number of students.

4.2.24. It had been recognised that if the plan to rehabilitate Child R was to be successful he had to be fully and constructively occupied. The failure to arrange a meaningful programme of education left a significant gap. Providing a good vocational scheme for Child R to join immediately on his return home could have substantially increased the chances of his placement at home succeeding.

4.2.25. Ironically there were several professionals with an education brief involved once Child R returned to Harrow, including a worker from the Harrow Tuition Centre, the local authority officer with responsibility for attendance of looked after children and the Youth Offending Team education worker. Together with the allocated social worker and the EIS worker, all three made efforts to ensure that Child R received some education. However there was no overall coordination of the activity and no clear view as to who should have coordinated it. It is not clear whether this was a task that should have fallen to the allocated social worker and (despite its importance) was not prioritised or whether he believed he could rely on one of the education specialists to undertake it.

4.2.26. The LAC review held on 15 May 2013 attempted to ensure that this was prioritised, however by then it was probably too late for effective action to be taken as Child R's behaviour was deteriorating and the placement with his mother was already under considerable strain.

4.2.27. Child R's educational needs were badly served by Harrow's arrangements throughout the period when he was looked after. Whilst its activity is not obviously one which has a safeguarding focus it is clear from this case history that if the virtual school does not function effectively it can have a significant negative impact on services and outcomes for children. It should therefore in future be monitored and challenged by the LSCB, directly or via the work of another body such as the Corporate Parenting Panel. The review has made a recommendation in relation to this. (See recommendation 8)

4.3. Provision of Child and Adolescent Mental Health Services (CAMHS)

Provision while Child R was looked after and living in Harrow (October 2011 – May 2012)

4.3.1. Child R had been known to the consultant at Harrow CAMHS for three years when he became looked after by the local authority in October 2011. He had been prescribed medication for ADHD and to help regulate his sleep. He had not been taken to his three most recent CAMHS appointments. During his placement in London he was also prescribed an anti-depressant which was later withdrawn because of possible side-effects. It is impossible to be certain how far Child R complied with his ADHD medication. A number of the other professionals involved (including some social workers and managers, staff in some residential units and a psychiatrist in a specialist forensic unit) were ambivalent about the merit of Child R taking medication and uncertain of its effectiveness.

4.3.2. During the period under review, liaison between social worker staff and the CAMHS service was weak. The psychiatrist was not informed about sexual allegations against Child R. The psychiatrist was also not informed about the decision to place Child R outside London or consulted about the type of placement that Child R needed. Although she told later wrote to the CAMHS service North Wales that she was 'worried' that she had heard nothing about Child R for some time, she had not sought information from professionals in Harrow. It is reasonable to expect other professionals to provide updates about significant developments, however all agencies should have systems to track their own patients and expectations about the action required by staff if vulnerable patients have not been in contact.

Provision in North Wales

4.3.3. Child R lived in North Wales between June and October 2012. Two parallel processes were put in place to offer mental health support. In August a therapeutic counselling service commissioned by the residential unit on behalf of Harrow began a six week assessment. The therapists concerned attended a number of meetings about Child R. The assessment appointments were followed by sessions which came to an end because Child R's behaviour deteriorated and his placement ended.

4.3.4. In August 2012 Child R's GP in North Wales referred to the local CAMHS service by his GP for monitoring of his medication. He missed the two appointments offered.

4.3.5. In mid-September a meeting of professionals in Harrow agreed to make a further referral and it was agreed that the Harrow social worker would contact Harrow CAMHS and inform them of Child R's placement and liaise with Harrow health commissioners to clarify funding arrangements for his health care in North Wales. The meeting agreed that the local CAMHS service would see Child R for assessment and then can agree a package of care with the Harrow commissioners.

4.3.6. It is significant that this discussion was only taking place four months into the placement, rather than at the beginning. It is notable that the social worker appears not to have understood how a CAMHS service should be commissioned without the benefit of a lengthy explanation being provided by the service in Wales, attending a meeting and then discussing it with commissioners in Harrow.

4.3.7. The local authority may have believed that the sort of therapeutic assessment and support that Child R needed was part of the package that had been commissioned from the residential placement. At the June 2012 LAC review it was noted that '… *this placement was chosen specifically in order to provide a therapeutic environment for Child R to explore issues that may have led to criminality and substance misuse issues'.* The residential unit manager explained that '*support could come via CAMHS or external sources and may need to be bought in by the local authority. This issue has been highlighted to managers in Harrow with a request the awaited assessment is discussed as soon as it becomes available.'* There appears to have been at the least a mis-match of expectations which should have been clear at the point of commissioning and placement.

4.3.8. In October 2012 Child R saw a local psychiatrist for a primary mental health assessment. This identified historic risks of self-harm (cutting) and drug use but did not find that Child R had a low mood or current risk of suicide. It was noted that medication reviews were needed and a professionals meeting was proposed with a view to completing a secondary care assessment and Child R being allocated a care coordinator under the Welsh mental health service arrangements. This did not happen before Child R was moved to secure accommodation.

4.3.9. Prior to this Child R was assessed urgently in hospital after absconding and taking an overdose. The concerning assessment supported his transfer to secure accommodation. CAMHS staff worked closely with the local authority social worker during this episode. The psychiatrist wrote to social worker 2 asking him to pass information about the recent CAMHS involvement to the service in Northumberland.

<u>Provision in the secure unit in Northumberland</u>

4.3.10. On admission to the Northumberland secure unit Child R was screened by a mental health nurse and then seen by the consultant psychiatrist

from the local forensic service. Initially the psychiatrist continued to prescribe Child R medication for ADHD but having asked staff to monitor him with symptom and behaviour checklists he formed the view that there was no evidence that Child R had the condition and decided to take him off the medication. This was done with no adverse effect being noted.

4.3.11. The psychiatrist also believed that previous depressive symptoms were likely to have arisen from Child R's adverse social circumstances and substance misuse. Child R stopped taking his sleep medication and reported that he was in fact sleeping better without it.

4.3.12. Throughout the psychiatrist relied on his own observations and assessment, supported by observations and standardised assessment protocols for ADHD completed by staff caring for and working with Child R. He did not seek information from the Harrow CAMHS service.

4.3.13. The psychiatrist reported his assessment and views on medication in a report to the Family Court which was made available to social worker 2 and Child R's GP in Harrow who in turn later passed it to the Harrow CAMHS service. He also copied reports to Harrow CAMHS though for reasons that cannot be ascertained, not all of them became part of the service records.

4.3.14. Child R said that he was happy with the changes in treatment. The report stated that he was '*fully aware that the medication … prescribed for hyperactivity was an amphetamine based product and he was extremely keen not to use this type of drug for fear of abusing illicit similar substances…'.* Prior to discharge the psychiatrist explained the changes to Child R's mother and advised her that he did not have ADHD.

4.3.15. In the documents and interviews described in Appendix 2 both Child R and his mother take a very different view, indicating that they felt that Child R benefitted from taking medication for ADHD.

<u>Discharge from the secure unit and care while living at home</u>

4.3.16. It had been agreed that Child R would be referred to CAMHS in Harrow on his discharge from the secure unit but there was confusion about who was to do this which contributed to a substantial delay. Notes of a planning meeting on 16 April 2013 state that Child R's mother '*informed the meeting that she had made an appointment at the GP for a referral to CAMHS for counselling / therapeutic support which she was keen to progress*'. However the evidence is that this appointment was only made much later.

4.3.17. Child R's social worker believed that the psychiatrist in Northumberland had referred Child R directly to Harrow CAMHS. He had not done so and the Northumberland psychiatrist's recommendation was in fact for a

review appointment to take place some weeks after Child R returned home, because he did not believe that Child R required medication.

4.3.18. At the LAC review on 15 May 2013 it was noted that Child R was no longer taking any medication, but needed to be seen at CAMHS for monitoring and it was agreed that the GP and social worker 2 would both be asked to make referrals. The IRO described it as being 'imperative' that CAMHS come on board noting that Child R had not lived in the community without medication for a significant time.

4.3.19. The CAMHS appointment in fact only took place in June 2013, after a decision had already been made to return Child R to secure accommodation. The Harrow psychiatrist confirmed her previous assessment that Child R had ADHD and should be taking medication for this as well as medication to help him sleep.

Provision during the remainder of Child R's time in care

4.3.20. Child R continued to take this medication during the remainder of his time in care. It was reviewed by the psychiatrist linked to the secure unit in Essex, who at one point increased the dose. It did not in itself have a notable positive benefit as records from the Essex secure unit indicate that Child R's behaviour there was more difficult than it had been in the secure unit in Northumberland. The medication was transferred with Child R to the unit in Sussex and at that point it had been planned that (as had happened in the residential unit in North Wales a year previously) either the CAMHS service or a counselling service known to the residential unit could be engaged to work with Child R.

Evaluation of provision made

4.3.21. A number of concerns arise from the account of mental health provision.

4.3.22. There were radical differences in the diagnosis and treatment approach between the two main psychiatrists involved with Child R, linked to different views on the role of substance misuse in his difficulties. One believed that he met the diagnostic criteria for ADHD and required treatment for anxiety and depression which she believed were the underlying drivers behind his substance misuse. Having closely monitored him for symptoms of ADHD, the second believed that Child R did not meet the diagnostic criteria and that his problems were rooted in his history of high levels of substance misuse which had begun in early adolescence.

4.3.23. The task of the Serious Case Review is not to determine who was right but to recognise that the differences in diagnosis and treatment regime caused uncertainty and confusion for family members and professionals

alike. On the part of the psychiatrists there was no evidence of any attempt to reach a shared understanding of Child R's condition or consideration of the implications for the family or professionals. There was no evidence that other members of the professional network actively reflected upon this significant diversion in opinions.

4.3.24. On three occasions when Child R moved to new placement there was no arrangement to provide for continuity of mental health services. It was left for the new carer or placement to refer him as they thought necessary for his needs to be assessed. This meant that assessments were started 'from scratch' with little or no access to information from previous services.

4.3.25. This contributed to differences in the provision that different services made – some of which was focused on the use of medication and some on the use of counselling. As placements offered different approaches it became much more difficult to know what was working.

4.3.26. The records make various references to Child R receiving 'counselling', however it is never clear what form this had taken or whether the approach was one that had a firm evidence base. Social workers and reviewing officers were left to accept this on trust without access to expertise that would enable them to assess the potential value of proposed approaches.

4.3.27. In comparison to the arrangements that are in place for substance misuse services (described in Section 5.1 below) there is no coherent national system with agreed standards and protocols for transfer of cases to guarantee (or at least strive to achieve) continuity of service. Handover relies on clinicians (who as has been demonstrated may have different views, are likely to have imperfect information and may not even know that a child has moved placement) recognising that it would be useful to seek or provide information about the patient.

4.3.28. Transfer of information via GPs is imperfect because of the delays in transfer of records described in Section 4.1.

4.3.29. In practice the role of the child's social worker is pivotal because clinicians in CAMHS can only transfer records if they are told that a child has moved and where to. In Child R's case there were a number of occasions when this went undone among all the other tasks that the social worker was required to fulfil whenever Child R moved. The LAC review could in theory act as a safety net to ensure that tasks had been completed, but in reality the reviews are held too infrequently to ensure the timely implementation of such tasks or to enforce decisions made. Even the IRO scrutiny of the care plan between LAC reviews now required by statutory guidance (discussed in Section 4.6) can leave a gap of at least three months during which actions may drift.

4.3.30. An effective LAC health service could play a coordinating role in relation to children who have complex health needs or are placed at a distance from Harrow. However this would only happen if it was sufficiently well-resourced to allow the LAC nurse to play a much more significant role in relevant cases and the working arrangements between the LAC health service, CAMHS and the local authority were clearly set out.

4.3.31. When Child R was discharged home in April 2013 it is clear that – despite there being numerous planning meetings and discussions – both professionals and family members held differing expectations about the role of CAMHS.

4.3.32. The Harrow CAMHS consultant told the Serious Case Review that she had kept Child R's case open and would have readily seen Child R again on the advice of the social worker without needing a re-referral from the GP. Social care staff reported that this was completely at odds with their understanding about the referral arrangements that have been agreed with health commissioners (i.e. that specialist CAMHS services only accept referrals from GPs). This is supported by the fact that on at least two occasions in the last two years concerns about the lack of direct referral route to CAMHS (from schools and social care staff) have been discussed at the Corporate Parenting Panel, thought the difficulty was not resolved.

4.3.33. It has been evident during the course of the Serious Case Review that the relationship between the local authority and the CAMHS service in Harrow is in need of repair. Sharing of information and collaborative working were weak. Although she had known Child R for as long as any other professional, the psychiatrist was not involved in key meetings and not informed of some important decisions and events. Contributors to the Serious Case Review demonstrated a degree of ill feeling about recent decisions which the local authority had made about the commissioning and decommissioning of some CAMHS services – and the way in which they were perceived as having been reached.

4.3.34. Taking as its starting point the finding that the coordination of mental health provision was one of the weakest aspects of service provision, three things are needed:

- Agreement between the local authority and CAMHS providers on how the services should be working together in relation to looked after children, covering issues such as attendance of CAMHS at meetings; how CAMHS clinicians are notified of significant changes in children's lives and consulted about important decisions
- Agreement on common expectations as to how professionals should be working when looked after children are placed away from Harrow covering issues such as whether cases remain open to the CAMHS service and for how long, how information is transferred between different areas and

- Effective monitoring and challenge by the Corporate Parenting Board and the LSCB in relation to provision made for the mental health of looked after children.

The review has made recommendations in relation to these. (See recommendation 12 and 13)

4.4. Placement in secure accommodation, discharge and rehabilitation

Background

4.4.1. Child R spent two periods amounting to 11 months in secure accommodation. On each occasion considerable thought was given to deciding whether this denial of liberty was necessary, either by the senior agency decision maker and (after January 2013) by the Family Court which would have taken account of the views of Child R, represented through his solicitor and the independent Children's Guardian. In line with statutory requirements, stays in secure accommodation were reviewed by a panel which had an independent chair and representatives.

4.4.2. Even with the benefit of hindsight, it is impossible to know whether these were the right decisions, but it is clear that all were properly made and that on each occasion there was ample evidence that Child R would have been likely to abscond and place himself at a very high level of risk if he not been detained in secure accommodation.

4.4.3. The care with which the decisions were taken is illustrated by the first time that an application was considered by the senior local authority manager responsible (in May 2012) when in the face of strong arguments by managers, supported by the IRO, the request was not sanctioned, on the basis that there were other alternatives that needed to be explored. There is evidence that when Child R was in secure accommodation, managers in the local authority and the Children's Guardian thought carefully about the risks of him remaining – including the likelihood that Child R would cease to cooperate with services altogether – as well as the potential benefits.

4.4.4. Having made the decision it was not easy to move Child R into secure accommodation and each time it involved tense and difficult contacts with him and his mother.

4.4.5. Child R made it clear that he did not want to be in secure accommodation. However he largely made good use of the time there and appears to have benefited from the structure, predictability and relief from pressures of the real world that secure accommodation offered. In particular he was able to make good progress in education. There were a small number of episodes when he was aggressive to staff, but none was very serious.

4.4.6. Child R made particularly good progress during a stay of nearly seven months in a secure unit in Northumberland. The most significant disadvantage in him being placed there was that it was much more difficult and time consuming for family members and professionals from Harrow to visit, though both did so. The review saw no evidence that active consideration was given to moving him to a comparable unit closer to London, though once he had settled in Northumberland there would have been a balance to be struck between disturbing some good relationships that he had formed and the ease of visiting and arranging meetings with staff.

Arrangements for discharge

4.4.7. The plan to discharge Child R to the care of his mother from the secure unit in Northumberland was agreed in principle at a Family Court hearing in January 2013. The local authority commissioned an independent viability assessment which confirmed the plan. It was a lengthy report which looked at the different aspects of Child R's needs and the difficulties that he might face if he moved home, but offered no real insight into the factors that had led to the difficulties in their relationship or how his mother might respond if Child R's behaviour became a concern again. It was submitted on 21 February 2013 and on 7 March 2013 the court decided that Child R should return to the care of his mother on 18 April 2013, leaving the local authority and family members 6 weeks to prepare and make detailed arrangements.

4.4.8. Several planning meetings took place in this period and there were numerous discussions with Child R. As he found it difficult to explain and accept any responsibility for the problems he had experienced in the past, professionals found it difficult to engage him in discussions about what he was going to do differently in the future. There were also several discussions with his mother about her role and about the different services that would be involved. These included discussions with the EIS worker who had worked very successfully with her over her care of her other children.

4.4.9. Details of the plans and the interventions that were made by agencies and services are set out in the sections 4.1 – 4.3 of this report which deal with the specific services. Overall a considerable effort went into coordinating the interventions, based on the idea that it was important to occupy Child R for as much of the time as possible and offer regular drug testing so that if he did start to have difficulties they would be recognised early on. There were also regular YOT appointments which were still required to comply with the last two months of his Youth Rehabilitation Order.

4.4.10. When Child R started not to comply with the agreed plan, a number of meetings were held to plan the response, usually chaired by senior members of staff in the local authority.

4.4.11. The key weakness in the plan was that no proper arrangement was put in place for Child R's education or for a review appointment with the CAMHS service. The detailed reasons for this are set out in Sections 4.2 and 4.3. The absence of a training programme in which Child R wanted to engage meant that (in his mind at least) there were too many appointments with too many agencies, the majority of which were designed to monitor and control his whereabouts and behaviour, rather than being constructive or interesting.

4.4.12. It is difficult not to have a degree of sympathy for this view, given the lack of an educational programme matched to his needs. However given his past difficulties and the risks that he had exposed himself to, it was understandable that agencies wished to drug test Child R so that any concerns about substance misuse could be identified quickly.

4.4.13. A number of the professionals involved have recognised that the interventions were only coordinated in a very limited way (i.e. professionals coordinated their visits so that they were spaced throughout the week and did not clash). Professionals in different agencies remained largely focused on their separate responsibilities.

4.4.14. This is a very clear example of the much wider challenges that confront professionals in dealing with very troubled adolescents set out in Section 3.1. How can an overall picture of need be obtained? How can interventions aimed at dealing with a range of risks best be coordinated? How far should professionals allow adolescents to take responsibility for risk? How can interventions be designed which work with the aspirations of young people? And how can professionals best re-establish trusting relationships with young people and their families?

<u>Wider lessons in relation to the use of secure accommodation</u>

4.4.15. The Serious Case Review has highlighted a number of factors which may make young people more vulnerable when they leave secure accommodation and which pose challenges to professionals. These are likely to apply more widely.

4.4.16. As courts are understandably unwilling to make Secure Accommodation Orders for lengthy periods, the continuing need for secure accommodation is subject to periodic independent review. This means that local authorities and other professionals usually do not have long to make arrangements for the discharge of young people and may not know exactly when a discharge will happen.

4.4.17. There is less predictability for young people detained under welfare provision than those sentenced in the youth secure estate where

sentence length is determined in advance and there are standard and well established arrangements for early release and transfer of responsibility to community services.

4.4.18. Young people are only placed in secure accommodation for welfare reasons because they have absconded from other accommodation and placed themselves or others at risk. While a young person is detained it is impossible (or at least extremely difficult) for the young person to continue behaving in the way that led to their detention in the first place, making it very difficult to predict how they will act on discharge. This was particularly relevant in Child R's case. While he was in secure accommodation he could not abscond, take drugs or place himself at risk by offending. Relative to some other young people he was not violent. His behaviour in secure accommodation was always going to be a poor guide to his behaviour once he was discharged. He had taken up some help during two stays in secure accommodation, but it was very difficult to predict whether he would continue to cooperate with professionals.

4.4.19. In the case of a young person who has taken drugs (particularly one who has overdosed) there is the added risk that their physical tolerance may have reduced while they have had no access to drugs.

4.4.20. Secure accommodation units seek to counter these risks by offering a period of 'mobilisation' activities and outside visits prior to a planned discharge date but their ability to do this is limited if the period of notice is short, especially if it revised at short notice. The specific legal status of secure accommodation makes it more difficult to offer flexibility about transitional arrangements and leaving dates. There are no arrangements comparable to the home leave to which patients detained under mental health legislation can receive or flexible contacts in the community under early release arrangements which governors of young offender institutions frequently grant. It is usually impossible to do that in the young person's own community because most placements are a great distance from the young person's home local authority.

4.4.21. The Serious Case Review has not been able to establish if there is any reliable data on the risks faced by young people leaving secure accommodation and the outcomes of their stays after a follow up of several months.[29] In 2010 Ofsted published a study of the experience of young people and their families which obtained the views of a number of people leaving both secure youth justice and welfare

[29] Cafcass has informed the review of six other young people known to its service who have died after having been detained in secure accommodation over a five year period, though the circumstances vary considerably and the numbers involved are two small to draw any clear conclusions from the sample

provision.[30] This found that the level of support provided after discharge did not match the needs of young people, particularly when there had been limited opportunities to plan.

4.4.22. The report made two recommendations to local authorities (which impact on the work of all local agencies). These were that local authorities should:

- ensure that young people moving out of secure settings have a guaranteed education or training place arranged for them
- ensure that firm discharge plans, based on the assessed need of the individual young person, are in place sufficiently early to enable transitional work with any new placement or facilities.

4.4.23. Whilst the numbers of young people affected will be small the Serious Case Review will recommend that Harrow Council implements these recommendations and that it can demonstrate to the LSCB that it offers well planned and effective support to this very vulnerable group of young people (see recommendation 4).

Discharge on Fridays

4.4.24. A point of detail, but potential significance, emerged in discussion with practitioners about the draft of this report. It was established that – to this surprise of some professionals present - Child R's discharge from his secure unit in Essex after which he went missing (though not his discharge from the unit in Northumberland) had taken place on a Friday. The only reason for this was that the Family Court sat that day and the Secure Accommodation Order had expired that day. Professionals present noted that established practice in substance misuse services is not to arrange patient discharge on Fridays because of the lack of support services in place over the weekend.

4.4.25. It was recognised that there was useful learning for all services involved and it was agreed that the LSCB should ask agencies to disseminate learning in relation to this. Recommendation 26 addresses this.

[30] Ofsted (August 2010) *Admission and discharge from secure accommodation*

4.5. The response to young people who are absent or missing from care

Overview of the history

4.5.1. Child R went missing on a very large number of occasions, both from home and from open residential units. There is no obvious simple pattern to, or explanation for, his behaviour and he gave a number of reasons. In most of his placements there was a honeymoon period during which Child R did not go missing for several days (sometimes longer) after the beginning of the placement. The obvious exception to that was when he went missing from his final placement (which was in West Sussex) on only his second day there.

4.5.2. Child R's mother and a former service manager from the local authority told the review that they believed that one residential unit had been insufficiently vigilant because they had allowed Child R to associate with another young person who was prone to run away and had taken the two young people out together. However there is no record of any official challenge being made to the unit over its behaviour. No concern was raised with Ofsted (which regulates residential care homes for children) about the quality of care provided by any of the units.

4.5.3. There is thus no clear evidence that any of the residential units were negligent or careless in the arrangements that were made. Staff in an open establishment are not entitled physically to prevent a young person from leaving though they can offer a high level of supervision and it follows that the better the staff know the young person the sooner they may see signs that he or she is unsettled and try to distract them or persuade them not to leave.

4.5.4. Research suggests that some units have much higher rates of absconding than others.[31] It would be expected that residential units should be able to keep data on their record in relation to this. In future it would be useful for Harrow's commissioning service to seek information on this before making placements.

4.5.5. It is an expectation of guidance that children who go missing are spoken to on their return. Given the very large number of incidents in a large number of residential units it is impossible to be certain that best practice was implemented on every occasion, but there is plenty of evidence that staff frequently went to considerable lengths to talk to Child R and that local police officers were often involved. He sometimes gave an indication of what he had been doing and why he had gone,

[31] Dr. Karen Shalev Greene and Professor Carol Hayden (July 2014) *Repeat reports to the police of missing people: locations and characteristics*, University of Portsmouth, Centre for the Study of Missing Persons

but this never enabled any residential unit to develop a strategy which managed to prevent him from going missing altogether. There is evidence that residential units adjusted their risk assessments after episodes of Child R running away and those that were equipped to do so implemented drug tests.

Policy in relation to children who go missing or are absent

4.5.6. There is a tension in current social policy about young people who leave care placements without authorisation. On the one hand, following guidance from the Association of Chief Police Officers (ACPO) police forces have introduced the operational distinction between young people who go 'missing' and those who are 'absent'. The research previously cited provides useful background to the thinking that has been used to justify this approach:
'Missing people, in our sample, do not travel very far, usually travelling under 5 miles. In terms of missing persons vulnerability, only a minority of young people, in this sample, are categorised as 'high risk' and only a small minority report injury or harm while missing or are known to be involved in criminal activity'.

4.5.7. This makes it hard for the police to justify spending large amounts of time actively searching for significant numbers of young people who leave their placements on many occasions but are rarely either highly vulnerable or a risk to others. To take the same approach to every case reduces the resources available to find the children who are most at risk.

4.5.8. On the other hand current concerns about sexual exploitation and trafficking have highlighted the fact that there are groups of looked after children who may be at a very high level of risk if they have left a residential unit, foster home or independent living arrangement without authorisation.

4.5.9. It is impossible easily to reconcile the two sets of legitimate concerns because as well as being among the most vulnerable young people in care are also among those most likely to be frequently absent without causing themselves or others great harm.

4.5.10. The Sussex Police policy defines the two categories as follows: A missing person is one whose '*whereabouts cannot be established and where the circumstances are out of character. The person maybe the subject of crime or at risk of harm (to) themselves or another*'. In contrast the guidance defines an absent person as *'a person not at a place where they are expected or required to be (…when) there are grounds to believe the absence is careless or deliberate AND there is no apparent risk to them or the risk level is tolerable in that risks are not*

sufficiently serious to cause the person to be categorised as a missing person'.[32]

4.5.11. The guidance provides examples of 'absent' circumstances including. '*those running away from a care home after a dispute with a staff member, failing to return on time or staying at a known location with a friend'*.[33] No list of examples such as those given could possibly cover all eventualities. It is extremely difficult to write absolutely comprehensive procedures and to do so will sometimes unhelpfully restrict professional judgement of unusual circumstances.

4.5.12. If a child is categorised as 'missing' the police will actively seek to find the child and coordinate the actions of other agencies. If categorised as 'absent' the police will record the child's details in full, alert officers and supervisors within Sussex Police and keep the child's circumstances under periodic review. This poses three challenges:

- ensuring that the risk assessment is informed by all of the relevant information
- making judgements which match the response to the circumstances of the child and are consistent and
- ensuring that all of the professionals involved have a common understanding of the arrangements so that they know what action will be taken and can challenge judgements.

<u>Response to Child R's disappearance from the residential unit in Sussex</u>

4.5.13. Judgements about whether Child R should have been categorised as being 'missing' or 'absent' were important in relation to his disappearance before his death.

4.5.14. Paragraphs 106 - 120 of Appendix 1 set out the details of the action taken by residential unit workers, local authority social care staff and Sussex Police when Child R left the residential unit five days before his death. The following evaluation has drawn on review of social care records, discussion with staff in the residential unit and the independently supervised review by the Sussex Police Professional Standards Department of the actions taken by the police service.

4.5.15. There is no suggestion that the residential unit was negligent in its care of Child R. He was left unsupervised momentarily, towards the end of a day during which he had showed no signs of planning to leave or of being agitated or distressed or having thoughts about self-harm or suicide. During the course of the day he had had numerous, more advantageous opportunities to run away, but he did not do so. The

[32] From Sussex Police Professional Standards Department Investigation Report

[33] The policy had itself been the agreed outcome of a multi-disciplinary and multi-agency working group with agencies from East Sussex, West Sussex and Brighton and Hove with responsibilities in relation to missing children.

residential unit reported his disappearance immediately after staff had searched the vicinity, in line with the unit policy.

4.5.16. His disappearance was risk assessed by a Sussex Police call taker and categorised as an absence under the police procedures. It was re-categorised as 'missing' approximately 48 hours later because Child R had not returned. During the intervening period the case had been subject to regular review by officers but the police had not actively taken or coordinated steps to find Child R.

4.5.17. The residential unit informed Harrow's Emergency Duty Team (EDT) immediately after phoning the police.[34] At the time Harrow's procedure was that reports of absent children were notified to the council's out of hours customer contact centre, which deals with a range of contacts from the public. The customer contact centre noted such calls over a period of a few hours before passing them onto a qualified social worker at EDT, usually at a shift handover. A duplicate notification of the child's details was made to the social care team responsible for the child. Experience was that many notifications never needed active management because children had returned to their placements by the time the information was handed over.

4.5.18. The Harrow records show that on this occasion details of Child R (and other absent children) were recorded by the customer contact centre, but were never handed over. This is believed to be due to a temporary breakdown in the contact centre computer system which the EDT manager told the review was a common occurrence at that time. As no handover was made, the EDT social worker did not have the opportunity to review the full range of information held in Child R's records and decide whether to ask the police to take any additional action.

4.5.19. Child R was well known to the EDT as a result of having run away and put himself at risk on a large number of occasions. It is therefore possible, though by no means certain, that the EDT would have asked Sussex Police to treat Child R as missing and to take more active steps to search for him. The manager responsible for EDT told the review that his team were very aware of the distinction between being reported 'absent' and 'missing' and of the difference in levels of response. However he could not cite recent examples of cases in which team members had actively challenged the police over the categorisation of a child.

[34] Harrow runs an EDT service in conjunction with a neighbouring borough. Normally one qualified social worker is on duty at any time, covering emergencies in relation to children at risk, vulnerable adults and mental health services across the two boroughs which have a combined population of 570 000. The social worker has access to children's records and management advice if needed.

4.5.20. In the event, because Child R had left the unit on a Saturday night, it was not until Monday morning that the Harrow social worker responsible for his case was aware of his disappearance. He was then able to advise the police of the level of his concerns, by which time Sussex Police had re categorised Child R as a young person who was missing.

Missing or absent?

4.5.21. Records (including a recording of the phone call) confirm that during the initial categorisation the Sussex Police computerised call management system promoted the call taker to ask the residential manager a series of standard questions. Positive answers were given confirming that Child R had a history of self-harm, suicide attempts linked to overdoses and that he was taking medication because of ADHD. His age (16) and the fact that he had absconded from a residential unit were noted. These factors were not explored further. The residential manager presented the circumstances as being a young person who was 'absent' and did not challenge the police call taker's categorisation of it as such.

4.5.22. Information provided by the call taker to the police review of the episode provides some useful context. It was not unusual for call takers to receive up to five reports of young people who had absconded from children's residential units in Sussex on some evenings. Children reported absent in these circumstances frequently had a history of substance abuse and self-harm, so the references to these factors in Child R's history were also not unusual. This strongly suggests that while these factors should be identified in the check list they do not in themselves assist substantially in differentiating the risk to individual children. This in turn suggests that more detail about such risks should be obtained before a risk categorisation is made. The SCR has made a recommendation in relation to this. (See recommendation 18)

4.5.23. It is highly likely that any police call taker would have dealt with the call from the residential unit in the same way, made the same judgements and felt (correctly) that they were complying with the Sussex Police policy. It would therefore be wrong to suggest that there was any individual error in the way in which this call was categorised. There are concerns about the way in which the system as a whole operated.

4.5.24. Reviewing the background information that was available to the local authority and the company which owned the residential unit, it is clear that there was significantly more contextual information which, if it had been made available, should have led to a different categorisation or a swifter review of the categorisation. In particular the profile document that was circulated in order to seek a placement for Child R and

provided to senior staff in the company that owned the residential unit contains a number of entries which, albeit briefly, indicate that if Child R absconded he might be at considerable risk.[35]

4.5.25. For example the placement profile noted that Child R '*has a tendency to be aggressive at times and also he usually misuse (sic) drugs, which puts him at significant risk of harm'.* The section on 'risk taking behaviour' states that '*Child R takes a lot of risks in dealing with his unmet needs. He sometimes carries himself as an adult. (He) regularly goes missing from his residential unit and puts himself at risk of harm due to his behaviour of using drugs / alcohol. He also usually steals / shoplifting (sic) when he is missing from placements.'* The section 'identified special needs' includes the following: '*There is a significant history of Child R absconding from his placement, and usually to use drugs. He has however not used drugs since July 2013'.* The document provided a more detailed and specific understanding of factors which while not unusual among looked after children were potentially very significant and more serious in Child R's case.

4.5.26. In these particular circumstances the most pertinent information was that Child R had just been discharged from secure accommodation into a placement and an area that he did not know. He had been severely restricted for several months and had no tie to the local area or the people who were looking after him. Most importantly he had not used drugs for several months, making his tolerance lower and the likelihood of overdose greater. This additional risk had been discussed with Child R (both when he left the Northumberland secure unit and when he moved to his final placement) but there is no clear evidence that it was identified as an additional risk factor in discussions between Harrow and staff at his new unit.

4.5.27. It would have taken a calm, well informed and reflective assessment to have recognised this combination of risk factors and discussed them with the residential unit. In the heat of the moment, alongside all of the practical tasks that must be done during the final hearing of care proceedings and making arrangements for a placement, it did not happen.

4.5.28. This assessment of relevant risks does not rely on the benefit of hindsight. Both Child R's mother and social worker 3 drew exactly these conclusions when they were informed that he had left the residential unit. As he went missing at the weekend this did not happen until he had been missing for two days.

[35] More detail is given on the content and purpose of the placement profile documents in Section 4.6

Information held and provided by the residential unit

4.5.29. When a member of the Serious Case Review team met staff in the residential unit it was not possible to establish with certainty whether the placement profile (which the Harrow commissioners had supplied to the parent company as part of the process of selecting and commissioning the placement) was part of the records held by the children's home when Child R went missing and if so how many of the staff on duty had read it. It was clear that staff had relied much more on verbal information provided in the course of Child R's introductory visit to the residential unit, during which he was accompanied by residential workers from the Essex secure unit. There had also been phone calls between the two residential units prior to the placement. Because Child R had been relatively calm while in the secure unit (and could not abscond or misuse substances) these reports were relatively positive.

4.5.30. Other background documents which were part of Child R's social care records – such as his Essential Information Record, Care Plan and LAC review minutes – would have also provided much more context. It was not unusual that these had not been transferred to the placement at that point. Child R had only been there for two days and it is much more common for such documents to be transferred at the initial planning meeting (which was scheduled for early the following week). Normally transfer of such documents at an early planning meeting will be enough to provide an acceptable standard of care though residential units and foster carers often complain that (in very many cases across many local authorities) they do not receive such documents for weeks or sometimes months.

4.5.31. To its credit the residential unit had prepared risk assessment and management documents in relation to potentially concerning aspects of Child R's behaviour, including substance misuse and absconding. Staff had evidently thought about these problems carefully. Understandably the strategies largely focus on how to prevent such problems and how to respond once Child R had been found and returned. They do not deal explicitly with the question of whether Child R should be treated as missing or absent and what might inform that decision.

4.5.32. Taking into account their experience in dealing with a range of other cases, the police call taker's recollection was that '*care home staff reporting absences frequently have little information to go on'* and that in this case the residential manager *'had rather more information to hand than is sometimes the case'.* However later when Child R had been categorised as missing and a police officer visited the unit he commented that the 'black folder' that staff relied on to brief the police '*contained little information'*. This is most likely a reference to a lack of information that would have helped find Child R (such as a recent

photograph and details of associates and places he had run away to). Given that the unit had only known Child R for just over 24 hours the absence of such information is not surprising and it would have been more likely to obtain this from the placing local authority.

Findings and proposed action

4.5.33. Considering carefully the material that is available from Sussex Police, Harrow social care and the residential unit, it is concerning that when Child R left the residential unit he was not immediately classified as being missing. This is more likely to have happened if the full range of information that was held about Child R at that time, particularly by Harrow children's social care had been properly reflected in the risk assessment that took place. However it is not possible to draw any conclusion as to whether Child R would have been located before his death, as it is apparent that he was not at an address that he was known to frequent, or with his family, or with known associates. Even if he had been actively sought he may well not have come to police notice.

4.5.34. A number of issues need to be addressed as a result of this episode. Harrow's process for commissioning and making placements should take fuller account of the effectiveness of any proposed placement in preventing children from going missing and responding when they do.

4.5.35. In considering the needs of individual children it should underline the distinction between children who are 'missing' and those who are 'absent'. When a placement is made one of the matters to be agreed should be how – in the event of a child absconding or leaving a placement – the event will be reported to the police and whether the placement and provider will specifically ask the police to record the child as being 'missing'. The documents and formats provided in the Harrow LSCB guidance document S*afeguarding Children who go missing from Education, Home or Care* would provide the means to do this.[36] The categorisation could only ever be an indication, because judgements would always be needed in specific circumstances, but it would be a useful one.

4.5.36. Children often go missing at weekends and out of office hours so it is essential that the Harrow EDT has all the information required to play an active role in relation to a missing child if necessary. The EDT should review the case and its recent relevant history, rather than just note the information. The EDT must be prepared to challenge the police categorisation of the episode if necessary.

[36] The guidance has a 'pre-incident risk assessment form' which would have served exactly this purpose

4.5.37. Once Child R went missing further delay occurred because Harrow social care could not provide the police with a recent photograph. Members of the looked after children social work service told the Serious Case Review that this was a long-standing issue that had not been resolved because of technical difficulties and concerns about data protection and the security of a photographs being held and transferred. The local authority should find a way of resolving this without any further delay so as to ensure that there is always a full pack of information available to support police who are trying to locate a missing child. This should include recent photographs and a full list of contacts and possible addresses.

4.5.38. The review has made a number of recommendations about policy and practice for children who go missing. (See recommendations 18 - 22)

Existing Harrow LSCB guidance

4.5.39. Harrow LSCB has an extremely comprehensive protocol and guidance document on children who are missing.[37] However there is no evidence that it was ever referred to or used in relation to Child R. The document had been published in July 2013 and senior managers told the Serious Case Review that at the time of Child R's disappearance work was still underway to ensure that all relevant staff knew about it and were able to understand and implement it.

4.5.40. The LSCB should revisit this guidance and ensure that it is now properly understood by key groups of staff and is now being implemented.

4.6. The quality of early intervention and targeted social work services

4.6.1. This section of the review focuses on aspects of provision made by the local authority social care and early intervention services from which there is wider learning. These are:

- The working arrangements between early intervention services and targeted social work services provided by the local authority
- Level of knowledge and experience of allocated social workers
- The ability of staff to practice in a reflective way
- Lack of overall assessment of Child R's needs once he became looked after
- Failure to achieve a plan for permanency for Child R in the months immediately after he came into care
- Limited placement choice

[37] Harrow LSCB (July 2013) *Safeguarding Children who go missing from Education, Home or Care*

- Role of Independent Reviewing Officer

The pattern of local authority service provision

4.6.2. There were substantial conflicts and differences in philosophy and approach between staff in different local authority services working with Child R. In order to understand these it is necessary to describe the pattern of local authority services.

4.6.3. Local authority provision for vulnerable children in Harrow is organised in two divisions, both led at the time by a head of service (or assistant director) who reported to the Director of Children's Services. The Targeted Services Division is responsible for children who are looked after; children who are subject to child protection plans; children in need; children who are the subject of care proceedings and the service which undertakes assessments on children referred to the local authority. The Early Intervention Services (EIS) is responsible for a range of preventative services, often referred to as 'early help'.

4.6.4. The teams and services that make up EIS were created as a result of several government service initiatives developed between 2000 and 2011.[38] Harrow, like many other local authorities, brought them together with the intention of providing a coherent preventative service. Staff in the EIS service had a range of skills and qualifications, seeking to combine high levels of practical support to families with therapeutic approaches.

4.6.5. The EIS may also be involved in work with children and families whose cases are being managed by targeted services. When workers from both services are involved, the targeted service holds overall case responsibility.

4.6.6. Until April 2012 the two divisions used different information systems and staff could not see records made by the other service relating to the same family.

4.6.7. Staff from both divisions worked with Child R and his family. When the children were made subject to child protection plans in 2010 the work was allocated to social worker 1 (who worked in targeted services). As keyworker for the child protection plan she had responsibility for coordinating the work of the professional network as a whole. This was the first time that any worker had had an overall coordinating role.

4.6.8. In February 2012 as a result of a departmental service reorganisation, teams in the Targeted Service Division moved to the same location as the Youth Offending Service and the teams that made up the EIS.

[38] These include the Children's Fund, Family Intervention Project, Troubled Families and various initiatives on family support and parenting

Targeted service staff were also divided into between those working with looked after children and those working with other children in need. At that point the family social worker (social worker 1) retained responsibility for work with the children who were living at home. Social worker 2 assumed responsibility for Child R. This social worker had a caseload consisting exclusively of looked after children.

4.6.9. The review has heard different views about the effectiveness of this reorganisation. Some managers have said that there was wide consultation about its objectives and the approach adopted. Other managers and staff told the review that in practice staff and most managers felt that they had not been consulted. Nor did they believe that the restructuring of services and relocation of staff had led to consistent improvements in the way in which different local authority services worked together.

Working relationships between the EIS and staff in targeted services

4.6.10. Working relationships over Child R between the worker from EIS and social workers and managers from targeted services were very poor at a number of points. Staff in targeted services were genuinely concerned and suspicious about the way in which the EIS worker related to the family. There were complaints that important information was not recorded or brought to the attention of social work staff. The EIS service told the review that social work colleagues did not understand the frequency of visiting and the intensive level of engagement that was normal for its staff.

4.6.11. The disagreements were very serious and there is no doubt that they adversely affected the ability of both services to work with child R and his family, particularly during the periods when he was living in Harrow, if only because the conflict between professionals absorbed time and energy. Despite numerous meetings, more senior staff were unable to resolve the difficulties.

4.6.12. It is impossible to be certain why there was a lack of trust and mutual respect between different staff in the local authority. Interviews with all those involved confirmed them to be well meaning and responsible people who desperately wanted to do what they believed would be in Child R's best interests. They all claim to have worked effectively with the other service on other cases, though senior managers point to other examples of conflict between the services over cases.

4.6.13. Aside from any personal factors, the difficult working relationships between professionals are likely to have reflected some of the inherent difficulties in working with very troubled adolescents, referred to previously (Section 3.1).

4.6.14. There was evidently a very high level of anxiety and frustration that everyone involved felt because of the repeated breakdown in plans and placements and the high level of risk to which Child R exposed himself. These episodes reflect to a degree fundamental tensions about the way in which risk should be managed in work with troubled adolescents, different philosophies and styles of working, disputes about how much faith can be placed in family networks and how closely Child R needed to be monitored.

4.6.15. These factors affected all of the agencies involved to some degree. Records show numerous examples of differences in opinion and perspective not being resolved or discussed productively, including for example whether R needed medical treatment for a physical addiction to opiates; what sort of psychiatric care he needed; whether the approach to drug treatment was adequate or whether more compulsion could have been used.

4.6.16. Both within and between agencies there was often not time, or an effective mechanism, to contain the level of anxiety that staff felt and to channel it into a constructive discussion.

4.6.17. The review has made a recommendation in relation to this. (See recommendation 24). It is essential that staff groups with different approaches and skills learn to value one another's contributions and work together constructively in a consistent way.

The capacity and quality of social work staff

4.6.18. A number of professionals and Child R's mother expressed concerns to the review about the quality of social work provided by staff in Harrow's Targeted Services Division. The complexity of Child R's case and the range and difficulty of tasks required would have challenged the most experienced, able social worker. However it was only two months before his death that responsibility for his case was allocated to an experienced social worker. In contrast other services took particular care, and were usually able, to allocate very experienced staff to work with Child R. The youth offending team deliberately allocated work to two members of staff at the point when he returned to live with his mother in mid-2013.

4.6.19. Child R's mother has been extremely critical of the social worker who was responsible for the children when they were subject to a child protection plan. It is impossible for the review to come to a judgement about interactions that took place in private. This social worker was newly qualified and inexperienced when she took on Child R's case. The evidence is that she has grown in competence as a practitioner in the last three years since and she offered clear ideas to the review about ways in which she would now try to work differently with Child R.

4.6.20. Social worker 2 told the review that the case had absorbed an enormous amount of time and energy (including days when he only dealt with Child R and his family at the expense of his other work) and acknowledged that the work had been extremely challenging and at times upsetting and stressful.

4.6.21. At times both the amount and complexity of the work that was required were beyond this social worker. He had qualified in a country in which the roles and responsibilities of social workers are entirely different to those of social workers undertaking statutory work on children's cases in the UK. Child R's case was the first complex case that he had dealt with. The case was made more onerous because a very large number of coordinating tasks fell solely on the shoulders of the social worker. [39]

4.6.22. Social worker 3 was an experienced social worker and held a management position. He allocated responsibility for Child R case to himself because he knew the details and background well and believed that it required an experienced worker. His motives were worthy and entirely understandable but in practice it was not a sensible decision because at the time he had a full caseload, management responsibilities in his own team and he was assisting in covering some of the management role in the second LAC team. As a result he relied on others to undertake tasks that a social worker should have fulfilled, such as visiting Child R's final placement in person.

Organisational influences on social work

4.6.23. The ability of staff to deal with complex and challenging work is a product of the overall strategy of the council and the environment in which professionals are required to work, not just individual aptitude. Staff in Harrow's looked after children's service had reasonable caseloads, both in absolute terms and in comparison to most other London local authorities. However many social work staff lacked experience. The former service manager for looked after children told the review that when he first came to work in Harrow in 2010 the council had chosen to fill social work posts with recruits, many of whom were newly qualified and some of whom he believed did not have the skills and knowledge required to undertake difficult work.

4.6.24. Senior management arrangements in the local authority have not been stable. Team management arrangements in the looked after service appear to be more stable, but in fact key staff had long periods of sickness. The combination of these factors will have made it more difficult to develop the competency of inexperienced staff.

[39] (See Section 4.2 dealing with the Virtual School and Section 4.1 dealing with the health of looked after children)

4.6.25. Throughout the period under review, staff and managers very rarely had the time and capacity to reflect calmly on the work with Child R without being subject to the anxiety of having to manage an immediate risk or to make a decision between two unpalatable alternatives. Such capacity would have been extremely beneficial and might have allowed more reflective consideration of issues such as for example, Child R's early development or cultural aspects of the case (Section 3.); differences in mental health diagnosis and treatment regime (Section 4.3); anxiety levels of staff and the reasons for conflict between staff (above) and the more careful planning of Child R's return home (Section 4.4).

4.6.26. In Harrow's children in need service the local authority has implemented a model of case management based loosely on the approach developed in Hackney Council which provides more reflective ways of working, but it has not yet been actively promoted in the looked after children service. [40]

4.6.27. Such 'thinking time' to consider the effectiveness of previous interventions, recurring patterns of behaviour and the exploration of alternative narratives about the motivation of Child R and other family members are not a luxury. It might have enhanced the capacity of staff to work on the case, improved outcomes and (in the medium term) saved money. As Munro has put it: *'ensuring that staff have the appropriate level of experience and training is a first step, but the agency also needs to provide adequate support in terms of both technological equipment and administrative backup, so that front line workers have the time…to receive good supervision and critically review what they have been doing'.*[41]

4.6.28. All of the professionals dealing with a complex case such as this need to have continuous access to range of advice on practical aspects of service provision, ways of reflecting on and managing the most difficult aspects of cases and means of resolving disagreements when they arise. Review of the records and interviews with staff suggest that this happened more in other agencies than in the local authority.

4.6.29. The LSCB should consider how it can best assist agencies in creating the conditions in which professionals can reflect constructively over the most complex and difficult work and resolve the differences that sometimes inevitably arise. The review has made a recommendation in relation to this. (See recommendation 16)

[40] S Goodman and I Trowler (eds) (2012) *Social Work Reclaimed*, Jessica Kingsley; London
[41] Eileen Munro (2008) *Effective Child Protection* (Second edition) SAGE

Updated assessment and reflection on the case

4.6.30. The pressure to react to events was generated by the behaviour of Child R but exacerbated by the fact that once he became looked after there was no overall re-assessment of his needs. This would have provided an opportunity to explore in more detail his early childhood history and the potential for extended family members in his country of origin to look after him. Throughout the case history, assessment activity was triggered by immediate events, or focused on specific aspects of care (the youth offending assessment ASSET, substance misuse assessments, immediate risk assessments). These narrow, task-focused assessments have their place but they do not provide the basis for planning an effective way to think about how Child R's needs would be best met by agencies collectively in the medium to long term.

4.6.31. This very real weakness is most likely to be explained by the fact that once a child becomes looked after there is no procedural requirement (either in national or local guidance) to carry out or update a core assessment, except when a child has not been assessed before becoming looked after.[42]

4.6.32. It is characteristic of the compliance based approach to children's social care that in the absence of a specific procedural requirement to undertake an overall assessment, no one would be likely to ask for one to be completed, however potentially useful it might be.

4.6.33. It would be equally unhelpful for this review to propose a procedure for such an assessment to become a routine requirement. It is hoped that the greater emphasis on the use of professional discretion to determine the action needed for a child would enable staff and managers to think about the value of such an exercise when working with a looked after child. The review has made a recommendation in relation to this. (See recommendation 3)

[42] Children Act guidance states that '*most children who become looked after are already known to children's social care services. Many will therefore already have an up to date core assessment under the Assessment Framework. Where a child has not been assessed before becoming looked after, a core assessment will be required in order to inform the care plan ...* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336072/The_Children_Act_1989_Care_planning_placement_case_review.pdf [2.23]...There would have been a core assessment of Child R and his siblings– in the form of a Section 47 assessment focused on risks to the children when the children were made subject to a child protection plan in 2010.

The need for a period of concerted and focused activity when a child becomes looked after

4.6.34. Child R was accommodated under Section 20 Children Act 1989 (a voluntary accommodation agreement with his mother) at the end of October 2011, when he was just under 15. The decision to accommodate him was justified and in his best interests. However the most effective use was not made of the seven month period that he spent in his first placement.

4.6.35. When a child comes into care the activity that takes place in the early weeks can be critical in shaping the outcome. It is a long established research finding that children who remain looked after for more than a few weeks are more likely to remain in care for a lengthy period.[43] Whereas the work that was undertaken with Child R's mother and the children who remained at home was focused and successful, the work undertaken with Child R responded to the specific risks that had been identified (such as substance misuse and offending) but did not address the overall risks that would arise from him remaining looked after in the long term without there being a clear plan as to how his needs would be met.

4.6.36. It is recognised that working with Child R on this was particularly difficult because neither he nor his mother trusted professionals sufficiently to discuss the reasons why he was in care or what needed to change for him to live safely at home. It was not until more than two years later that his mother was able to give him an explanation of why he had been placed in local authority care. The absence of any explanation led Child R to deny that he needed to work constructively with professionals about his future.

4.6.37. The independent reviewing officer (IRO) and the allocated social worker both believed that Child R would not return to live at home as the level of risk was too high. It was to be determined whether he was to continue in care until 16 and then have some form of independent living arrangement, but this would depend how he got on. Beyond that there was little specific planning until his placement began to break down in April 2012.

4.6.38. The local authority held looked after children (LAC) reviews as required but they struggled to establish a clear purpose for Child R's placement. The lack of progress in determining what the care plan should be is reflected in the fact that the minutes of the first LAC review (held three weeks after Child R was accommodated) and the second (held three

[43] Department of Health (1989) *Patterns and outcomes in child placement – messages from current research and their implications* HMSO London

months later) sum up the purpose of the placement in exactly the same terms:

'The placement should be monitored carefully to ensure it continues to meet Child R's needs, the care plan also needs to be continually reviewed to ensure the arrangements are keeping Child R safe and within an environment whereby he can achieve to the best of his potential'.

By the time of the second review the local authority should have had a much more developed care plan.

4.6.39. Between the LAC review meetings there was no effective forum to coordinate the work with Child R. The first LAC review allocated a series of tasks to different agencies (social worker 1, mental health, YOT and substance misuse service). The IRO believed that because Child R was still subject to a child protection plan the work with Child R would continue to be coordinated and regularly monitored through the child protection core group. In reality this was unlikely to happen as the focus of that group was always likely to be in the younger children. Instinctively professionals were more likely to place reliance on the residential unit to act as the focus for work with Child R, but this did not happen.

4.6.40. At the second LAC review the IRO sensibly recommended that the professionals involved with Child R should hold regular meetings in order to coordinate their work, but subsequently such meetings tended only to happen when there was a crisis. The SCR has made a recommendation in relation to this. (See recommendation 1)

<u>Social work input</u>

4.6.41. For all the reasons previously described, there is a need for intensive contact between social workers and children who become looked after in order to avoid drift in planning. However the circumstances in this case led to a reduction in social work contact. Social worker 1 told the Serious Case Review that when Child R became looked after she reduced the frequency of visiting to Child R to four weekly (in line with his status as a looked after child and the assumed lower level of risk) whereas the children in the family who were subject to child protection plans continued to be visited every two weeks (because part of the social worker's role was face to face monitoring of the children's welfare). The EIS worker continued to work with the rest of the family and continued to have a high level of contact with Child R until March 2012, but she was marginal to the main decisions and plans.

4.6.42. The continuity of work with Child R suffered further when – as a result of a departmental restructuring – responsibility for Child R was reallocated to a different social worker in January 2012, whilst the original social worker retained case responsibility for his siblings.

Looked after children have often described how it is not worth confiding in or trusting a social worker who from experience they believe will soon move to a different job.[44] The Serious Case Review has been told that in similar circumstances today greater emphasis would be placed on maintaining continuity of social worker involvement.

Findings for the local authority

4.6.43. It is important that there is a period of intensive and focused activity when a child becomes looked after in order to establish a care plan and improve the chances of a child achieving a positive plan for permanency, either within their family network, in substitute care or living independently. Within the constraints of the Serious Case Review it has not been possible to establish whether the drift which occurred in Child R's case reflects other children's experiences when they are first looked after by Harrow Council.

4.6.44. The Serious Case Review will therefore recommend that the local authority reviews the effectiveness of its work with children to the point of the second LAC review (four months after a child is accommodated) taking account of the themes and concerns identified in this section of the report, namely: the quality of LAC reviews and the care plan made for the child; the implementation of key actions identified at the first review and the level and quality of social worker's involvement in the case. The local authority and partners may identify other areas that should be considered. (See recommendation 1)

Placement choice and quality

4.6.45. The table on page 10 of this report shows details of the eight different care placements in which Child R lived in two years. All of these were residential placements as no fostering agency responded positively to placement searches. In addition he spent two months living at home with his family, while the subject of an Interim Care Order.

4.6.46. Five of the eight care placements were open residential units, including the placement that Child R went missing from shortly before his death. Harrow social care ended the four other open placements by removing Child R because he was placing himself at an unacceptable level of risk because of his absconding and misusing illicit drugs and alcohol (which made him very vulnerable to overdose and exploitation and placed others at risk).

4.6.47. The remaining four placements (one of which Child R lived in twice) were secure residential units. Two of these placements were very

[44] This is a common research finding, but most clearly expressed through young people's own accounts such as Paolo Hewitt (2015) *The looked after kid – my life in a children's home,* Jessica Kingsley (2nd edition)

short, where Child R was place briefly pending transfer. The other two secure unit placements lasted a total of 11 months.

4.6.48. The placements were located in areas as far apart as West Sussex, Essex, North Wales and Northumberland. This necessarily curtailed the level of contact that he was able to have with family members although visiting was encouraged and facilitated in all of the placements.

Method of placement search

4.6.49. Placement searches were undertaken by the commissioning or Access to Resources section of Harrow Council. On each occasion the allocated social workers completed a profile document outlining Child R's needs, usually explaining the difficulties that he was experiencing in the current placement. This document was then circulated by the commissioner to a large number of prospective placement providers. The profiles were always revised and updated each time a placement was needed, building on and modifying previously completed documents.

4.6.50. These documents made no attempt to disguise the difficulties that caring for Child R might pose. Occasionally they may have included information about previous difficulties which had been resolved. With the exception of the final profile they all included references to an unsubstantiated allegation of sexual assault against Child R, which must have severely limited the placements available. This is discussed further in Section 5.3.

4.6.51. The placement profiles drew on knowledge from the professional network but with one exception did not contain detailed information about health or educational needs. With a small number of exceptions, placement selection was always a social care responsibility with the consequence that aspects of need other than the pressing social concerns (absconding, drug misuse) were not considered in such detail and carried far less weight.

4.6.52. In the short term this meant that when Child R arrived at some of the placements it became apparent that key aspects of his needs could not be met there – such as for example in North Wales where it emerged after the placement was made that professionals in Harrow and professionals in Wales had a different understanding about whether a drug testing regime was available for young people. In the long term it meant that aspects of the child's needs which contribute most to long term stability and development such as education, health and mental health provision, had been given relatively little weight in placement choice.

4.6.53. During 2013 there was a change in this pattern in that colleagues from the substance misuse service visited potential placements in order to

form a view as to whether the proposed residential unit and the local services should be able to meet the needs of Child R. Although the selected placements did not prove to be successful this was a very useful approach which showed that agencies had tried to learn from experience.

Placement choice

4.6.54. The key criterion for finding a residential unit in London was that it was within travelling distance of Child R's education project. The unit selected (the only one which met that criterion) was clear that it only offered accommodation, care and supervision and that staff had no additional specialist skills. Child R's mother and a number of professionals have been highly critical of the quality of care provided at this unit and there is evidence that staff struggled with difficult aspects of Child R's behaviour (regular absconding, substance misuse, some evidence of sexualised behaviour). The Serious Case Review found no evidence of a proactive plan to challenge and manage Child R's behaviour and sometimes staff appear to have lacked support.

4.6.55. In all of the later placement searches the 'Holy Grail' was an open residential care placement which was both 'therapeutic', and 'intensive' and could offer a good level of expertise in the management of young people with substance misuse problems.

4.6.56. In practice this meant units that offered a high staff / young person ratio; some access to therapeutic or counselling services in the local area or that staff received additional supervision or consultation from a trained professional such as a psychologist. Staff in some of the units were said to have had expertise in helping young people with substance misuse problems; however it proved difficult to engage Child R's interest.

4.6.57. One unit was believed to offer such specialist expertise, and was registered with the national treatment agency for substance misuse, but appears in reality only to have had weekly visits from the local substance misuse service. Harrow believed on another occasion that it had bought 'therapeutic support' as part of a package of care, but later it was established that this would need to be accessed through a referral to the local CAMHS service, funded by health commissioners in Harrow.

4.6.58. The key factor in all of these units was that – even if Child R had a member of staff assigned to him at all times – there could be no guarantee that he would not abscond.

Explaining the lack of placement choice

4.6.59. It is notable that each placement search produced only one positive, suitable response. This underlines the very limited range of options available, even though (once Child R was placed outside of London) the local authority was prepared to consider any location. The lack of placement choice is caused by a range of factors, which can be influenced by the local authority to different degrees.

4.6.60. All of the placements were sought as a response to a crisis caused by the breakdown in the previous placement or by the decision that the criteria for placement in secure accommodation no longer applied. This limited placement choice, because potential placements are less likely to respond to a demand for a quick admission when a child has severe difficulties. It also meant that placements were usually made with relatively little preparation. Child R's final placement, which was triggered by a court-scheduled timetable, was in fact the best planned and prepared of all of his placements.

4.6.61. The repeated need to move Child R in crisis had a negative impact on the likely success of the next placement. Whereas secure units often have very structured admission arrangements and established links to local services, when placements were made in a distant location in an open unit it largely fell to social workers (and to a lesser degree colleagues in other Harrow agencies) to set up complex care packages each time from scratch. This added considerably to the workload of social workers, even when there was a good level of support from other agencies (such as for example there was with the Harrow substance misuse service). It may have contributed to the fact that on a number of occasions sharing of important pieces of information was delayed or did not happen. This makes it more difficult to begin good work in the next placement, which in turn increases the risk of placement breakdown.

4.6.62. Until 2010 Harrow Council ran a residential unit as part of a partnership with a national children's charity, when a proposal was put forward to re-commission it as a facility for young people leaving care. This followed an evaluation of the needs of the population of looked after children and a long standing concern that outcomes for the borough's care leavers needed to be improved. In 2013 the council agreed the closure of this project as part of a wider package of financial savings.

4.6.63. Some factors are beyond the control of local authorities. Over the last decade the provision of residential care for young people has come to be dominated by small, private sector providers as a result of which the distribution of provision is largely driven by market forces which reflect very poorly the needs of young people. Very few local authorities in London and the South East run their own residential establishments.

Prohibitively high London property prices dictate that there is very little residential provision, though the capital has a large number of professionals with relevant skills in local authorities, the NHS and voluntary organisations.

4.6.64. This leaves all local authorities with difficult decisions about how to prioritise the use of funding and management time. Local early help strategies may reduce the number of children who need to be looked after, but some will always require care away from home. If resources can be developed or commissioned most of Harrow's looked after children would want to and should be able to live close to Harrow. There will remain a small number of children and young people who because they have very specialist needs will need to be placed at a distance from Harrow. These children will be particularly vulnerable and it is much more challenging to ensure that their needs are met.

4.6.65. The research cited in Section 3.1 has highlighted the need for agencies to think collectively about whether their current range of provision for adolescents is reflects the best current thinking about how to meet the needs of very troubled adolescents. Consideration of the balance between resources committed to early help as opposed to residential care and other forms of care and consideration of the need for care placements near the home authority should form part of that discussion. The review has made a recommendation in relation to this. (See recommendation 17)

Independent Reviewing Officer (IRO) involvement

4.6.66. Throughout his time in care the same IRO was responsible for Child R's case. This continuity was one of the strengths of the provision made for Child R.

4.6.67. The duties of a reviewing officer are set out in statute, regulations and guidance.[45] In the Children Act 1989 they are described as follows:

- to monitor the performance by the local authority of its functions in relation to the child's case
- to participate in any review of the child's case
- to ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the appropriate authority.

4.6.68. Legislation that came into force in 2010 widened the role of IROs '*from monitoring the performance by the local authority of its functions in relation to a child's review to monitoring the performance by the local authority of their functions in relation to a child's case…. The intention*

[45] All quotations in the following paragraphs are from *The IRO handbook - Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children* published by HM Government in 2010.

is that these changes will enable the IRO to have an effective independent oversight of the child's case and ensure that the child's interests are protected throughout the care planning process'. (emphasis in the original).

4.6.69. The guidance explains that there are now '*two clear and separate aspects to the function of the IRO: 1) chairing the child's review and 2) monitoring the child's case on an ongoing basis'*. As part of the monitoring function, '*the IRO also has a duty to monitor the performance of the local authority's function as a corporate parent and to identify any areas of poor practice'.* Local authorities were expected to implement these changes when revised statutory guidance was issued in 2010.

4.6.70. Child R's IRO sought to carry out these roles to the full, chairing LAC reviews in line with the expectations of guidance, seeking to engage Child R in those meetings and to consult him before them; intervening when there were concerning developments at key points between reviews. She repeatedly reviewed case notes to identify risks and opportunities, to act as an advocate and to challenge other professionals and managers when she felt that it was necessary. She knew Child R well and made important interventions, for example she was the first professional to consistently advocate that consideration needed to be given to the use of secure accommodation.

4.6.71. Although she kept an oversight of Child R's needs the IRO could not fundamentally alter the trajectory of events. She recognised that the LAC review meetings became meetings to plan the immediate steps needed to safeguard and support Child R, rather than a forum for review of the longer term care plan. After February 2012 no two LAC reviews were ever held in the same placement; each review had a range of issues such as substance misuse services and therapy services to arrange. There was no stability from one review to the next and there was always a high level of anxiety among professionals.

4.6.72. The statutory guidance envisages a substantial and independent role for the IRO, in which for example the IRO may initiate a formal complaint or seek independent legal advice about a child's circumstances.[46] The review has considered whether in practice the IRO should have done more and whether, in principle, the service has sufficient independence to be able to do that. There is no evidence that the IRO should have tried to play a larger or more challenging role in relation to Child R. His case was already being closely monitored by senior managers, in good part because the IRO had repeatedly voiced her concerns over the level of risk. The review is also satisfied that

[46] IRO Handbook Chapter 6

IROs in Harrow understand this role and are willing to seek independent advice on behalf of a looked after child when this is required.

4.6.73. From January 2013 onwards a Children's Guardian was involved and both Child R and his mother had access to independent legal advice. Sadly neither the involvement of the Children's Guardian nor the fact that decision making was located in the independent court arena could alter the fundamental difficulties that everyone involved experienced.

5. ADDITIONAL LEARNING

This section of the report provides an evaluation of other services which are less critical in relation to Child R and where there are fewer findings and recommendations of wider significance.

5.1. Substance misuse services

Overview of provision

5.1.1. The Harrow substance misuse service had worked with Child R since February 2012 when he had been referred by the Youth Offending Team. This followed an assessment which identified substance misuse as having been an important factor contributing to his offending and a source of potential vulnerability.

5.1.2. The service remained involved with Child R from then until his final residential placement in Sussex. Three different members of the team worked with Child R, each of whom had a good knowledge of Child R and key events in his history.

5.1.3. Local substance misuse services were also in contact with Child R at each of his residential placements, except the last as he had just moved there.

The focus of interventions

5.1.4. Throughout the period under review, interventions focused on seeking to help Child R understand the potential impact of substance misuse, including the risks associated with particular drugs, injecting and overdose. In common with many young substance misusers Child R was sometimes critical of the need to have to attend sessions such as this, stating that he already knew enough about drugs.

5.1.5. As well as offering advice in the form of standardised programmes and interventions, substance misuse professionals sought to engage Child R in a more individual discussion about the personal and family factors underlying his substance misuse. He consistently avoided this sort of discussion. He would frequently tell substance misuse workers that he would soon offer a major insight or make a significant revelation about why he took drugs, but it never came.

5.1.6. As a result the same messages and advice were often repeated. In the absence of any meaningful and active engagement from the young person, professionals are left with little real alternative and they would have been open to criticism if they had not underlined the potential risks, particularly at times when Child R had tested positive for opiates or had overdosed. The Harrow service has used the experience of working with Child R to inform its current work with young people,

recognising that a more imaginative range of approaches, linked to the preferred 'learning style' of the young person, needs to be developed.

5.1.7. During the periods when he was living in the community Child R was tested either on a regular basis under the terms of the Youth Court order or because he was known to have absconded and placed himself at risk. Not all of these tests were effective as Child R appears to have found ways of 'cheating' them. On one occasion in mid-2013 (when he was living in Harrow) the test results were emailed back to the substance misuse service but not immediately accessed by staff. The substance misuse service believes that it has learnt valuable lessons and that the service has made changes to its testing regime since the period under review, using drug tests in combination and accessing results of the most reliable tests more quickly.

Coordination of provision

5.1.8. Although there is no national substance misuse service, there is a national network of commissioned substance misuse programmes with a protocol system for transferring responsibility for a patient from one service to another. As Child R was in care it was also seen as the responsibility of the Harrow service to remain involved and to monitor his progress, when services were being provided in another area. This enabled the substance misuse services to avoid some of the obvious discontinuities in service provision that mental health services suffered from (described in Section 4.3). It meant that in each of his placements (other than the very short term ones) Child R received contact with the local substance misuse service which had been informed by a knowledge of his history and previous interventions.

5.1.9. Within the national strategy each area commissions substance misuse services according to local perceptions of need, which may not coincide with the needs of looked after children placed by other local authorities. Thresholds vary and services are commissioned from a variety of providers with different skills and focus in their programmes. Transfer arrangements between services in different areas exist but are basic.

5.1.10. At some points the Harrow service appears to have been content with the service provided locally (e.g. in the Northumberland secure unit) whereas at other times there was frustration about either the lack of a specific service or the approach being taken. For example when Child R was in North Wales, Harrow staff understood that there was no drug testing service for under 18s, but this had not been established before he moved there. Harrow professionals were frustrated that Child R was apparently allowed to withdraw from the substance misuse service in North Wales because he did not feel he needed to be involved, whereas a better overview of his history would have suggested that he would continue to need a service, even if for a brief period his substances

misuse was 'in remission'. Professionals in North Wales perceived both of these issues differently, for example questioning the legal basis for compulsory drug testing of Child R provided by the Youth Court.

5.1.11. This underlined the fact that that at the point at which placements were made, it was not always clear what service would be provided. For placements made during 2012 this was only discovered after the event. During 2013 the commissioning process used by the local authority was improved to enable substance misuse staff to visit placements to test out more thoroughly whether the provision was likely to meet Child R's likely needs. However it was still not always possible to tell how effective a substance misuse service would be ahead of the young person moving to live in the locality. On paper, and on inspection the West Midlands placement made in 2013 offered a comprehensive substance misuse service, however both Child R's mother and the service manager from the local authority social care service have been highly critical of the provision actually made there and the unit's management of Child R's behaviour.

5.1.12. The search for placements for Child R highlighted the lack of provision tailored to meet the needs of provision for younger substance misusers with other behavioural problems (such as absconding) who might not always be highly motivated to address their substance misuse.

Inter-agency working

5.1.13. The Harrow substance misuse service has recognised that there were points in the case history at which it had concerns about the care plan for Child R (or the way in which it was being implemented) which could have been addressed with other professionals in a more assertive way. The service has made changes to its procedures as a result.

5.2. Youth Offending Services

5.2.1. Child R became involved with the Youth Offending Team (YOT) in 2008 when he was referred to the YISP, a project with the responsibility to develop services to reduce the risk of offending and anti-social behaviour.

5.2.2. Child R's committed offences throughout the period under review, except when he was in secure accommodation, all apparently motivated by the need to obtain money to obtain drugs or to pay debts associated with substance misuse. Offences included thefts from cars, burglaries and robberies.

5.2.3. He remained in contact with the YOT until August 2013, when the Youth Rehabilitation Order (made on him originally in 2011 but subsequently extended) expired. As he spent most of this time living at

a distance from Harrow, some of it in secure accommodation, the YOT involvement was in reality much more intermittent.

5.2.4. It has been acknowledged that when Child R was first in contact with the YOT (up to May 2012) it was not a well-functioning service.[47] Weaknesses in work with Child R are therefore likely to have been a reflection of wider shortcomings.

5.2.5. When Child R moved to North Wales in 2012, his case should have been transferred to the local YOT as part of a 'caretaking' arrangement under an agreed national protocol. Although the local team was notified about the case it was not sent significant information that it needed to undertake its work, despite several requests. Child R's YOT worker does not seem to have understood the procedure and there was insufficient management oversight. This will have made the provision by the YOT in North Wales less effective.

5.2.6. In October 2012 Child R was placed in secure accommodation, where he remained until April 2013. This was an unusually lengthy stay and made the operation of a community punishment difficult. Harrow YOT therefore played no active role with Child R but continued to liaise with staff at the secure unit, particularly the substance misuse worker, to ensure that the unit was carrying out the sort of work that the YOT would have been doing.

5.2.7. In January 2013 discussions began about Child R returning to the care of his mother in Harrow. Harrow YOT became closely involved in planning the provision that would be made to support and monitor the placement and members of the YOT attended planning meetings in Northumberland and Harrow.

5.2.8. When Child R left the secure unit in April 2013 the YOT allocated two experienced members of staff (a senior practitioner and a probation officer) to work with him. In addition the YOT education officer made an input.

5.2.9. This was a far higher level of involvement than would have been expected for a young person with Child R's criminal record whose statutory order had only had a few weeks to run. It reflected the YOT's understanding of the very high level of vulnerability of Child R and an acknowledgement that it was very important for Child R's rehabilitation to succeed in what might be very difficult circumstances. This was entirely appropriate. Activities organised by the YOT featured centrally

[47] The Core Case Inspection of youth offending work in England and Wales published in 2011 found substantial shortcomings in assessment, intervention and management oversight and identified the need for '*substantial'* or '*drastic'* improvements in key areas. Criminal Justice Joint Inspection (2011) *Report on youth offending work in Harrow*

in Child R's programme when he returned to Harrow. Section 4.4 has a more detailed discussion of this episode.

5.2.10. The overall YOT intervention with Child R is difficult to evaluate because it was so unusual. For example some offences were processed through the courts in a procedural manner because by the time they came to court Child R had moved to another area or was in secure accommodation. He frequently failed to comply with the conditions of court orders (such as curfews) but was not breached because it was judged that the best chance of progress was to find him a better placement, including secure placements. Arrangements for tagging and curfew sometimes became confused because Child R moved so often. As a result the consequences of offending (either for victims or for Child R himself) and the consequences of not complying with orders were often not apparent to Child R.

5.2.11. It is impossible to draw wider conclusions about the effectiveness of the work of Harrow YOT from one case but it is very clear that the work undertaken with Child R in 2013 was markedly more thoughtful and better planned than the work undertaken in 2011 - 12.

5.2.12. Research and inspection reports have identified the very high level of vulnerability of young people placed away from their home borough who are also involved in the criminal justice system. Taking this into account and recognising the wider findings of this Serious Case Review it will recommend that Harrow YOT undertakes an evaluation of its work with young people who are placed at a distance from Harrow to consider whether it is as effective as possible. (See recommendation 10)

5.2.13. Given Child R's history of gang affiliation while he was still in primary school the LSCB should also seek assurance as to the quality of work that is being undertaken by agencies in relation to gang affiliation of young people in Harrow, especially primary school aged children and young adolescents. (See recommendation 11)

5.3. Acting on allegations from a child centred perspective

5.3.1. During Child R's stay in the residential unit in London two incidents occurred which illustrate the importance of dealing with criminal and disciplinary allegations in a child-centred way.

<u>The incidents</u>

5.3.2. In January 2012 Child R reported that he had been assaulted during an altercation with care worker at the residential unit. The residential worker was suspended but Child R did not provide information to the police or social care to substantiate his original allegation. The police made several attempts to reach Child R, but without success. A

number of members of staff and other young people were clear that they did not believe the incident was likely to have happened and in the absence of any firm evidence the worker was allowed to return to work some two months after the alleged incident.

5.3.3. In early May 2012 a female staff member at the residential unit alleged that Child R sexually assaulted her. Her account is that he was under the influence of drugs or alcohol. This was investigated by the police but the criminal case was not resolved for some six months, until the women who had made the allegation failed to give evidence at court.

5.3.4. At around the time of the alleged episode there were other incidents which caused concern. Child R was noted to have accessed an adult porn site and made sexual comments to other female members of staff. The former is very common and easy to do. It is not clear whether the language used was very different to the kind of language and behaviour that is commonplace among some young people but produced a more concerned reaction because it was heard by professionals.

5.3.5. The dates given in preceding paragraphs indicate that the two trigger events took place four months apart. This is supported by the independent notes of several agencies. Child R's mother believed that they took place within a few days or at the very most a few weeks of one another and that there was a direct connection between the two (in the sense that the allegation against Child R was somehow made to discredit him). There is no evidence to support this though it is possible that she only heard about the first incident shortly before the second.

How the incidents were managed

5.3.6. Staff interviewed for the Serious Case Review held conflicting views about whether the two incidents described happened and how significant they were.

5.3.7. In line with normal safeguarding procedures an investigation involving Harrow social care, the local authority where the residential unit was located and the Metropolitan Police was initiated in relation to the allegation against a member of staff. Child R may have been disadvantaged in dealing with the allegation. Police records state that after missing a number of opportunities to give a statement he was asked to present himself for an interview at the local police station at 8am in the morning. The reasons for this are not clear, but not surprisingly he didn't do so.

5.3.8. Child R was reported by one member of staff interviewed to have been surprised and upset that he did not know the member of staff who he said assaulted him was going to return to work. Other professional stated that Child R was aware of this in advance and had no difficulty

over it. It is impossible to be certain exactly what took place, an indication of the inconsistent communication and recording around the matter. The local authority designated officer (LADO) in the borough where the residential unit was located had responsibility for oversight of such the investigation. The LADO records give an account of the first stages of the enquiry, but not its conclusion.

5.3.9. The sexual allegation against Child R was properly investigated by the police. However, despite its gravity and impact this allegation was not reported to the CAMHS service which could have arranged a more specialist assessment to assist professionals in understanding whether Child R did in fact pose a risk of sexual harm. It is disappointing that although the sexual allegation was dealt with correctly from a procedural perspective there was no specific focus on the needs of Child R, leaving him uncertain what was going to happen and leaving professionals unclear whether he posed a sexual risk to other young people.

5.3.10. The failure to resolve the incident had a lasting effect because placement profiles on Child R continued to contain references to the allegation, even after the charge had been dropped. This severely limited placement choice for Child R because very few establishments would have felt that they could make adequate provision for a young person who posed a sexual risk, on top of all his other difficulties.

5.3.11. It is important that when such incidents arise as well as following the correct procedural route, incidents are considered from the perspective of the needs of the child (whether victim or alleged perpetrator). This is learning that can perhaps most easily be reinforced through discussion with those who habitually undertake or coordinate such investigations including the Local Authority Designated Officer (LADO), police officers, social worker managers, reviewing officers and staff in HR departments. (See recommendation 23)

5.4. Complaints

5.4.1. Child R's mother made formal complaints under the Children Act 1989 about his care whilst he was looked after. On each occasion these were investigated and she was given a full response. The Serious Case Review has not reviewed these in detail. However it was of concern that there was no reference to these complaints in the child's electronic case records, as the corporate complaints service had separate records. This would have meant that subsequent social workers and managers might have been unaware of these complaints and the learning arising from them. In contrast it is recognised that the Director of Children's Services at the time took a close interest in the number and type of complaints received by the authority and their outcomes. No recommendation has been made about this as the review has been told

that systems are now in place to ensure that records of complaints are recorded within the child's file.

Appendices

Appendix 1	Detailed narrative of events
Appendix 2	Views of Child R and other family members
Appendix 3	Terms of reference and method for carrying out the review
Appendix 4	SCR review team members
Appendix 5	Documents and materials considered and staff involved
Appendix 6	References
Appendix 7	Association of Directors of Children's Services / Research in practice principles for work with adolescents

Appendix I

NARRATIVE

Family background and history prior to the period under review

1. Child R was the second child in a large family of Eastern European descent. The younger children are his half siblings. Child R's father died when he was an infant though the exact circumstances were not known to any of the agencies working with Child R in the UK.

2. Child R came to Harrow when he was nine, following his mother who had left their country of origin a year earlier. During the period under review agencies had very limited knowledge of Child R's life before he came to the UK and not all agencies had the same information. Agency records contain partial accounts of how the mother supported the family, though there is agreement that when the children were made subject to a child protection plan (in 2010) she was spending long periods away from them. She told this review that she was working very long hours as a cleaner. One agency record refers to allegations of domestic violence in the family, though this is not confirmed.

3. Child R's mother misled professionals about important family relationships, including the identity of the younger children's father. She made it clear to the review that for long periods of time she did not trust the professionals working with the family.

4. Child R was referred to the Youth Inclusion Support Panel (YISP)[48] in 2008 and also to Harrow Child and Adolescent Service Mental Health Service (CAMHS) and to the local authority social care service. In late 2009 he was permanently excluded from school after threatening violence to rob another pupil. He was placed on the roll of Harrow Tuition Service (which was responsible for providing education for excluded pupils) and from this point his education became the responsibility of the local authority. He never subsequently attended mainstream education.

5. In February 2010 a service offering intensive family support (the Family Intervention Project (FIP)[49] began to work with the family as a

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[48] A central government initiative '*to identify and support young people aged 8–13 who are at high risk of offending and antisocial behaviour before they enter the youth justice system, and were regarded as a key component of the Government's campaign to prevent crime and combat antisocial behaviour*', linked to Youth Offending Teams (YOT) and often managed as part of the YOT http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RW018.pdf

[49] A national network of Family Intervention Projects (FIPs) was set up as part of the Government Respect Action Plan, launched in January 2006. These projects aimed to reduce anti-social behaviour (ASB) perpetrated by the most anti-social and challenging families, prevent cycles of

whole. The work was mostly undertaken by a worker who is subsequently referred to as the Early Intervention Service (EIS) worker.[50] At this time the Youth Court made Child R the subject of a Supervision Order (for robbery, attempted robbery and theft from a motor vehicle). For the first time consideration was given to Child R becoming looked after because of his involvement in criminal activities and was beyond the control of his mother.

6. The exact nature of Child R's involvement in criminal activity is not clear. Different agency records give different accounts about this including gang activity with peers and acting as an accomplice to older criminals, some of whom may have been members of his community.

7. Child R's mother told the SCR that while still at primary school Child R began to associate with older youths and adults from the same Eastern European background who involved him in criminal activity including selling drugs. Later he became involved in a Harrow youth gang which had members from a variety of ethnic backgrounds. Associates repeatedly threatened him over debts making him fear violence from the gang and getting caught by the police. Child R had not wanted the family to know the full details of this.

8. In November 2010 all of the children in the family were made the subject of child protection plans because of neglect. At this point responsibility for them was allocated to a social worker (referred to subsequently as social worker 1). The EIS worker remained involved with the family undertaking regular visits to help the mother improve practical and emotional aspects of her parenting.

9. In April 2011 Child R started to attend a motor mechanics course linked to a school in Hertfordshire. He attended well at this point because he was taken each day by the EIS worker. Child R consistently said that he preferred this sort of vocational education. In mid-2011 his relationship with his mother and her partner deteriorated and he began to live with a member of his extended family. However this proved to be an unstable arrangement.

10. In August 2011 Child R took a drug overdose. During treatment he tested positive for cocaine, cannabis, heroin and alcohol. It started to be recognised that his level and type of substance misuse was serious

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homelessness due to ASB and achieve the five Every Child Matters outcomes for children and young people. FIPs use an 'assertive' and 'persistent' style of working to challenge and support families to address the root causes of their ASB. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222321/DCSF-RW047.pdf

[50] Although the worker was at that point employed to work in the FIP and the EIS was only created from a combination of different services in 2012

and had been underestimated, possibly because he had been able to manipulate drug test results. In September 2011 the Youth Court made Child R the subject of a 12 month Youth Rehabilitation Order (YRO)[51] which included a number of specific treatment and attendance requirements (drug testing and counselling, alcohol misuse and supervision).

Residential placement in London: October 2011 – May 2012

11. At the end of October 2011 the local authority agreed to accommodate Child R under Section 20 Children Act 1989 (a voluntary accommodation agreement with his mother). His admission to a residential unit in a neighbouring borough followed further offending and an overdose, together with a worsening relationship between his mother and maternal grandmother, with whom Child R had briefly lived.

12. The Harrow Council commissioning service circulated Child R's details to a large number of fostering and residential providers. It is notable that no fostering service offered Child R a placement. Three residential units in London did, though two were too far away from the vocational project Child R was attending to be a practical alternative. The unit selected offered care, supervision and accommodation but made no claim to offer additional therapeutic support for residents.

13. When he entered the residential unit Child R had medication for Attention Deficit Hyperactivity Disorder (ADHD) and medication to enable him to sleep better. A number of professionals doubted the value and efficacy of the medications and there is no firm evidence as to how reliably Child R took it at this time. Prior to becoming looked after he had not been taken to three CAMHS appointments.

14. In November 2011 the Youth Court re-sentenced Child R to a further 12 month YRO, maintaining the same additional conditions (effectively extending the original sentence). Child R found it difficult to settle consistently in the residential unit and was challenging and threatening to staff a number of times. Drug testing continued at the YOT but in hindsight comparison with Child R's behaviour suggests that it was not frequent or strict enough to identify the extent of his substance misuse. Child R may have tampered with the samples.

15. Once Child R was in residential care his attendance at the mechanics course declined and in early 2012 ceased altogether. The local authority and unit staff believed that he could make the journey there

[51] http://www.inbrief.co.uk/court-judgements/youth-rehabilitation-order.htm The offences were theft from motor vehicle, interfering/tampering with a motor vehicle and going equipped for theft and burglary of a non-dwelling (committed in June and September 2011)

independently by public transport and did not need to be taken. Other young people attending the programme – all from another local authority – were generally taken there by taxi. The CAMHS psychiatrist told the Serious Case Review that Child R suffered an anxiety condition and was frightened to go on public transport. Staff at the residential unit knew that at other times he would do so and believed that he wanted to be driven because he liked having contact with the EIS worker. There are also references in records to Child R's fears of other young people, though there are no details of this.

16. In January 2012 Child R reported that he had been assaulted during an altercation with a care worker at the residential unit. After the alleged incident he had run away. There are conflicting accounts of how this allegation was dealt with and views about how satisfactory the process was. The residential worker was suspended for some time but Child R did not provide information to the police and social care to substantiate his allegation. The police made several attempts were made to reach Child R, but without success. On one occasion the local authority record refers to him being told to attend a police station at 8a.m. to make a statement, which not surprisingly he failed to do.

17. Neither staff nor residents could corroborate the allegation and the experience of both was that Child R was often very unreliable in his accounts of events. In the absence of any firm evidence the worker returned to work. There are conflicting accounts of how this was explained to Child R, whether he know about it before meeting the worker and how concerned he was about it. This episode is considered further in Section 5.3 of this report alongside another in which Child R was himself the subject of an allegation.

18. Child R ceased to be the subject to the child protection plan in January 2012 on the basis that he was now looked after by the local authority. The other children in family remained so for some months and in due course their mother's care was judged to have become much better. The other children remained with their mother throughout.

19. During January 2012 a departmental reorganisation was implemented in the local authority. This redefined the roles of social work teams and led to responsibility for Child R being transferred to another social worker (referred to subsequently as social worker 2), while the original social worker retained responsibility for work with the other children in the family.

20. During February 2012 there was evidence of tensions within the professional network, particularly between the EIS worker and a number of other professional, including Child R's allocated social worker. These centred on suspicions that the EIS worker was withholding information from other professionals and not working

collaboratively with colleagues. Meetings were held between staff and managers involved in an attempt to resolve these difficulties but it is apparent from the records that they remained a feature of the case spasmodically for at least the next year.

21. During March 2012 Child R's drug tests were positive for opiates on a number of occasions, confirming long held staff suspicions about the nature and extent of his drug use. Child R explained these as 'one off' episodes.

22. In April 2012 a professionals meeting was held attended by YOT, EIS, Targeted Services (the allocated social worker 1 and his manager), substance misuse services and education staff. This recognised the deterioration in Child R's behaviour and that he had lost his place in the motor project. There was no immediate or simple answer to Child R's educational problem because there were fears that he was too vulnerable to be able to attend a Pupil Referral Unit, either in the borough in which he was living or in Harrow. The YOT had to consider whether to breach the order made by the Youth Court because of Child R's repeated positive drug tests. Social care records indicate that one of the decisions made at this meeting was that the local authority would seek a 'therapeutic residential placement' for Child R. Section 4.6 of the report considers the practical reality of seeking placements for a young person such as Child R.

23. Child R's YRO was not breached at this point or later. At each stage the decision was made that it was better to continue to work with him and find a more suitable placement.

24. In early May 2012 a female staff member at the residential unit alleged that Child R sexually assaulted her, while he was under the influence of drugs or alcohol. This was investigated by the police but the criminal case was not resolved for some six months, until the alleged victim failed to give evidence at court. This incident and some less specific concerns about Child R's 'sexualised' behaviour featured in profiles that were circulated to seek placements for Child R for the next 17 months.

25. On 4 May 2012 Social Worker 2 made an emergency placement request seeking a residential unit some distance from London for Child R. The placement referral noted the recent escalation of aspects of risk and the difficulties that Child R was having in working constructively with the YOT, the substance misuse service, the local authority and his placement.

Brief open residential unit placement in the Midlands

26. On 17 May 2012 the local authority placed Child R in an open residential unit in the Midlands. At the same time discussion began about the need for an application for a Secure Accommodation Order and a Care Order.[52] The unit had opened relatively recently. Once again it was the only one which offered a positive response to the placement profile. This was intended to be a temporary placement until one was found that would offer services specifically to address Child R's substance misuse.

27. The placement was terminated by the provider after heroin was found in Child R's room and he was alleged to have involved another resident in substance misuse. The local authority and the local YOT expressed concerns that they had not been informed of the placement and so could not identify potential risks to other young people.

Residential placement in North Wales: June – October 2012

28. In June 2012 Child R moved to open residential placement in North Wales. This was a well-established unit, understood to specialise in offering therapeutic support to young people with drug and behavioural problems. After some initial difficulties settling when Child R was aggressive to staff the placement lasted for four months (making it Child R's longest open placement outside London).

29. Child R was noted to have self-harmed in September 2012, when frustrated over the imposition of sanctions by staff. At around this time he began to go missing frequently. In mid-September he was missing for several days and told the police that *'he had not intended to abscond but had gone away from the carers for a smoke. He was then offered substances and since that time he had spent the next few days taking drugs and living rough….He disclosed that he had injected heroin in that period'.*

30. There was extensive information sharing between substance misuse services in Harrow and North Wales. However it was only established after the placement had been made that the local substance misuse provider did not offer a drug testing facility for young people under 18, which had been a key feature of the provision in Harrow. There was disagreement between the two services when the local service sought to end its contact with Child R on the grounds that he had no access to drugs where he was living and that the 'underlying' problems needed to be addressed. The Harrow service felt that based on a more long term understanding of Child R's needs a consistent intervention needed to be in place even if his substance misuse appeared to have

[52] Sections 25 and 31 Children Act 1989

abated. Professionals in North Wales have offered different perspectives on both of these issues.

31. When Child R moved to North Wales, Harrow YOT referred the case to the local YOT in order for it to take on a 'caretaker' role. This was in line with the national Youth Justice Board protocol. However the Harrow YOT worker appears to have been ambivalent or confused about the handover and did not provided proper information to support the transfer. Section 5.2 considers in detail the role of YOT services in the case history.

32. There was no immediate communication between the CAMHS service and colleagues in North Wales because Harrow CAMHS had not been informed that Child R had been moved out of London until the CAMHS service in the placement area made contact with the service in London.

33. Child R was not initially referred to the local CAMHS service, though he was seen by CAMHS staff at the end of the placement after he had overdosed. Consequently he did not have medication. In August 2012 the residential unit referred Child R to a counselling service linked to the unit. An assessment and an introductory treatment session took place shortly before Child R's placement ended.

34. In September 2012 after Child R had taken an overdose he was referred to the local CAMHS service by hospital staff and assessed.

35. On 13 October 2012 Child R took a heroin overdose leading to A&E attendance. He admitted what records describe as *'deliberate self-harm in the form of cutting arms and chest as an act of release rather than intent to end his life'.* He told staff that he *'absconds when things get on top of him and he feels sad and then he uses drugs'.* Residential unit staff were clear that in discussions with Child R he had expressed suicidal intentions.

36. At this point Harrow social care determined that the risks to Child R were not being managed safely in the open residential unit and began considering whether the criteria for secure accommodation were met and whether this form of placement was required. Although he continued to abscond and place himself at risk on 16 October 2012 Child R told a psychiatrist that '*his mental state was much changed and with no suicidal ideation and claiming he would only kill himself because he was worried about going to a secure placement'.*

37. Section 4.3 evaluates the effectiveness of CAMHS services throughout the case history.

Placement in the Secure Unit in Northumberland: October 2012 – April 2013

38. Child R was placed in the secure unit directly from the hospital where he had been taken after his overdose. The initial placement was made for 72 hours and Child R remained in the secure unit, under the terms of Secure Accommodation Orders and Interim Care Orders, until 16 April 2013 when (still under the terms of an Interim Care Order) he returned to live in the care of his mother in Harrow.

39. Child R initially found it difficult to settle in the unit. The mental health screening appointment two weeks later noted that '*Child R was very vague in what he shared re past history of criminal activity and substance use. He denied any suicidal ideation or thoughts to self-harm and stated he felt quite settled on the unit.'*

40. Child R's care plan stated that staff would address the following aspects of his history and behaviour: absconding; self-harm; relationships with family; Child R's behaviour towards those around him, such as his anger with adults and the fact that he appeared to have no awareness of or respect for other people's privacy or personal space; and his sexualised comments. Child R's most frequent (and the records suggest most fulfilling) contact was with the worker from the local substance misuse service.

41. Mental health input came from the psychiatrist and team at the forensic mental health unit attached to the secure unit. The psychiatrist there decided after assessment meetings and a series of observations by care staff that Child R should be removed from all medication and that he had '*no pronounced symptoms of ADHD, or depressive disorder or evidence of dependence to substances'* and did not fit the diagnostic criteria for ADHD. The psychiatrist's view was that Child R's symptoms were secondary to his substance misuse. He was kept under review with specific observations by staff throughout the period in the secure unit. No concerning changes were noted when he ceased taking medication. This is discussed further in Section 4.3.

42. It was not in practice feasible for Harrow YOT or the local YOT to provide a community sentence when Child R was held in conditions of security, so the secure unit effectively took over the work focused on Child R's offending. Outstanding criminal cases were dealt with by means of conditional discharges and Child R admitted a number of other offences which were not pursued in the public interest. Offences such as criminal damage were committed in the secure unit and dealt with in the same way.

43. In mid-November the Harrow EIS worker ceased working with Child R's mother and other family members in Harrow due to the very good

progress that the mother had made in caring for the other children. However she later attended meetings at the secure unit and in Harrow to plan Child R's planned discharge to the care of his mother.

44. In January 2013 Harrow Council initiated care proceedings in relation to Child R. It is unclear from the records exactly why the local authority decided to apply for the interim order at this point, though it had been an option under consideration for some months because of the level of risk to which Child R was exposing himself and the fact that Child R's mother had not consistently cooperated with the local authority's plans. Account was taken of the fact that a court may have been less likely to make a Secure Accommodation Order on a young person of 16 in the face of opposition from the young person and his mother unless there was a Care Order (or an interim order).

45. Having granted the Interim Care Order the Family Court instructed the local authority to evaluate the feasibility of Child R being returned home to live with his mother by testing his mother's ability to look after him safely and seeking to provide college placement, sporting activities, therapeutic support and anger management, drug and alcohol relapse prevention services; and behaviour management or parenting courses for his mother. There was to be an assessment report provided by the treating psychiatrist (in the secure unit). A report was prepared on behalf of the court by an independent social worker which recommended a trial return home.

46. The substance misuse service commissioned to work with the secure unit provided an assessment, counselling services and detailed proposals to support discharge of Child R when this was planned. The worker from this service appears to have made a positive and consistent contribution throughout the stay in secure accommodation and been the most significant professional person in Child R's life during this period.

47. In February 2013 the local authority convened a planning meeting to discuss and agree on support package for Child R to return back to his mother's full time care. This was attended by Harrow social care staff; the service managers for EIS and YOT; the placement team; YOT; Harrow substance misuse service and the EIS worker.

48. The proposed package included the majority of areas listed by the court above, and a range of practical and financial assistance to the family. Referral arrangements for education would be made as soon as possible ahead of Child R's return to Harrow. Outside of the meeting some doubts were expressed by the YOT as to the level of risk and likelihood of success. The view was formed that Child R would require substantial monitoring to maximise chances of success.

49. In March 2013 Social Worker 2 and the EIS worker made a home visit and identified positive changes that Child R's mother was making in preparation for his return. The mother expressed some concern about him having to go to certain parts of Harrow for activities because of potential contact with former associates.

50. Shortly after this, the secure unit expressed concern about the lack of specific updates from Harrow social care and the limited time that would be available in order to work further with Child R (allowing him visits and supervised activities in the community) before his return to Harrow. This concern was reiterated later by Child R. Active preparation began on 25 March 2013 after a secure accommodation panel agreed to discharge Child R from the secure unit on 17 April.

51. A planning meeting was held on 4 April 2013 involving service managers and other staff from Harrow. It agreed that the detailed plan would have the following components: frequent substance misuse testing; activities and support for Child R; educational provision to be made through a local college so that Child R could explore options for the summer term.

52. In contacts between the substance misuse services in Northumberland and Harrow it was noted that Child R continued to minimise or avoid discussion around risk associated with his drug use. The focus of further sessions in the secure unit was to be on the danger of reduced drug tolerance (as Child R had been drug free for several months) and risks of relapse. A detailed plan was developed for the work that would be undertaken with Child R in Harrow.

53. Recognising the serious of the potential risks Harrow YOT allocated two workers to the case even though there was a relatively short time left for Child R's YRO to run.

<u>Placement with family in Harrow: April – June 2013</u>

54. On 15 April 2013 Child R was discharged to the care of his mother in Harrow. The recorded plan was as follows (outcomes in relation to aspects of the plan are also noted):

- Referral to Harrow CAMHS for continued monitoring and support. However there were delays in this and his first appointment occurred after his placement at home had broken down. CAMHS staff were not invited to planning meetings or reviews. This is discussed in Section 4.3.
- Regular appointments and testing at the substance misuse service. These took place, though they came to be seen by Child R as part of a package that was insufficiently positive and overly restrictive. The fact that so many tests could be seen as evidence that they were necessary.

- Local authority to support Child R's education through the virtual school and Harrow Tuition Service. However it is apparent that no specific plan was in place at the point of return beyond Child R presenting himself at the tuition centre.
- Child R was registered with Harrow Leisure Centre to join swimming club and the gym as part of the Looked After Team partnership agreement with the centre.
- Social care records state that Child R and his family were to be supported by the Early Intervention Team for a period of six months. This happened and later Harrow social care commissioned an additional care package via a private provider to undertake activities with Child R and 'fill his time'.
- Child R was to attend twice weekly appointments with his YOT worker to ensure his compliance with the activity requirement of his YRO. The areas of work with Child R included standard youth justice programmes dealing with offending behaviour, consequential thinking, victim awareness, understanding and resisting peer pressure to offend and help making the decision not to offend. The programme was to be reviewed after six weeks to determine the progress.
- The allocated social worker was to have regular contact with Child R for up to four hours per week and to coordinate the activities of all involved professionals and the family to ensure compliance with the elements of the programme and to identify any unmet needs or emerging risks.

55. During the period when Child R remained living with his mother there were a number of meetings to address the effectiveness of the plan and (after the first two weeks) emerging non-compliance.

56. On his return agencies drew up a 'working agreement' which Child R and his mother formally accepted, though Child R complained that it was equivalent to being in secure accommodation. 11 days after returning home Child R was reported missing for the first time. His mother blamed the lack of preparation and the fact that he was not taking ADHD medicine (though the records from the secure unit indicate that this had been discussed and agreed with her).

57. Almost four weeks after returning home Child R was registered at the family GP surgery. Both the local authority and his mother had stated in meetings that this was a priority though neither had ensured that it happened. It took a further two weeks for Child R to attend an appointment with the GP who then referred him to Harrow CAMHS. The referral was very general (and stated incorrectly that Child R had been recently released from prison). As the GP records were still held

by the previous practice the Harrow GP had no background information to work from.

58. A looked after child (LAC) review meeting was held on 15 May 2013, attended by all of the professionals who were directly involved at that point and by Child R and his mother. In the pre-meeting with the Independent Reviewing Officer (IRO) Child R stated his feeling that he had 'too many appointments' and that professionals were too focused on testing whether he would fail. Professionals stated that they were anxious to ensure Child R was occupied during the week and that in the early stages he could be supported and monitored in the transition home. It was noted that he had already been missing for three days and as such had breached his community sentence. Professionals would need to continue to monitor the arrangements.

59. The LAC review meeting noted that the vocational course 'had been identified'. A request was made for Child R to have more money as he claimed that disposable income went on fares.

60. The following day social care staff and managers met with Child R's mother to discuss current needs and the future care plan. They stated that an application could be made for a Supervision Order if the current plan was seen to work. The mother asked for a CAMHS appointment to provide medication for ADHD and sleep problems and an experienced mentor to work with Child R.

61. Concerns emerged over the following days because Child R missed some substance misuse and YOT appointments and had positive drug tests for cannabis and on one occasion for opiates. However there was a delay of two weeks in receiving drug test results. Child R began to miss more school.

62. On 22 May 2013, following a test which proved positive for cannabis, opiates and cocaine, there was a lengthy professionals meeting reviewing the current concerns and the extent to which Child R and his mother were committed to implementing the agreed plan. There was concern that the mother was not effectively implementing the curfew or able to exert any influence over Child R. It was reported that Child R's mother had refused a suggestion that she should swop Child R's bedroom so that it was less easy for him to leave the house unnoticed at night. Child R He appeared to be taking drugs at the weekend when his activity was not supervised. Child R described as '*charming, controlling and engaging positively. However, also not reliable or honest'.*

63. Professionals told Child R and his mother that they planned to continue to support Child R at home. Arrangements were made to offer more weekend support and possibly respite care stays. However

consideration was also given to the possible need for an alternative placement and a request was submitted seeking *'a therapeutic placement that has experience of drug and behaviour treatment to meet Child R's needs (able to meet and manage his offending, drug problems and criminal behaviour)…. A high level of supervision for his own safety and the protection of staff members and people in the community …placed out of borough because of his close associates in Harrow / London who allegedly supply him drugs and influence his behaviour negatively.*

64. On 24 May 2013 service managers from social care and substance misuse service met to consider potential provision and approaches. The social care service manager made a home visit following this.

65. The next day Child R's GP saw him and identified the need for referral to a cardiologist to undertake tests. This was because Child R had reported that he had a heart problem diagnosed in his country of origin.

66. On 30 May 2013 professionals from social care, YOT and substance misuse service decided that despite the high level of input that he was receiving Child R was taking illicit drugs when he had the opportunity and presented a risk to himself and others. He seemed unconcerned about his substance misuse or the risks arising from the associated lifestyle. The assessment of the substance misuse team was that it could no longer safely manage the risks to Child R in the community.

67. On 31 May 2013 the EIS worker took Child R for a GP appointment. The GP advised against recommencing ADHD medication until Child R had been seen by a CAMHS psychiatrist. The EIS worker chased up the CAMHS appointment. On receipt of the referral the psychiatrist started to gather information as she had no information from the service in Northumberland.

68. On 5 and 6 June 2013 there were discussions between Child R and the substance misuse service about his dishonest accounts of his substance misuse. It was believed that he was presenting himself as being dependent on opiates in order to be prescribed a heroin substitute. Reflecting recent concerns, professionals agreed to explore two potential options for placements: one apparently offering specialist management of drug problems for young people; the other was a short term activity-based programme.

69. On 10 June 2013 Child R was arrested for attempted theft from a motor vehicle. In custody he was seen by a substance misuse worker who was concerned about possible withdrawal symptoms. However this was not subsequently confirmed by medical assessment at the

substance misuse service. This became a source of tension between the agencies involved.

70. A meeting of professionals on 13 June 2013 proposed that due to the increased chaotic substance misuse, the current level of risk could not be managed safely in the community and that a return to secure accommodation was needed. The Divisional Director agreed and granted permission for a three day secure admission beginning on 14 June 2013.

71. Between 14 and 24 June 2013 Child R was held at the secure unit in Northumberland. The unit's impressions demonstrate the impact on Child R of living at home. In comparison to the point when had left the unit two months earlier '*Child R arrived back …and had lost weight, he was visibly gaunt and did not present as lively or engaging as he had during his last stay period, he was subdued in his interactions'*. There was concern that Child R was in physical withdrawal from narcotics on admission and very ill for some days, though the cause of this has not been confirmed.

72. During this period Harrow social care commissioners identified a possible residential placement in Staffordshire. Professionals in Harrow understood that it was a residential rehabilitation placement which was equipped to help address Child R's substance use, mental health and offending.

<u>Staffordshire residential unit: 24 June – 29 July 2013</u>

73. On 24 June 2013 Harrow social care placed Child R at an open residential unit in Staffordshire. Prior to the placement Harrow substance misuse service had visited and confirmed that the services available should be able to assist Child R's substance misuse. On admission there was a very detailed handover between the Harrow social worker and substance misuse staff and the residential unit. This covered the identified risks, transfer of information, substance misuse concerns and provision previously made. The unit agreed to provide daily substance misuse support and interventions and to urine drug test Child R weekly and on his return if he went missing. The unit was alerted to the possibility of tests being tampered with. It was agreed that the unit worker would liaise regularly with the Harrow service to receive advise and support. Family contact would be actively encouraged.

74. Discussion about mental health support focused on priority referral to CAMHS and there was discussion about involving a service from the local mental health charity.

75. Over the following month Child R went missing on at least 14 occasions. There was no consistent pattern or explanation for his behaviour. Episodes included occasions when he absconded briefly stating that he had experienced 'bad thoughts'; absconded and returned to family home in Harrow; went missing opportunistically with other young people in the unit and times when he went missing around the time of court appearances.

76. Tests conducted on his return confirmed that on most occasions Child R gained access to alcohol and illicit drugs. He admitted taking or was tested positive for cocaine and other stimulants, heroin and cannabis.

77. His behaviour placed him at increased risk. On one occasion he was set upon by local youths leading to a hospital admission. On another he gave an account of how his attempts to obtain money led to him being sexually assaulted or at least having put himself at risk of abuse.

78. Despite this Child R spoke positively about the placement on several occasions, agreed that the services he was receiving were very helpful and repeated his commitment to remain there and change his behaviour.

79. His mother's view was that the difficulty with this placement was that too much emphasis was placed on substance misuse. She stated that this was in contrast to the placement in Wales in 2012 which she felt had been successful as there had been no drug service there and so no reminder of drugs for Child R.

80. During the placement a CAMHS referral was made. Child R declined to be involved in counselling but had met with the 'life coach' attached to the residential unit. By the end of the placement Child R had been offered two CAMHS appointments, one in Harrow – which he attended – and one in Staffordshire.

81. By mid-July all of the professionals had serious doubts about the effectiveness of the placement. A meeting was convened which agreed a range of further steps to try to reduce the likelihood of Child R absconding. It was agreed that a local psychologist would contact Harrow CAMHS in order to achieve a shared understanding of Child R's diagnosis and the type of treatment or provision that would best meet his needs. Immediate help was made available to address health needs linked to reported injecting drug use.

82. On 29 July 2013, after Child R had absconded several more times a secure accommodation panel reconvened, attended by all key local authority, substance misuse service and YOT professionals. It recognised that much to the residential unit's frustration Child R's placement was not suitable because it was not managing the risk he

posed. Suspicions were voiced that Child R's mother was giving him money during contact sessions making it more difficult to control his substance misuse. Harrow social care decided to place Child R in secure accommodation and notified the Children's Guardian and the Family Court accordingly.

83. Prior to the secure placement Child R was taken to a psychiatric appointment at Harrow CAMHS. He reported that he found it very hard to concentrate and had 'bad thoughts' which made him feel anxious. The notes of the appointment set out clearly this psychiatrist's views that Child R suffered from ADHD and needed medication and that he was more likely to seek illegal drugs if he was not able to take medication. The psychiatrist described Child R as having much more extreme anxiety than the average person so that he works himself up to expect the worst possible outcome and relieves this highly stressful feeling by taking drugs or running away. Child R told her that he felt as if his life was 'back to square one' when he was taken off his medication.

84. Child R was prescribed Ritalin again (for ADHD) and it was left for staff at the placement to monitor whether he continued to be unusually anxious. If so further medication might be warranted. Child R continued to be prescribed this medication until his death and the evidence is that for long periods of time he took it. He arrived with it at his final placement.

85. Child R's mother attended the CAMHS appointment and was said to be very emotional when her son described his difficulties. In the words of one professional she had moved '*from finding (his) difficulties and offending behaviour funny to feeling sad about his current situation and state of mind*'. Mother was disappointed that Child R was to be moved to a secure unit, especially after what she felt was a positive CAMHS appointment; however she was relieved that he was being moved from the Staffordshire placement.

86. In line with the usual experience of local authorities the search for a secure placement proved to be very difficult. This led to Child R being placed initially in a secure unit in the North West in which a proportion of the places were commissioned by the Youth Justice Board as part of the secure estate.

87. Understandably Child R's family objected to him sharing accommodation with young people who had been convicted of a range of offences and he was moved after a few day to a secure placement in Essex run exclusively as a welfare unit. At about this time Harrow's placement commissioners first approached the open residential unit in West Sussex which was to serve as Child R's final placement to

explore whether he could move there. However it was agreed by the local authority and the court that at this point he should have a secure placement.

Essex Secure Placement: August – November 2013

88. On 7 August 2013 Child R was moved to the secure unit in Essex. A planning meeting held two days later agreed that copies of the core assessment, chronology of placements, last LAC review, Placement Information Record, Personal Education Plan and psychiatric report will be made available. It was agreed that the psychiatrist attached to the unit would review Child R's ADHD medication and a clinician from the local CAMHS service would carry out a baseline mental health assessment. The local LAC nurse would undertake a general health assessment. The baseline mental health screening was sent to the allocated social worker on 12 August 2013.

89. On 16 August 2013 the Family Court granted the local authority a four week Secure Accommodation Order. The initial report from the unit was that it would focus on the following areas during the planned stay: social skills, drug and alcohol misuse, risk taking behaviour and anger management. Child R experienced some behavioural difficulties in early days at the unit, including being aggressive to staff. When he returned from a court appearance he had obtained cigarettes and had distributed them to other residents.

90. Child R continued to take his ADHD medication which was increased slightly on review by a local psychiatrist. Letters about medication were copied to Harrow CAMHS. Child R continued to report serious problems in sleeping which were confirmed by staff.

91. In September 2013 Child R's case was reallocated to a senior practitioner in Harrow's looked after children service (referred to subsequently as social worker 3). He knew the case well and had previously provided some supervision to social worker 2. It is clear from interviews with staff and managers that there was at this point a widespread view – both within the local authority and among colleagues in other agencies – that despite putting a huge amount of time and effort into working on the case, social worker 2 was not dealing effectively with such a difficult piece of work.

92. On 3 September 2013 a baseline assessment of Child R's educational attainment levels was undertaken by the secure unit. This is the first time that such an exercise is mentioned in the chronology though possibly not the first time one had been done.

93. Entries in the chronology show that for the remainder of his stay in the secure unit Child R received a range of provision to meet his health,

education and welfare needs. His engagement overall with the unit remained poor because he was very frustrated at having to be there and at restrictions imposed on him. Child R had regular minor aggressive outburst. They usually happened when staff challenged his behaviour or restricted his privileges. These included some restrictions on the form of contact that took place because there were concerns that Child R's mother was trying to pass him money and cigarettes.

94. Throughout this time Child R had access to a confidential advocacy service in order to offer him a stronger voice both in relation to his immediate concerns and to help him participate as fully as possible in the Family Court proceedings.

95. On 16 October 2013 a visit was made by Child R, his mother, social worker 3 and the substance misuse worker to a residential substance misuse treatment facility in Surrey. This is notable because it was the first time that all of the key people involved had had the opportunity to visit a potential placement in a planned way, rather than seeking a placement in response to a crisis. Staff and family were optimistic, but the unit decided that it could not meet Child R's needs. In hindsight it appears to have been targeted at more mature substance misusers with a strong personal commitment to quit and no obvious behavioural problems.

96. On 18 October 2013 the local authority decided that it would not apply to extend the Secure Accommodation Order beyond 1 November 2013. Its thinking is likely to have been strongly influenced by that the fact that the Children's Guardian had made it clear that he felt that there was no prospect of Child R ever successfully engaging with discussions about the causes and meaning of his substance misuse while his liberty was being restricted and he would therefore be unlikely to support the continuation of the order.

97. On 22 October 2013 the residential substance misuse facility refused a placement for Child R. The local authority asked the secure unit to continue Child R's 'mobility' activities, making it clear that there would be no further secure application.

98. From 23 October 2013 the local authority was now working within shortened timescales set out by the schedule of court hearings and the decision (pragmatic but possibly inevitable) not to seek an extension of the Secure Accommodation Order beyond 1 November.

99. Social worker 3 immediately prepared a further placement profile which stated that Child R '*required a therapeutic residential placement with experience of drug and behaviour treatment to meet young children's needs (able to meet and manage his offending, drug problems and criminal behaviour). Due to R's absconding history, he*

required a high level of supervision for his own safety and other people in the community.'

100. The profile said he needed '*a specialist placement to meet his needs through intense therapeutic intervention, love, affection, care, supervision, guidance and boundaries with positive role models as well as educational needs'*. Further '*R needed to be placed out of borough because of his close associates in Harrow/London who allegedly supplied him drugs and influenced his behaviour negatively'*. This profile included an amended reference to the allegation of sexual assault dating from 2012.

101. Once again there was only one positive response to this profile – from a company which ran a number of small children's homes in Sussex. The feedback provided by the commissioning unit in Harrow explained further that the unit was additionally recommended by a senior member of staff from Child R's current secure unit. There were lengthy discussion between the residential units regarding Child R's needs and the challenges experienced at the secure unit.

102. The commissioning service noted that '*the unit had a consultant psychotherapist supporting the staff team and contributing to the treatment plans for the young people. They also commission therapists for young people in line with their care plans and in consultation with the placing local authorities. Young people are looked after on a one to one staffing ratio and weekly progress reports are provided to the local authority'*. The unit commented that it had '*successfully supported young people who have experienced substance misuse issues and absconding behaviour. Each young person has a 24 hour management plan which identifies the areas of the day where the young people are most vulnerable and considers the best support at these times'*. There were two other looked after young people living in the home, both young women.

103. On 28 October 2013 the proposed placement was agreed by service managers within the local authority after consultation with the substance misuse service. The final placement was agreed at the Access to Resources Panel (which had been set up by the local authority to monitor more carefully the quality and outcomes of placements). The placement was supported by the Children's Guardian who Cafcass say had '*made his own enquiries'*.

104. Child R visited the unit with his mother and staff from the secure unit. He was positive about it and told social worker 3 that he felt it was a placement where he would be able to work on his problems. His mother was concerned about the presence of young women in the unit since she felt that they might be a distraction for Child R, who might

become the subject of allegations. Reassurance was sought over this with the unit which provided details of staff cover, supervision and care arrangements at night. Child R's mother also identified a potential concern that Child R would need to be referred to the local CAMHS service and so would not receive support immediately. The unit said that it would also be possible to make a 'private' referral with the support of the local authority.

105. On 1 November 2013 the Family Court made a Care Order on Child R with the support of the Children's Guardian. Both Child R and his mother opposed the order and Child R presented a letter to the magistrates which argued that the majority of his problems had been caused by the local authority offering the wrong kind of support and making bad decisions about his care. His letter asked the court to return him home under the terms of a Supervision Order. The court considered his letter and noted its contents in setting out the reasons for its decisions. The greatest weight was placed on there being more likelihood that Child R would benefit from the services he needed if he was living in a residential unit. Child R's letter is referred to in more detail in Appendix 2.

Final placement in Sussex and the response of agencies when Child R left the residential unit without permission

106. Child R was placed at the residential unit at about 18.30 on Friday 1 November 2013 by his keyworker and a member of staff from the secure unit. Staff believed that he settled well during the evening and there were no difficulties noted.

107. The following day (2 November 2013) staff took Child R and the other young people on a day outing. He appeared to very much enjoy the trip and was again apparently settled in the early part of the evening. He left the unit, followed by a staff member, to try to obtain cigarettes from the local shop, and returned. However at about 20.30 he disappeared from the home when he was momentarily left without immediate supervision. His motivation for absconding is unclear as are most of his movements and actions over the following days.

108. After searching in the immediate vicinity the manager on duty reported Child R's disappearance to the police. Information about a variety of potential risk factors was recorded (confirmation of Child R's age and the fact that he had absconded from a residential care home; past self-harm and suicide attempts including a previous overdose; Child R's diagnosed ADHD and medication). In discussion between the unit and the call taker at Sussex Police the episode was classified under the Sussex Police protocol as being a report of the child being absent, due largely to the fact that the behaviour was 'not out of

character'. This meant that the police notified officers in the local force but did not actively take steps to seek Child R, such as arranging to visit addresses where he might have gone (and asking other the Metropolitan Police to do so).

109. The residential unit also contacted Harrow's Out of Hours customer contact service which noted the information. The referral was not passed to the Emergency Duty Team in the normal way because the computer system which would have enabled this was not functioning properly that weekend. Information was passed to the team in the looked after service on Monday 4 November.

110. The categorisation as an absentee was confirmed by supervisors in Sussex Police on several occasions during the next 24 hours.

111. Review by a more senior officer on 4 November 2013 led to the decision that Child R should be reclassified as 'missing', which meant that the police would now actively gather information and lead enquires to establish his whereabouts. Police officers attended the residential unit and obtained fuller information.

112. Police records state that the unit was able to provide only limited details of Child R based on the information received from Harrow social care and the secure unit. Details did however include his ADHD medication, Harrow social work contact details and his mother's contact details. The unit had no photograph of Child R and no clear information as to whether or not he had a mobile phone via which he could be contacted. His property check and handover from the secure unit had revealed no mobile phone, though another resident said that she had seen him use one.

113. The actions of the residential unit, the police and the local authority are considered in detail in Section 4.5.

114. At 16.47 Child R was graded as a low risk missing person based on information received from the residential unit. Answers 'no' were given to the following questions: '*recent absconding, risk of suicide, physical or mental illness, child protection (but noted that he was subject to a Care Order) and drug/alcohol'.* An hour later the risk assessment was upgraded to 'medium' by a more senior police officer and seven immediate actions was set out for police officers to implement.

115. Two hours later Child R's mother's address was visited and searched by the Metropolitan Police Service. His mother was judged to be genuinely surprised by his absence and readily provided names and addressed of family members and associates, none of which proved fruitful in establishing his whereabouts.

116. During the morning of 5 November 2013, Sussex Police were contacted by social worker 3 and by mother separately alerting them to their views that Child R was at a high level of risk of self-harm or drug misuse.

117. There is strong evidence that during the evening Child R was one of two young people who jointly attempted to rob a person in Ealing. His description, clothing and minor injuries that he sustained closely match the description of one of the perpetrators.

118. The following morning Child R was found dead at a flat in Ealing. He had come to the address (which was the home of a recent acquaintance) the night before, having been previously staying at the house of another friend.

119. The post mortem findings show that he had taken an overdose of three drugs, cocaine, heroin and a strong painkiller that is available on prescription but often also used illicitly, as well as alcohol. The levels of substances found in the blood stream were sufficient to be toxic but are below normally lethal levels. The post mortem report indicates that Child R's death would have been caused by the effect of taking the drugs in combination.

120. It is reasonable to draw the inference that Child R's tolerance to drugs which he had taken previously on a large number of occasions had been reduced because he had spent the previous three months in secure accommodation during which time he had not had access to drugs or alcohol.

Appendix II

VIEWS OF CHILD R AND HIS FAMILY

Introduction

1. During his life Child R made many comments and a number of written statements about the services that he was receiving. His mother and other family members were interviewed by two independent members of the Serious Case Review team. The views of Child R and other family members are reported here without being tested or triangulated against the records and experiences of professionals, some of whom would offer very different views.

2. There was for a lot of the time a considerable gulf between most of the professionals involved and Child R and his family. The family say that there was no professional in whom they felt able to place consistent trust. It is understandable that when dealing with complex difficulties and very risky behaviour family members and professionals will have different perspectives. The need to establish a degree of trust in the working relationship between family and professionals (and among professionals themselves) is fundamental because without it there is very little prospect of either party achieving its objectives.

Steps taken to establish Child R's wishes and feelings

3. Professionals almost universally describe Child R as intelligent, charming and even charismatic young person. Compared to many young people of his age, he had a very good record of attending meetings with professionals, including looked after and secure accommodation reviews. Records say that he consistently engaged very well and gave his views in a very articulate way. Records of looked after review meetings show that the independent reviewing officer consistently spoke to him before review meetings and then either encouraged Child R to present his views or did so on his behalf.

4. Professionals from all agencies made substantial efforts to try to obtain and listen to the views of Child R, to understand them and to use them to help formulate assessments and plans. A number gave the review a very similar account, i.e. that they spent what initially seemed like productive time with him, but that they knew that their engagement was very superficial and that Child R would usually not follow through on commitments he had made. A number of professionals commented on how he repeatedly offered the prospect of 'an important revelation' which would explain why he was the way he was and what would change in future. Sadly no such moment ever came and professionals found him almost always reticent to talk about his behaviour, such as his offending, or the underlying reasons for any of his difficulties.

Views of Child R

5. This summary of Child R's views draws on records of many discussions that professionals had with him, including notes of the independent reviewing officer's formal consultations and discussions with Child R the before or at looked after review meetings. It also relies on two documents that Child R produced: a letter written as a contribution to his secure accommodation review in August 2013 and a lengthy letter passed to the magistrates in the Family Court at the final hearing in the care proceedings in November 2013. Though they do not acknowledge many of his difficulties, both are carefully written and well-constructed statements. At points they refer to previous reports and documents that he must have remembered existed.

6. It is possible that Child R was assisted in preparing one or both by an independent advocate who visited him at secure unit, though this is not certain.[53]

7. In August 2013 Child R accepted that he should stay for a further month in the secure unit because he was taking medication and receiving treatment from a psychologist who was helping him find ways of dealing with stress and anxiety without resorting to taking drugs. He stated that he had been promised an apprenticeship in motor mechanics starting in October with a friend of a member of his family. He complained that in 2011 he had been attending a motor mechanics project which was 'taken away' because he was placed in a children's home too far away from it and not taken there.

8. He stated that his worker (unnamed but probably his EIS worker) has also been taken away and asked to speak to her again, though he said that this request had been denied. As he had done so badly since he had been in care, he did not want to be on a Care Order. However he agreed to move (after the secure placement) to a place which will offer 'therapy and drug support together'. He reported speaking to his mother during contact visits including some discussions about why she had agreed to put him into care.

9. The letter presented to the magistrates on 1 November 2013 restated the same information and made additional points. Child R stated that he had been moved too often. He noted that in North Wales he had not been given any support in relation to substance misuse, but this turned out to be a good thing because for quite a long time he did not think about drugs. He stated that in this placement he had not been given the therapeutic support that he had been promised.

[53] It is known that the advocate visited the Secure Unit while Child R was there; however as the service is confidential it is not possible to establish whether the advocate saw Child R or what they discussed.

10. When he had returned to live at home in mid-2013 his 'unrealistic timetable' made him very anxious. His social worker had refused to write in his notes that he had 'suffered from severe anxiety'.

11. Child R recognised that the last two years of his life had been wasted and that he felt it was important 'to make something of my life before it is too late'. He described the impact of being in care as being extremely negative because it had resulted in him having no friends, constantly being moved and having no qualifications

12. He stated that he was 'very keen to have therapy' when he returned to the community' and that care homes had not worked. He promised that if he went home he would attend therapy and that he would not need to take drugs if he did so.

13. He predicted that he would not succeed if he was placed in another care home and asked the court to allow him to live at home on a Supervision Order.

Views of Child R's mother and other family members

14. When Child R's mother was interviewed by members of the Serious Case Review panel she made some use of an interpreter. She says that her English is now considerably better than it was when Child R first had problems and became looked after (2008-2011).

15. Child R's mother said that on at least two occasions interpreters had come to the house who spoke the wrong language.

16. The overall attitude of family members was that the mother would not have agreed to Child R being accommodated if she had realised that the provision for him would be so poor at times and he would be moved so many times and to different parts of the country

17. She would have complained much more forcibly when she was not happy and would – if she had realised – demanded a replacement for social worker 1 who she felt was too inexperienced to be able to understand and assist with problems. According to the mother this worker relied on a 'checklist' approach and she was threatening. She said that Child R and the other children did not like her and no one trusted her. She believed that this had been her first case after qualifying. She was concerned that social worker 2 was also inexperienced and that neither was suitable to be responsible for such a difficult case

18. Child R's mother said that she had found it very hard to trust professionals and that it had taken her about two years to begin to trust the EIS worker. As a result the mother deliberately missed appointments and gave misleading information. Child R had taken

several months to start trusting the same worker. She acknowledged that Child R himself, members of the extended family and other people in her community were telling the mother not to trust social care.

19. Later Child R had wanted someone to talk to such as a therapist who would offer a confidential service and would not report what had been said back to social care.

20. Often the standard of work had been poor, social workers were very busy and made simple mistakes like mixing up the names of children. The mother felt that work had focused on finding fault and threatening to take the children away rather than supporting her to be a better parent. In hindsight she felt that she wished she had trusted the EIS worker sooner, but on the other hand she wished she had been more assertive and made more complaints when she believed that things were done wrongly.

21. Child R's mother was very critical of the care that had been provided for her son at the residential unit in London and at one of the residential units in the Midlands, where she said that staff had taken Child R out with another local child when there was a very high risk of him absconding.

22. Too little effort had been made by the local authority to find a placement that could help Child R with his substance misuse. She did not understand why she had been able to find a placement on the internet which social care had not found.[54]

23. Other resources that Child R was sent to were not as good as they should have been. For example one unit was supposed to be 'the best unit for drug treatment in the country' but when Child R was placed there she believed that the local substance misuse service just offered weekly appointments and the unit offered aromatherapy.

24. The mother's greatest concern was that the plan to rehabilitate Child R to live with her in April 2013 had been poor. There had been too many monitoring appointments, Child R had not been offered a place back at the motor project and he had not been offered a CAMHS appointment, which had been promised. She was disappointed that the Interim Care Order had been continued because there had been a very thorough and positive home assessment. Even though Child R was nearly 17 at the time of the final care hearing, his mother felt it was important to fight the Care Order because she believed that she would have no say

[54] This is the placement referred to in paragraph 95 of Appendix 1, which did not in the end accept Child R).

over what happened to Child R until he was 18 and that she might not even see him.

Appendix III

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

Working Together to Safeguard Children 2013 (Sections 4.9 and 4.10)

Child R Serious Case Review Terms of Reference

1. What were the key points for assessment and decision making for Child R during his time as a Looked After Young Person, and what can we learn from these?
2. What was the professional understanding of R's risk and vulnerability at key decision making points?
3. How did assessments and interventions with the family seek to understand and evaluate issues of diversity, including ethnicity in particular?
4. To what extent did family views and involvement affect planning, including the court proceedings?
5. When and in what ways were the young person's wishes and feelings ascertained and taken account of?
6. What implications does this review have for multi-agency groups, which consider the needs of vulnerable young people?
7. The review to evaluate:

a. Impact on Looked After Children planning and service delivery when children are moved frequently and/or placed a long way from home

b. Implications for LSCBs when vulnerable children from other local authorities are placed in their areas.

8. Where can we identify good practice in this case?
9. How can the LSCBs involved make sure the learning from this review leads to lasting service improvements?
10. What can LSCBs do to hold agencies to account to improve the quality of services to looked after children?

The SCR will identify how the learning will be acted upon by agencies and within which timescales, in order to improve safeguarding practice in the borough, and other local authority areas involved, and provide learning for interventions, particularly for vulnerable young people.

How the review was undertaken

1. The review compiled a chronology of key events based on the written and electronic agency records. A large number of original records and documents were submitted by participating agencies and seen by members of the review team.

2. Members of the review team conducted interviews with staff who had been involved with the family and with senior representatives of the agencies who could advise on agency policy and organisational matters. In total some 30 staff had face to face interviews and a number more telephone interviews. The roles of those interviewed are listed in Appendix 2. The intention of the review was to understand as fully as possible the actions and decisions that had been taken and the reasons for them. A lead reviewer held meetings with groups of staff who worked with Child R in Northumberland (his longest placement) and Sussex (his final placement).

3. It was not considered proportionate use of time to hold interviews of meetings with staff from other areas, so scrutiny of services by the review team focused on chronologies, records and reports.

4. Staff currently working in Harrow agencies who had been involved were invited to a workshop to discuss the emerging thinking and findings of the review in order to be able to test and shape its findings. A further meeting was held in order to explain the findings and discuss the recommendations. Both influenced the final report.

5. Meetings of the review team considered detailed notes of the interviews with staff and managers as well as some individual case records and background documents.

6. The lead reviewers prepared a draft copy of this report which was discussed at a review team meeting. The findings of the review were then discussed at meetings with staff and managers who had been directly involved. A draft of this report was circulated to all participating agencies and LSCBs for comment on any factual matters and findings.

<u>The review team</u>

7. A full list of the roles and job titles of Serious Case Review team members is set out in Appendix 4 of this report. Review team members are experienced clinicians or managers in member agencies or designated health professionals with substantial experience of safeguarding children.

8. The LSCB commissioned Edi Carmi and Keith Ibbetson to act as lead reviewers, chair meetings of the review team and prepare this report

on its behalf. Both have attended a number of training programmes in relation to the conduct of Serious Case Reviews and had previously carried out a large number of independent reviews. Neither has any connection with the agencies involved or any relationship with individuals concerned with it. Edi Carmi has undertaken previous multi-agency management reviews on behalf of Harrow LSCB.

A review that is fair as well as thorough

9. As well as being thorough in its scrutiny of events, the Serious Case Review has sought to be fair. It has judged the actions of professionals and agencies against established standards of good practice as they applied when the events in question took place. When the actions of individuals, groups of professionals or agencies as a whole, are found to fall short of established professional standards this is stated, together (where possible) with an explanation of why that happened.

10. Attention is sometimes focused on the actions and decisions of individuals, because they made (or could have made) a difference. The review has also tried to understand the influence of a range of organisational factors. The focus on the team, the service, the agency as a whole and the collective actions of agencies does not diminish the responsibility of individuals to act professionally and to work effectively. It explains the factors that sometimes make it harder for them to do so.

11. There is self-evidently some advantage in being able to review the history of professional involvement with a young person armed with an overview of events and knowledge of the outcome. However, along with the clarity that hindsight offers, the Serious Case Review has taken account of the danger of what is termed 'hindsight bias'. More can be learnt by understanding the reasons for actions and decisions than by simply commenting that they were part of a sequence of events that had a tragic outcome.

12. The review has considered both the work of individual agencies and multi-agency working and it has sought to understand the role that individual, professional and organisational factors played in shaping the actions taken and decisions made.

Appendix IV

SCR REVIEW TEAM MEMBERSHIP

Agency	Designation
Edi Carmi	Independent Lead Reviewers
Keith Ibbetson	
Harrow Clinical Commissioning Group	Designated Nurse
	Designated Doctor
Central and North West London NHS Foundation Trust	Assistant Director of Operations
Metropolitan Police Service	Serious Incident Review Officer
	Detective Inspector Harrow CAIT
Harrow Council	Assistant Director Targeted Services
	Assistant Director EIS
	Service Manager
	Principal Lawyer
Cafcass	Head of Safeguarding / Senior Service Manager
Northumberland LSCB	Principal Social Worker
Harrow Safeguarding Children Board	Governor Representative / Lay person
	Business Manager
	Administrator
	Independent Chair (Observer)

Appendix V

List of documents and material considered by the Serious Case Review team and roles of professionals who contributed

Chronologies of contact with family members from participating agencies.

Child R - Looked After Child Review meetings and other professionals meeting minutes

Child R - Child Protection Conference minutes and strategy meeting minutes

Child R - Placement profiles

Harrow Council - Responses to formal complaints

Report of Sussex Police Professional Standards Department Review

Reports and correspondence from consultant psychiatrists

Report of independent social worker

Report of Children's Guardian

Statement of Facts and Reasons

Report of preliminary disciplinary investigation

Correspondence and reports from health trusts and clinical commissioning group in relation to the Harrow looked after children's health service

Minutes of Harrow Corporate Parenting Panel

Minutes of Harrow Health and Wellbeing Board

Submission to court made by Child R

Submission to secure accommodation panel of Child R

Chronology of electronic tag incidents

Correspondence from vocational project

Residential units - risk assessments and management plans

Interviews with staff and former staff

Social workers

Social work team managers

Social work service managers

Independent Reviewing Officer

Worker and manager – Harrow Commissioning Service

Heads of Service – targeted services and early intervention services

Substance misuse workers and team manager

Youth Offending Team workers and managers

Early Intervention Service worker and managers

Director of Children's Services

Consultant Psychiatrist

Virtual school attendance officer

Head – vocational skills project

Children's residential unit worker and deputy manager

LSCB former independent chair

Telephone conversations

General Practitioner

Staff at Harrow Tuition Service

Group discussions

Residential care staff and managers, psychiatrist and substance misuse worker Northumberland

Residential care staff and managers Sussex

Appendix VI

References

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Appendix 7 **See separate document**

That Difficult Age: Developing a more effective response to risks in adolescence – seven principles

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