Cambridgeshire LSCB

Serious Case Review of Child G

Executive Summary

Date of Death 2009

Cambridgeshire Local Safeguarding Children Board

Report by:
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1. Introduction

1.1. The Serious Case Review (SCR) of Child G was established under paragraphs 8.2, 8.3 and 8.6 of Working Together to Safeguard Children 2006 in order to identify any lessons to be learned about the ways the agencies involved worked together to safeguard and protect the welfare of Child G. It was intended to identify clearly what those lessons were, how they would be acted on and what changes those actions were intended to achieve.

1.2. This Executive Summary describes the key facts and findings from the SCR. Eleven agencies contributed to the SCR, each providing an Independent Management Review (IMR) on the basis of case records and interviews with staff who had been involved with the family from each agency. The Executive summary was prepared jointly by the overview author and the Independent Chair of the Serious Case Review Panel.

1.3. The agencies who contributed to the SCR are listed below:

- Cambridgeshire Community Services (NHS)
- General Practitioner
- Cambridgeshire Constabulary
- Cambridgeshire Education Department
- Cambridgeshire Children and Young People's Services – Social Care Agency
- Youth Offending Service
- Connexions
- Queen Elizabeth Hospital NHS Trust
- Hinchingbrooke Healthcare NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust

1.4. The decision to conduct a SCR was made by the Serious Case Review Panel (SCRP) on 24.3.09. The scope and terms of reference for the SCR were established by the SCRP, which was independently chaired and made up of senior officers from the key agencies who provide services to children in Cambridgeshire. The SCR Panel provided managerial oversight of the IMR and SCR reports, which were approved by the Cambridgeshire Safeguarding Children Board on 8th December 2009.

2. Brief description of family circumstances and events leading up to Child G's death

2.1 Child G lived with his mother and younger siblings. He had support from his extended family. G was a white Irish young person.

2.2 Little is known about G's father and the role he played with G as a parent.

2.3 His first four years were characterised by frequent visits to the GP for minor ailments.

2.4 G's had frequent moves both between family members and other parts of Great Britain. There were reported incidences of domestic abuse towards his mother from some of her partners.

2.5 G was diagnosed with ADHD at 10. He experienced some behaviour problems at school and at home. He had frequent contact with a number of agencies for a range of problems relating to his health, his schooling, his social development and his emotional well-being.

2.6 His frequent changes in his family circumstances, coupled with the 'symptoms' of his diagnosis of ADHD exacerbated some of his behaviour difficulties which meant his mother regularly sought help from a number of agencies in relation to G as well as for herself.

2.7 G was a caring young person who tried hard to support his family in particular his younger sibling in times of family crisis.

2.8 G's unhappiness is reflected in the reports of his self harming behaviours. By 14 he was at risk both of becoming a persistent young offender and of having serious mental health problems.

2.9 At the age of 15 he made an unsuccessful suicide attempt. At this stage a significant number of agencies were in contact with him.

2.10 G received support from some family members and professionals which resulted in some positive changes, and aged 17 he had found work as a part time youth worker.

2.11 Just before his death he heard he had not been accepted for a job he was very keen to get. He had also lost his part time job.

2.12 He committed suicide in 2009.

2.13 G's death was a tragedy and he is sadly missed by the large number of friends and family that knew him.

3. Lessons Learnt

3.1 The material available to the Serious Case Review was carefully analysed in order to understand why, at each stage in G's life, the range of professionals from a number of agencies involved with G

made the decisions they did, the sequence of events, and what lessons could be learnt from G's death to help develop practice in the future

3.2 The Serious Case Review Panel concluded that it was unlikely that Child G's suicide could have been prevented. However, the review did identify a number of critical periods in Child G's life where things could have been done differently, which may have helped improve the support provided to G.

3.3 A number of key individuals, particularly staff in Child G's last school, showed exceptional commitment and skill in trying to help him. Their contribution was important but was affected by the difficulties resulting from other agencies not working effectively together.

3.4 The SCR has identified a number of key themes where lessons were learnt. The main lessons learnt across the LSCB network are that:

- **Inter-agency working is developed and strengthened and agencies share responsibility for taking a holistic approach to meeting a child's needs.** Agencies did not work effectively together and this meant that there were missed opportunities to provide more effective support to G and his family in the right way and at the right time.

- **There are appropriately trained and experienced social work staff who are able to support children and families with a range of needs, including mental health needs.** The background, context or family history of Child G was not properly identified or taken into account by any agency when they first met him or his family. Agencies dealt with the immediate problem and did not do a comprehensive assessment or identify what was most likely to improve things for him.

- **However complex the circumstance, a focus is maintained on the child.** Child G was rarely seen on his own. The majority of professionals in their contacts did not seek his views. There were missed opportunities for understanding the nature of his difficulties. Children in need must be seen alone by professional staff working with them, and their wishes and feelings recorded.

- **Missed appointments are seen as a key risk indicator, particularly when there is a pattern of missed appointments followed by new requests for help.** Child G and his mother had difficulties in keeping in contact with services, particularly Child & Adolescent Mental Health Services. It is important that when families with multiple problems do not engage with specific services it is not interpreted as the individual indicating they no longer need help. Agencies need to find alternative methods for engaging with them.

- **Training and development in understanding the risks attached to self harming and suicidal behaviour are important for staff working with young people with complex emotional and behavioural problems, as well as alcohol and substance abuse problems.** All staff working with adolescents need support to understand that when a young person makes a serious suicide attempt this must be treated as a serious safeguarding issue as well as a mental health issue. Staff need to be able to access advice and support to help them respond appropriately.

4. Recommendations:

4.1 Arising from the Overview Report the following recommendations are made:

Outcomes	Recommendations
Inter-agency working is developed and strengthened and agencies share responsibility for taking a holistic approach to meeting a child's needs.	• Agencies should share with one another any staffing difficulties which could affect their capacity to deliver a safe service. • The Children's Trust Board ensures consideration of the National Service Framework for Children. • The Children's Trust should make sure that effective jointly commissioned services for children are in place. • All staff should have individual Professional Development Plans which identify their training needs and ensure they are fully equipped to undertake their duties, make appropriate decisions and remain professional even when under pressure. • The Children's Trust ensures the further development and increased use of the common assessment framework in Cambridgeshire to ensure more effective early intervention and prevention.
There are appropriately trained and experienced social work staff who are able to support children and families with a range of needs, including mental health needs.	• Tools are developed to help Social Work staff recognise a range of serious risk factors and respond appropriately. • The referral and assessment system in Social Care is regularly examined to ensure it is effective and are suitably resourced • Staff working with adolescents should be able to recognise and respond to symptoms of distress in a young person which could lead to significant mental health problems • Staff working with adolescents should have basic training in suicide awareness and risk assessment.
However complex the circumstance, a focus is maintained on the child.	• All agencies should ensure that professional staff working with children and young people with specific needs see children on their own and should make sure that the views of children are recorded in all such

	cases so that they can inform any decisions made about them.
Missed appointments are seen as a key risk indicator, particularly when there is a pattern of missed appointments followed by new requests for help.	All agencies review the way they respond when people do not attend for their appointments, to make sure they are getting the services they want and need.
Training and development in understanding the risks attached to self harming and suicidal behaviour are important for staff working with young people with complex emotional and behavioural problems, as well as alcohol and substance abuse problems.	All staff working with adolescence will be supported to understand that when a young person makes a serious suicide attempt they must be treated as a serious safeguarding issue.

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Panel

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24.11.09