Islands Child Protection Committee

Working Together for the Children of Guernsey and Alderney

ISLANDS CHILD PROTECTION COMMITTEE

SERIOUS CASE REVIEW
Executive Summary

CHILD/ADULT Y

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INTRODUCTION

1. This Executive Summary sets out the findings of a Serious Case Review (SCR) about Child/Adult Y, a young woman who died having been hit by a car. The police investigation which followed the collision suggested she had taken her own life by deliberately stepping out in front of the car. Ultimately a Coroner's Inquest will decide if the cause of death was suicide.

2. At the time of her death Child/Adult Y was a young adult of 18 years. She was from an EU country and not of English-speaking origin or heritage, and had been in the care of Guernsey Health and Social Services Department since the age of 6 years. At the time of her death she was a care leaver.

3. The decision to hold a Serious Case Review was made using local, Channel Island, criteria, the rationale being that,
    - Child/Adult Y was a child looked after by Guernsey for a considerable period of time.
    - She was placed outside the jurisdiction by the Health and Social Services Department (HSSD) and her placement was approved through the Complex Needs Panel and funded by Guernsey.
    - After becoming 18 her placement continued to be funded and organised through social work services in Guernsey and she was considered a recent Guernsey care leaver.
    - All of the issues to be examined in a review of her case would be concerned with her time in care and her very recent transition leaving care.
    - Before she turned 18 a SCR could have been considered under regulation 5(2)(a) and (b)(ii).

4. The review was overseen by a SCR panel which had representatives of local agencies. They set the time frame of the review to consider the events relating to Child/Adult Y from the time of her first known overdose in January 2013 until the time of her death in January 2015. All relevant services were required to provide a detailed chronology of involvement. This time period was agreed in order to focus the review on the response of services to her physical and emotional wellbeing prior to her eventual death from suspected suicide.

5. Agencies were also asked to provide a chronology of key events in the life of Child/Adult Y prior to 2013 in order to see how key decisions were made in the light of practice at the time, and how those decisions impacted on her life. In fact it proved important to consider Child/Adult Y's life as a whole rather than be restricted to the final two years.

6. The SCR panel appointed an independent person to lead the SCR: Hilary Corrick Ranger who is an independent social work consultant. She has many years of experience, and had no previous links with agencies involved with Child/Adult Y.

7. Each agency which had been involved with Child/Adult Y was asked to provide a report about their engagement with her, as well as a chronology.

8. Although she had been in the care of Guernsey since the age of six years, and was a Guernsey care leaver, Child/Adult Y had spent most of the last six and a half years of her life in the UK, and key agencies in terms of care and decision making were on the UK mainland as well as in Guernsey. This made for particular difficulties for this review, and a meeting was held in the UK for agencies which had had involvement there with Child/Adult Y.

9. A learning event was held in the UK for frontline professionals who had worked with Child/Adult Y to share their experiences with each other, reflect together on the key events of her life, respectfully challenge each other and explore what, if anything, could have been done differently.

10. Child/Adult Y's mother and step-father were aware of the SCR from the start, and the author visited both of them and their child separately in order to make sure their views were heard and considered as part of the review. It did not prove possible to speak to Child/Adult Y's father.

11. The SCR panel identified a number of key issues at the start of the process under the headings of Assessment and Planning, Leaving Care and Out of Jurisdiction Placements, as well as General, which included areas of good practice and implications for practice, management and training. They asked that relevant research be included in the review. Inevitably, in the course of the review, other key themes and issues emerged:

    Themes:

    - Attachment issues
    - Identity/ethnicity/culture
    - Contact
    - Emotional development

    These were themes for Child/Adult Y throughout her life; as she became older other issues emerged:

    - Uncertainty about her future
    - Numbers of changes, eg, of social worker, and how to manage change

- Mental health

Key life events:

- Move to live in Guernsey;
- Permanency planning at the point of coming into the care system;
- Placement out of jurisdiction;
- Long term foster home breakdown;
- Placement at, and discharge from, a UK mental health hospital;
- Independent living placement

NARRATIVE

12. Child/Adult Y was born in an EU country where the main language is not English. Her parents separated when she was young. She spent her early years there, cared for by her mother, grandmother and maternal aunt. Her first language was not English.

13. Her mother went to Guernsey to work when Child/Adult Y was three years old, and she remained in the care of her grandmother and aunt. Her mother married in Guernsey and had another child when Child/Adult Y was four and a half.

14. Her mother brought Child/Adult Y to live with them when the half-sibling was a year old. At this time, Child/Adult Y's first language was still not English. In June 2002, Child/Adult Y returned to her original home country for 3 months as she was missing her grandmother, returning in September 2002, aged almost 6 years, to the care of her mother and stepfather.

15. There were concerns about the ability of Child/Adult Y's mother and step-father to give her the safe and consistent care she needed. The parents reported that they found it difficult to cope with some aspects of Child/Adult Y's behaviour; both admitted they had resorted to inappropriate physical chastisement to try to manage this.

Entry into care

16. Child/Adult Y was removed from her parents' care in June 2003, on a Place of Safety Order, following disclosures by her of serious physical punishment by both parents. A Fit Person Order (a Care Order) was granted in October 2004.

17. During this period significant, but unsuccessful, efforts were made to engage Child/Adult Y's mother and step-father in parenting assessment work.

18. Child/Adult Y consistently said that her wish was to remain in foster care. Contact with her family was often very difficult.

19. Between June 2003 and January 2007 Child/Adult Y was in four Guernsey foster homes. The third and fourth placement each lasted for over a year, and Child/Adult Y returned to the fourth placement for a period of ten months after a month's respite residential care, but all the foster placements broke down because of the inability of the carers and agencies to manage and contain her distressed and challenging behaviour. She then spent 18 months in residential provision in Guernsey. Here too staff found her behaviour hard to manage and police reports show that she went missing on a number of occasions.

20. Following a number of unsuccessful attempts to find a suitable foster home for Child/Adult Y on the island, it was agreed in July 2007 to family find in the UK and enquiries were made with a number of UK fostering agencies, on the basis of an assessment of her placement needs.

Out of jurisdiction

21. It took a year of family finding, matching and introductions before Child/Adult Y was able to be placed with long-term, experienced agency foster carers in the UK in July 2008. Social work visits were agreed as two-monthly, so much of the placement support was provided by the fostering agency supervising social workers. The relationship with the carers was often turbulent, with Child/Adult Y sometimes expressing rage and fury towards the foster mother.

22. Child/Adult Y was intellectually able, and at the age of 16 years, in November 2012, she was planning A levels and a long term future with the foster carers. In the following January (2013) however, she took an overdose after an argument with the carer. She was put on anti-depressants and offered therapeutic work with Child and Adolescent Mental Health Services (CAMHS). Despite attending a number of appointments Child/Adult Y refused to engage in therapeutic work. For the next few months she was very settled with her foster carers. She achieved 9 GCSEs A-C.

23. By December 2013 she was reported as low in mood, and the placement deteriorated. In January 2014 Child/Adult Y was placed with respite carers; her placement in the Sixth form was also breaking down. Several aspects of her life were in crisis with school advising that she was not keeping to the written contract she had signed, attendance and attitude to work was poor and there were incidents of unacceptable behaviour.

Placement ending

24. In January 2014 Child/Adult Y left the carers with whom she had lived for five and a half years after an argument. Although she had thought she could return the carers ended the placement two weeks later. Some months later they relocated, informing Child/Adult Y of their intentions when she visited them for a family gathering on 12th July 2014. On 19th July she helped her new foster carers with their house move. On 20th July she took a further, serious overdose, leaving a number of notes. There was serious concern about her liver function.

25. On 30th July she was transferred to a specialist mental health facility for adolescents up to the age of 18 years. She was very distressed when admitted, did not wish to stay and was assessed as at risk of ongoing self harm. Following a Mental Health Act assessment on 1st August she was placed on a Section 2 for 28 days.

26. Her carers visited her regularly at least once, sometimes twice a week, a round trip of 200 miles. She did not fully engage in therapeutic programmes at the hospital. She was distressed to learn in September that that her application to study at college was rejected. On return to the hospital she made a suicide gesture.

27. On the basis of a risk assessment, the fostering agency made the decision that she could not return to the care of her foster carers.

28. Child/Adult Y spent her 18th birthday with friends in the UK and a night two days later in a hotel near the hospital with her mother and uncle. Her birth father who lived with his family near the hospital and whom she had not seen for some years, joined them. The following day he called with his family to see her at the hospital. Although he was allowed to visit, he was not allowed to take her out with him. She became very angry and threatening towards staff. This behaviour continued the following day, and the hospital decided the placement should be terminated as she was now an adult and was placing younger patients at risk.

29. The hospital assessed that she did not meet the criteria for sectioning under the Mental Health Act and she was offered a bed at an adult unit, which she refused.

30. Her mother and step-father arranged for her to return to Guernsey.

Guernsey

31. Child/Adult Y managed her stay well in Guernsey with a family with whom she had not lived since she was a small child, but was always clear she wished to return to the UK where her friends were. She was visited on her first day back in Guernsey by a member of the adult mental health service and made aware she could access their services at any time. The GP maintained her prescribed medication. The CAMHS psychologist whom she had known as a child was also available to meet her.

Return to the UK: Independent living

32. Seven weeks after she left hospital (4th December 2014) Child/Adult Y returned to the UK to independent supported living in a flat. She received intensive support from her key worker. On 3rd January 2015 she took an overdose and called the ambulance but sent it away when it arrived. The Adult Mental Health team called her on the 5th but she said she was fine. On 8th January, late at night, she took a further overdose and was admitted to hospital. On the morning of 10th January she was assessed by the Psychiatric Liaison Team, as a result of which she was given transport back to her flat by the hospital, and discharged from their care. Her support worker visited her at lunch time and spent 2 hours with her.

33. Later that same day, in the evening, Child/Adult Y died in a road traffic incident.

AGENCY INVOLVEMENT

34. Each agency involved with Child/Adult Y completed a chronology of their contact with her, and a critical analysis of the professional practice by their agency. These reports were provided by Children's Social Care, General Practice in both Guernsey and the UK, CAMHS in both Guernsey and the UK, UK Hospitals and Support Services, the Looked After Children's nurse in the UK, the Independent Fostering Agency, the adolescent Hospital, Education, the police in both Guernsey and the UK, the Care Management agency, and Adult Mental Health in Guernsey.

35. Each of these reports identified good practice within the agency but also key issues of concern, such as missed opportunities and practice that could have been better.

REFLECTIONS ON TERMS OF REFERENCE AND KEY THEMES

36. Child/Adult Y had a number of major moves in her life, starting with her move from her home country, which meant the loss of key people to whom she was attached. It may be that it was this loss from which she never recovered.

37. The move into care, less than a year after she returned to Guernsey, and the move to the UK some six years later, led to the loss of her family, language and culture.

38. The placement in the UK, out of jurisdiction, took place because it had not proved possible to find appropriately skilled foster carers for Child/Adult Y in Guernsey. Nevertheless, it is simply not possible for an agency to support a child or young person in its care adequately from such a distance, respond promptly in an emergency, nor have a full awareness of local resources.

39. A young person who has developed friendship networks and links out of jurisdiction cannot easily return to their original place.

SUMMARY AND CONCLUSIONS

40. Child/Adult Y was a troubled and challenging child when she came into the care system at the age of 6 years, because it was evident that her mother and stepfather could not give her the safe and consistent care she needed. She had already had a number of broken attachments, and it proved impossible to find a family placement on the island to provide her with the care she needed. Therapeutic support was given to her while she lived in Guernsey but the extent of her needs was perhaps not fully recognised, and she moved out of jurisdiction with deep-seated unresolved emotional issues.

41. Attempts to engage with the wider family in her home country were insufficient to achieve a wider network of family support for Child/Adult Y. Work with Child/Adult Y's mother failed to establish a partnership approach to the care of the child, and as a result she was deprived of her language and her culture.

42. Her placement in the UK provided a level of stability and support for Child/Adult Y which she had not previously known. It was, however, at the cost of her links with her mother and sibling and her connections within Guernsey.

43. Child/Adult Y expressed her distress as a young child in anger; as a teenager she was perceived as determined and self willed. Professionals were also aware that she had a poor self-image and despite success, lacked confidence in her abilities. She was consistently unable to engage with therapy as provided by CAMHS, and at a distance it was difficult for Guernsey professionals to work with her. Her transition from specialist adolescent hospital was particularly traumatic and her move into independence, while it was clearly what she chose and wanted, and was well-supported, proved unmanageable for her.

44. The decision to place Child/Adult Y off-island was not taken lightly. The decision had far-reaching consequences, and money would have been saved in the end if it had been possible to provide more effective therapeutic work locally for Child/Adult Y.

45. Another major transition for Child/Adult Y was her move from being "in care" to becoming a care leaver, with implications for every aspect of her life. These aspects were fragmented because she was living in the UK, away from her family of origin and from core services which were well known to her social worker.

46. By the time of her death Child/Adult Y had attempted suicide on a number of occasions; notes to family and friends had been found on some of these occasions. It

could be said that this had become a pattern of behaviour; it could be argued that it was a behaviour that would persist until she was able to accept help to change.

47. It is not possible to say, however, that it was predictable that she would die, nor that her behaviour on that particular evening could have been prevented.

KEY LEARNING THEMES

1. Except in cases of criminal networks or family networks of abuse, good outcomes for children and young people in care are achieved by engaging their wider family throughout their care career;
2. Children with fractured attachments need imaginative, positive and sustained therapeutic work as soon as they enter the care system;
3. There are significant negative consequences of placing children far from their community;
4. Care leavers need support across a wide range of services well into adulthood;
5. Transition between CAMHS and AMH, as well as a range of other services should be undertaken in a holistic way, starting with joint work prior to adulthood and continuing for as long as necessary.

RECOMMENDATIONS

48. All agencies involved in the care of Child/Adult Y undertook management reviews of their engagement, to provide an independent, open and critical analysis of individual and organisational practice. These reports have resulted in a total of 30 recommendations focused on improving practice.

49. **Recommendations for the Island Child Protection Committee are:**

1. To consider the establishment of a Family Group Conference Service for children and families on the threshold of care, and within the care system, so that all family members are identified and engaged in finding solutions for children that keep them in touch with their origins.;

2. To explore and implement a range of mechanisms to work with hard to engage families that:
    a. Ensure that children and families are supported to communicate in their first language. Where necessary interpreters must be used.
    b. Respect and support children's origins.
    c. Ensure international links to families and support networks are considered at the earliest possible stage and that these efforts are properly recorded on the child's record.

3. To consider whether the creation of a therapeutic Fostering Service on the Island, with additional resources to provide wrap-around care from all agencies, would promote better outcomes for children, and, if so, to seek commissioning of such a service within the next financial year.

4. To require HSSD to consider engaging the services of locally-based social workers in areas where Guernsey has children placed out of jurisdiction, to act as advocate, support and intermediary for those children. They would be expected to have detailed knowledge of local services and would act as professional social workers on behalf of HSSD.

5. To receive a report on the review of the Terms of Reference and membership of the Complex Needs Panel as well as the role of the Convenor, and agree the frequency of monitoring reports for the ICPC on the care of children placed off island.

6. To consider how agencies can offer a holistic service to support children in care, and beyond, up to the age of 25 years. This should include a Named Doctor and Named Nurse for children in care, and additional resources for the Virtual School.

7. To require a report from the Education Department on the implications of the recommendations made by the UK Local Authority Education Department and their possible application in the islands, particularly in relation to the transition to Sixth Form and Further Education;

8. To ensure that all children, on entry into the care system, are assessed for psychological and emotional harm as part of their health assessment, and a plan put in place for their therapeutic support. This should be by a CAMHS psychologist, or equivalent. The use of Strengths and Difficulties Questionnaires (or similar) should be explored, and used as a mechanism to review children's mental well-being.

9. To require that all of the above become part of the regular reporting framework for the ICPC, and that the quality audit programme reports on the impact of these measures.