DORSET SAFEGUARDING CHILDREN BOARD
SYNOPSIS OF LEARNING FROM SERIOUS CASE REVIEWS
March 2016

Serious Case Reviews: S16, S17 and S18

INTRODUCTION

The DSCB completed three Serious Case reviews in March 2016 in relation to the deaths of two young people and the serious harm of a third young person.
The reviews were undertaken individually but the learning has been joined up to reflect the similarities in the challenges facing those working with teenagers, particularly when there are complex emotional needs.

BACKGROUND TO EACH CASE

The SCR for **Family S16** concerns:

- The suicide of a teenage girl, "Kate" following a relationship break up with her boyfriend
- The young person was adopted with her brother as a baby.
- Adoptive parents subsequently divorced
- Her sibling was verbally and physically aggressive over a number of years
- This had significant impact on the child who exhibited mood swings
- Mother remarried but step-dad accused of child sexual abuse by a young person out of the family. He subsequently left the home causing distress to the family
- Kate was referred to CAMHS but mother failed to respond to 'opt-in' letters and the case closed.

The SCR for **Family S17** concerns:

- "Mark", a looked after young person displaying self-harming behaviour
- Had a number of placements prior to being accommodated in a children's home
- Concerns continued around drug and alcohol use, mental health issues and sexually inappropriate behaviour
- Multiple incidents of hospital admittance and subsequent discharge
- A number of mental health assessments were completed
- Not able to be discharged from hospital to the children's home and subsequently agencies failed to work together effectively to meet his needs in a timely fashion
- Children's Services and Health agencies could not agree a process for finding an appropriate placement leading to delay in finding a suitable resource for Mark.

The SCR for **Family S18** concerns:

- The suicide of a teenage girl, "Mary", who lived in Dorset but close to the Hampshire border.
- The family received police and social care services in Dorset and education and health services in Hampshire.
- Mary was in a relationship with a man almost 5 years older than her and aged 13 she had a termination of pregnancy.
- He was cautioned by Police and mother assured that the relationship would end.
- This subsequently proved impossible with Mary insisting the relationship continue as it did for two and half years until her death.
- During this time Mary's emotional health fluctuated with concerns around low mood, weight loss, school attendance and poor peer relationships.
- Mary referred to CAMHS but mother failed to respond to 'opt-in' letters and case was closed
- Boyfriend was violent to his mother and should have been subject to MARAC but was not due to an administrative oversight.
- Mary's mood deteriorated, she believed her boyfriend has ended the relationship and took her own life.
- Following Mary's death her boyfriend has been convicted of 16 counts of possessing indecent images of her and sentenced to 4 years in prison.

LEARNING

Early intervention/use of Common Assessment Framework (present in S16 and S18)
Practitioners from a number of agencies tried to help both Mary and Kate but this was not coordinated. The information should have been brought together in one place using a tool such as the Common Assessment Framework and this would have supported better planned intervention and better risk assessment.

Social Care Assessment and consequences of closing the case (present in S18)
The assessment in this case was based only on the presenting issues. However, this resulted in information from a number of sources being missed including information about severe historic domestic violence, Mother's mental health and potential attachment issues. Given these complexities more support may have been offered to the family rather than the case being closed with the expectation that mother would manage the situation. Once Social Care closed the case other agencies did not think to question the child protection issues again even though practitioners knew the relationship continued.

Escalating concerns about a case (present in S17)
Professionals should take note of the multi-agency Escalation Policy in the Pan-Dorset Safeguarding Procedures and ensure that they use this when they experience difficulties in moving a case on. Escalation should be seen as a proactive way to move a case forward when interventions are not meeting the needs of a child. Face to face meetings and avoiding an overreliance on emails is encouraged to support this work.

Disguised compliance (present in S16)
The family in this case appeared engaged and used reasoned argument to convince practitioners of their compliance. However, they had knowledge of and were confident in dealing with the system. This resulted in the children continuing to be at risk and becoming complicit in the deceit around them.

Using a 'Contract of Expectations' (present in S16)
Professionals should consider the routine use of Contracts of Expectations, especially where family compliance is unreliable and with no clear sanction should the contract be broken. In this case it rendered the contract meaningless for the family, ineffective in protecting children and impossible to successfully monitor. The family in this case were clear that they followed it for two weeks but then opted to break it as the children missed their step-father and the family felt they knew what was best for their family.

Confusing teenage presentation (present in S16, S17 and S18)
Mood swings, pushing boundaries, separation from parents and exploring their identity is a part of normal teenage presentation. It can be difficult to work out which teenagers need extra support from specialist services. This is particularly difficult within the current culture of self-harming and depression among young people. Practitioners respected the adolescents they were working with and recognised they needed help however there was an overreliance on CAMHS who were not able to provide a responsive service. This review showed that young people need to engage with workers at their own pace and the best way to help them is with enduring professional relationships.

Assessing teenage relationships (present in S18)
There was a significant age gap between the young people in this case which was difficult for practitioners to risk assess. The age gap law is clear but where there is consent it is often unhelpful. Mary was determined to continue the relationship and would tell practitioners that it was not sexual. The relationship did not meet the criteria for Child Sexual Exploitation and although there may have been elements of control, it did not appear obviously abusive. It is significant that the only agency to interview Daniel were the Police during the investigation and during the case work, practitioners saw them as a couple and usually saw the child with her boyfriend present rather then on her own.

Relationship break ups (Present in S16 and S18)
Young people with significant emotional difficulties who may be dealing with issues of loss or attachment struggle to cope when romantic or sexual relationships break up and may exhibit impulsive and extreme reactions like Mary and Kate. There have been a small number of other young people in Dorset who have killed themselves at such times. There is no suggestion that it is possible to prevent every teenage suicide but practitioners need to be particularly sensitive to the context and risks when young people are trying to deal with the extremes of emotion.

Managing cases of sibling violence (present in S16)

There is insufficient recognition, knowledge or understanding of the impact of living with a violent sibling on the psychosocial development of children, this means that limited action is taken to protect them or address their needs. Often the focus of intervention is on the violent child and not the victim sibling.

Accommodation options for adolescents with complex needs (present in S17)

This review identified that whilst all professionals were working extremely hard on Mark's behalf, they were not able to address his needs. This was in part because of a lack of suitable services but also reflects an absence of systems for planning for young people with complex emotional problems. The review has shown that there is a need for more creative thinking about accommodation options and the importance of responding to children's unspoken needs as well as their expressed desires.

Dual diagnosis of mental health and substance misuse difficulties (present in S17)

The assessment services for adolescents with dual diagnosis of mental health and substance misuse difficulties are insufficiently integrated leading to partial assessments of needs and limited treatment options. A feature of this case was that agencies undertook their assessments separately and focused on individual diagnosis with the service provision being closely linked to that diagnosis.

Accessing mental health services without parental permission (present in S16)

Current practice in Dorset is for an opt-in letter to be sent to parents of a child referred to the CAMH Service. In this case Kate asked to be referred but her mother did not accept the appointments offered. Current practice is that a child cannot refer without parental permission but this is being reviewed as a result of the SCR. Professionals should be aware of current opt-in services and support children and families to accept the service being offered.

Services for 13 year old girls who become pregnant (present in S18)

It is unusual for children of this age to become pregnant and consequently terminations at this age are rare. All such children would benefit from a robust multi-agency assessment. The termination had a profound impact on Mary and practitioners involved did not know that the British Pregnancy Advisory Service (BPAS) could have offered her specialist counselling. Whether a 13 year old chooses to keep the baby or not it is likely that her parent will have significant input and their role should be equally assessed.

Assessment of young people who present a sexual risk to other children (present in S17)

Assessment in these cases should effectively determine whether a young person presents an on-going sexual abuse risk to other children. In this case, there were concerns about behaviour but these were never fully assessed despite recommendations for this. Treatment was therefore not offered and professionals appeared unclear as to the level of risk he posed. It also significantly restricted the accommodation options open to Mark due to the un-assessed risk.

Supporting children who have been adopted (present in S16)

The confidentiality surrounding adoption is essential; however the knowledge and skills of specialist adoption services are poorly integrated into first response services. This impacted in this situation when poor attachment behaviours were displayed in Kate's teenage years following adoption as a baby. Many workers were not aware that the child had been adopted into the family as a baby and did not therefore have the full information on which to base their assessment and intervention. The lack of integration of these services therefore detrimentally impacts on adopted children and their families.

ENSURE THIS REPORT MAKES A DIFFERENCE

Working with teenagers is a particularly complex area of work. These reviews have served as a reminder that support to practitioners working with complex teenagers must continue. Practitioners have a responsibility to take forward the messages about practice and the Board must ensure that partners provide with them with the training, tools, expertise, skills and time to do so.

There are lessons to be learned for anyone who reads this. Please ensure you improve your response to teenagers with complex emotional needs.
Please complete some feedback in respect of this learning by answering the questions attached below. These should be returned to Nina Coakley, DSCB Business Manager at n.coakley@dorsetcc.gcsc.gov.uk

To explore these issues in more depth, please refer to the full reports published on the DSCB Website

Dorset Safeguarding Children Board
March 2016

Synopsis of Learning Feedback

Family S16, Family S17 and Family S18
March 2016

Think about the learning points in the Synopsis of Learning you have just read and send us your thoughts on the following questions.

1. What changes have you already made or plan to make as a result of the learning?

2. How do you think these changes will help improve the lives of the children you are working with?

3. Are there any barriers that are preventing you from making further change to your practice? If so, what are these?

4. Please give any general views about this as a method of learning and feedback or any other comments about the Serious Case Review process.

Name:
Role:
Organisation:
Date:

Please return the above information to Nina Coakley, DSCB Business Manager.
For information about what has taken place in response to this combined feedback, please also contact Nina n.coakley@dorsetcc.gcsx.gov.uk

The comments you provide will be consolidated with those made by others and presented to the DSCB in order for them to work to ensure that Serious Case Reviews make a difference to children's lives.

Thank you