# Board Response – Serious Case Review – Child J

**Introduction:**

This document sets out the formal response of the Calderdale Safeguarding Children Board (CSCB) to the outcomes and learning identified through the Serious Case Review it commissioned following the death of Child J.

It provides key information about the Serious Case Review process and its purpose, gives an overview of how it was conducted and who was involved. Importantly it sets out the key learning that has been identified, what the respective agencies that were involved have done about this and what they intend to do in the future.

This Board Response sets out the learning for the CSCB as the partnership responsible for ensuring that joint working arrangements to protect children are effective. It also shows how the CSCB partnership will support and monitor the implementation of learning by each of the involved agencies.

All partners who are members of the CSCB have formally accepted the report and endorsed the findings. This response should be read in conjunction with the full Overview Report. These documents seek to demonstrate and support the transparent and objective approach all parties have taken to looking at and learning from the death of Child J.

## 1.0 Background

Working Together to Safeguard Children 2015 (WTSC, 2015) is clear that serious case reviews are a part of the learning and improvement framework that all Local Safeguarding Children Boards (LSCBs) must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

Serious case reviews (SCR) must seek to:

- Identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- Be transparent about the way information is collected and analysed; and
- Make use of relevant research and case evidence to inform the findings.

The purpose of a SCR is to conduct "a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children," (WTSC 2015, page 72).

## 2.0 Methodology

The CSCB decided that this case warranted a participative review with the emphasis upon professional and family involvement. To facilitate this CSCB set up a SCR panel with members who were independent of the family and who were senior managers within their organisations. The role of the SCR panel was to assist an independent lead reviewer to plan the process, consider the evidence and quality assure the report. The SCR panel developed terms of reference which are included in the SCR Overview Report. The SCR panel met on 11 occasions.

After considering the methodology and suitable authors who were available; Mark Dalton from Review Consulting Ltd was commissioned by the Board to undertake the review using the Significant Incident Learning Process (SILP). SILP is a learning model, which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. CSCB requested that the SILP model of review be used to consider the circumstances surrounding the death of a child known as J, in order to learn lessons about the way that agencies in Calderdale work together to safeguard children.

The SILP model involves the appointment of a lead person in each agency to gather information and prepare a chronology of involvement. Two learning events were held - attended by practitioners and their line managers involved in the case to help understand who did what and the reasons why; they also identified ways in which local practice should be improved. Each agency was asked to consider any lessons and recommendations to improve single agency or joint working effectiveness and this learning was drawn into the resulting action plan.

The SILP model of SCR adheres to the principles of;

- Proportionality
- Learning from good practice
- The active engagement of practitioners
- Engaging with families and
- Systems methodology

## 3.0 Board Response to the methodology used

The methodology is in contrast to a more traditional SCR. The traditional model uses Independent Management Reviews to explore cause and effect. The SILP process encourages practitioners to focus on where they think the learning may be and therefore the report may have gaps as the learning events are organic and allow learning to emerge through the discussion. It focuses on Key Practice episodes, which are significant events in the child's timeline, which were drawn from discussion with family, professionals, evidenced from a combined joint chronology to address the Terms of Reference.

The CSCB is currently undertaking an audit of local SCRs with a focus on methodologies, recommendations and outcomes. This SCR is part of the five SCRs which have been audited and will influence the commissioning and management of future SCRs and local learning lessons reviews through the CSCB Case Review Framework.

## 4.0 Key Learning

1. The Board notes that the report concludes that J's death was not predictable, even with the benefit of hindsight, but does acknowledge that there were many professionals and organisations involved with J and his family over a number of years. This means that each of these organizations have, through this review, carefully considered whether there was anything that could have been done that may have prevented J's suicide.
2. The Board acknowledges that J was a Looked After Child and as such the Local Authority and its partners had clear responsibilities that they shared with his family and in particular those family members who were designated as Connected Carers. It notes that the Local Authority and the other organisations and professionals involved have actively cooperated with this review, have identified and acted upon things that they have learnt.
3. The CSCB is responsible for ensuring that joint working arrangements are as effective as possible and therefore has identified how it and its partners responded to the lessons learned. These are included in the action plan written in response to the recommendations presented in section 5.0.
4. In considering the learning and recommendations identified, the CSCB has also identified some additional learning that it will act upon and these are presented below.
5. The family and the public need to have confidence that these lessons will be acted upon and it is the responsibility of the Board and its members to achieve this so we set out how we will do this at section 6.0

In considering and accepting the report, the CSCB has identified additional areas partners need to focus on to assure themselves and the Board that each area is effective in safeguarding and promoting the welfare of children and young people and that there is not a disconnect between policy and practice. The areas are:

- Self Harm and Adolescent Suicide
- Emotional wellbeing

The CSCB partnership will ensure these areas of joint working practice are reflected, in the revision of the business plan as a matter or priority. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.

Progress and impact will be managed through the appropriate CSCB work streams, with the Case Review sub group monitoring an overarching action plan.

## 5.0 SCR Recommendations

**RECOMMENDATIONS**

**<u>The recommendations for Calderdale LSCB are as follows:</u>**

a) The LSCB to review the West Yorkshire Procedures and Local Guidance where children are missing or are absent, with specific reference to information sharing and the notification of

partner agencies. This must include children who are placed by the LA outside of the area, whether they are currently missing/absent or not.

b) The LSCB should satisfy itself that the practice of removing children from a school site is not standard practice in other schools in the authority and that appropriate standards are followed when considering the need to suspend a pupil.

c) The LSCB should review the provision of training regarding young people and their use of social media, so that they can better understand the importance this can have in children's lives and how this works. This training should also be made available to Foster Carers and others who may have substantial contact with young people. Practitioners working with all young people should be sensitive to the likelihood that they are engaged in using social media. There should be a professional curiosity about their online usage and clear advice given about the potential risks, particularly for vulnerable children.

d) The LSCB website should include access to a wider range of material for children and young people and professionals on the subject of e-safety use of social media and related risks.

e) The LSCB uses Multi Agency Reflective Practice Sessions to encourage professionals to step back and reflect in families in crisis where there are lots of changes and further sessions will be commissioned.

f) The LSCB will strengthen guidance for practitioners regarding meeting without families, accepting that there are times when this is necessary to safeguard children.

An action plan for implementation of these recommendations has been developed and progress with it has been monitored through the Case Review sub group with periodic reporting to the Board in line with the LSCBs Case Review Framework. Each recommendation has produced several actions which have all been progressed and evidenced.

There are individual recommendations for each of the following agencies, which have all accepted the learning points and have provided evidence of completion for each of these recommendations. These have also been monitored and managed by the Case Review sub group and will continue to be scrutinised by the Board.

- Children's Social Care (Calderdale Metropolitan Borough Council)
- Independent Reviewing Service (CMBC)
- Calderdale and Huddersfield Foundation Trust
- Education (CMBC and all school governing bodies irrespective of status)

## 6.0 Dissemination, implementation and monitoring of impact of learning

The Board and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained and we will test this through regular monitoring and review. Our approach to this is outlined in the Learning and Improvement Framework; these are some examples of how the learning from this review has been be promoted and embedded in practice:

a. We have included the learning from this SCR in training, briefings, multi-agency practice sessions, staff supervision, appraisals and specially commissioned learning events
b. The Board has disseminate specific learning from this SCR through guidance and publications e.g. e-safety guides, 'practitioners meeting without families' guidance, supervision in education settings framework.
c. The learning from this SCR has informed policy and updated procedures e.g. missing policy, exclusion policy for schools and a new kinship carers service set up to replace connected carers,
d. We will use the learning from the methodology, the recommendations and the outcomes from this SCR to update the Case Review Framework
e. The learning from the review will influence the setting of future priorities e.g. ensuring that joint working is supported by policy, procedure, practice and multi agency training in respect of Emotional Well being, Adolescent self harm and suicide, and use of Social Media
f. Agreement to revised Self Harm and Suicide protocols is being sought across West Yorkshire
g. We will ensure that we will test out the performance of partners and also look at the quality of their practice in respect of the key learning in a Challenge Event.

### 6.1 How the Board will oversee and ensure that the recommendations are acted upon

a. The CSCB and its members have formally and regularly monitored the implementation of the action plan and recommendations in order to ensure progress is being made
b. The CSCB Case Review sub group maintains a register of all recommendations (single and multi agency) and requires both the CSCB and its partner organisations to report on progress on a quarterly basis.
c. The CSCB multi agency case file audit programme has been revised to reflect the learning from this case to test out changes to front line practice and line management; providing updates to the CSCB as to the progress.
d. The CSCB performance management framework reflects in its core indicators key areas of learning so that compliance can be evidenced and this is reported at every Board
e. The CSCB multi agency training programme has been amended to reflect key learning and is reported to the Board and in annual and quarterly evaluations.
f. The CSCB will review new and updated policies and procedures and where necessary update or put in place appropriate amendments/new policies etc
g. The CSCB, in its annual report, will report on the progress made and the wider impact across partners of the learning, in order to consider whether progress and impact has been good enough.

## 7.0 Conclusion

Whenever a child is looked after by the Local Authority there is a set of clear responsibilities to ensure that the needs of the child are understood and that all of the people including their family are working together to meet these needs and manage any risks the child may face from others or from themselves.

The reviewer appointed by the CSCB does not identify that there were any specific things that should have been done that were not done, but he does show that some of these things could have been done differently. The reviewer concludes that Js death was not a predicable event, as an impulsive rather than a pre-planned act, it could have potentially have been prevented if a number of circumstances had been slightly different, but these would not have been the conscious acts of individuals intervening to prevent suicide and no blame should be apportioned to individuals.

The review and the reviewer does however reflect the sincere views of the professionals involved and the considered response from each organisation of things that need to be done to reduce the chances of any child finding themselves in a position where they attempt and or take their own life.

Family members have been consulted about the report once it reached draft stage. This has resulted in some factual corrections and the independent author had also been asked to reflect on views of a number of family members. The SCR panel has carefully considered the points raised and agreed some changes on the basis of accuracy. Understandably such reports produce different and often strong views and feelings, and the panel has wherever possible tried to take these into account, whilst seeking to ensure that the reports and recommendations are thorough and objective.

As part of this consultation, the SCR Panel and the CSCB sought views from the Local Authority who continued to have parental responsibility for one of J's siblings. Having consulted with this sibling and sought the views of others directly involved, the LA formed a view that given the key stage the sibling's schooling was at, the level of sensitivity felt and likely to result from publication, that it would be better if publication was deferred for 12 months so as to allow completion of the next school year. It is understood that this was acceptable to and supported by the young person. The SCR Panel therefore carefully considered this and recommended to the Independent Chair that this was appropriate. He agreed that in this instance there was a strong case to priorities the welfare and interests of the young person and approval from the National Panel of Experts was sought and agreed.

## 8.0 Summary from Independent Chair

As the Independent Chair of the CSCB, I am required to ensure that the partner organisations that form the CSCB fulfil the requirements set out for LSCB's in Working Together 2015. These include a requirement to look at in detail the circumstances when a child or a young person dies, especially when professionals and organisations were involved with the young person and their family.

The purpose of this review is to help the organisations and the people who were working with the young person to look carefully to see if the tragedy could in anyway have been foreseen and prevented. These are of course the same questions that family members and friends will ask themselves when a child or young person dies, and especially in circumstances such as this where the young person takes their own life.

All those who knew the young person will therefore ask themselves was there anything I could or should have done that would not result in such a sad event. It is important to note that in this review the Board adopted an approach that involved many of the professionals who had worked closely with the young person and their family. It is clear from the review that this provided each of them with the opportunity to answer these difficult questions.

This cannot and should not be compared with the feelings that each of the family have, as their relationships were different, but it does help us to remember that although we have high standards and expectations of professionals; the death of a young person has an impact on them too.

Towards the end of the review process, those family members who felt they were able to be consulted, about the draft report to helped ensure that it was factually accurate and a number of changes were made as a result of this. It is always difficult to be reminded of such a sad episode and of course this can create strong emotions and further questions. It is not the purpose of a review to resolve any differences that people may have about their relationships with professionals or within families, but the review can help all concerned to more fully understand and reflect on what has been learned about events. Sadly such reviews do not always provide all the answers or necessarily result in a full agreement about events.

However given that the review has a specific purpose to support agencies and professionals to review their role and involvement, and through an independent review to identify key areas of learning for these organisations and professionals. I do believe that given the primary purpose fo the review, there has been a genuine effort to listen to the views of those family members who chose to contribute and where possible changes have been made.

Professionals are rightly responsible and accountable for their actions and judgements, as are the organisations that employ them. The review demonstrates that individual professionals generally sought to do the right thing in the right way. The learning from the review shows that with hindsight what professionals do and the judgements they make, can be improved. The review also demonstrates that organisations can develop and improve some of the ways in which they work together, especially in respect of sharing information when they make important decisions. There is wider learning for all in how we recognise and respond to situations when children and young people may be considering taking their own life.

As child J was in the public care, and placed with members of the family, it has been particularly important the review has looked at this closely, given the responsibilities this places on the Local Authority, its partners, the professionals and others involved. The review and the recommendations, many of which have already been acted on, do demonstrate how important it is to ensure that children in the public care wherever they are placed receive the highest standards of joint working and that their care benefits from the highest quality of planning and review.

It is not the purpose of the review process to look for or allocate blame, but it does and should ensure that each organisation who are responsible for the professionals they employ, are able to consider the review raises the possibility that there were instances when individuals made errors or did not act as they were required to.

It is important to note that organisations who took part in the review and the review itself did not identify any occasions where it was necessary to consider further actions either in respect organisational and individual errors.

The review also requires the LSCB to examine and consider its roles and responsibilities in the light of the evidence from the review and the recommendations, and as this response and the report demonstrates the LSCB partnership has accepted and started to address the recommendations.

In particular the review process does identify key areas where arrangements and practice can be improved, which will when implemented contribute to a better understanding of the needs of young people in general and in particular in relation to suicide.

The independent overview report author is clear in his judgement that this young person's death was not predictable. The author clearly concludes that there was no one thing any professional or anyone close to child J could have done but points out that there is learning to be acknowledged and acted upon. It is the purpose of such reviews to ask difficult questions of us, and the report identifies a number of key areas where with hindsight the way in which organisations and professionals worked together could be improved. Such improvements would not of course change the sad events, but they do point to how everyone whether they be a professional or a member of the public could be more aware of the pressures and difficulties some young people face.

In reaching the point where the Board and its members felt they were able to be sure that the review process was thorough and objective, it was important that as the Independent Chair I was assured that each organisation and their board member had engaged with the review process on the basis of being open and able to identify learning. I also have to be sure that in addition to this level of individual accountability and openness, that in their role as Board members, we were as a Board able to reflect and act upon what we need to learn. The CSCB is responsible for ensuring that the arrangements for how partner organisations work together to protect children and young people are both effective able to quickly learn from experience.

Board members and myself appreciate that members can have a different view and perspective on events and the review itself, and may not understandably be satisfied with all aspects of the report. However we do feel that it is as accurate as possible, and that it identifies learning for everyone, but of course cannot change what has already taken place.

Whilst accepting that grief and coming to terms with loss is a difficult, painful and lengthy process, as a Board we are grateful for the contribution of family members. We do not expect them to fully accept all aspects of the report or the review process, but hope that in time in some small way it may help them, especially if they can see that the learning that has been identified has and is being acted upon.

It will therefore be incumbent on myself as Independent Chair; the Board as a whole and for each partner organisation to act on the learning and recommendations, on the basis that we believe these reflect a careful, open and full consideration of how people exercised their responsibilities.

This process cannot compensate for the loss of a young life and the impact this will have on his family for years to come. Professionals who knew the young person will also be left with questions that this review may not be able to answer. It is clearly important that when responsibility for the care and wellbeing of a young person is shared between professionals and family, that everyone is able to make sure that these arrangements are of the highest quality.

We know from research and learning elsewhere that it is difficult to recognise when a young person reaches the point whereby he or she feels the need to take their own life, the outcomes of this review provide a series of detailed actions for each of the organisations, and many of these have already been acted upon. It also creates an opportunity for us all to learn more about and therefore

how to recognise the ways in which things get on top of a young person, and therefore offer more opportunities for them to seek help from people they feel they can trust.

The Board and its partners will respond to this challenge and be held to account for this as a mark of respect of the young person and their family, and in the belief that young people who may find themselves in similar circumstances will feel they have other choices.

Richard Burrows
Independent Chair
Calderdale Safeguarding Children Board
29th July 2016