Bradford BSCB Safeguarding Children Board

reconstruct
improving services for children
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Serious Case Review
Executive summary

Written about Child D for
Bradford Safeguarding Children Board

Born 27th May 1996
Died, aged 12
4th April 2009

Barry Raynes
27th November 2009

1. INTRODUCTION

1.1 This report relates to a disabled child, child D, who died of smoke inhalation caused by a fire in his home. Child D was a lovely, lively young man with diagnoses of autism at the severe end of the autistic spectrum continuum. He was 12 when he died. He lived all of his life with his mother and his sister and, until he was 11, with his father who remained in contact with him. He was well loved by his family and grandparents. The fire was allegedly started by young people who did not live in the house. Two young people are currently in custody and due to stand trial[1].

1.2 Because he and his family had been in receipt of services from a variety of agencies a serious case review was held. A serious case review is a series of meetings involving senior managers from services who work with children: social care, education, health, police and voluntary agencies and independent people who do not have links with the local area. The result is a series of reports called individual management reviews, (IMRs) an overview report and executive summary.

1.3 Each agency identifies a manager, who was not involved with the family, who writes an IMR about their agency's involvement. An independent person reads those reports, interviews staff and family members and writes an overview report, based upon the IMRs and interviews, which is confidential and is sent to the department for children, schools and families. This report is the executive summary of the overview report and is available to members of the public.

1.4 The whole process is overseen by a panel of senior managers which is chaired by another independent person. In this case the panel was chaired by Roger Thompson who is a former Director of Social Services, and Regional and National Director of the NSPCC and the overview report was written by Barry Raynes who is the chief executive of Reconstruct. The Panel consisted of the designated nurse for safeguarding children, NHS Bradford & Airedale, a group services manager from children's social care, a superintendent from Bradford, safer neighbourhoods and partnerships, West Yorkshire police, a patient services manager for children's services, Bradford teaching hospitals NHS foundation trust, a named doctor for safeguarding children, Bradford district care trust, the access and inclusion development manager from the special education needs team,

[1] The trial resulting from the death of Child D ended on 8 October 2010. There were no convictions.

Education Bradford and the safeguarding manager from Bradford's safeguarding children board. The panel met five times between June and November 2009 and completed further work between those meetings.

2. THE REVIEW PROCESS

2.1 Three IMRs were received from children's social care and one each from: adult social care services, the department of regeneration and housing, Education Bradford, child D's school and his sister's school, Bradford & Airedale community health services, Bradford PCT, Airedale NHS trust, Bradford district care trust, Barnardo's, supported lives and West Yorkshire police.

2.2 Members of staff have been interviewed by the IMR authors and the overview author. Child D's parents, sister and paternal grandparents have been seen on a number of occasions by the overview author.

2.3 The overview report and this executive summary has been seen and ratified by members of the panel and Bradford's safeguarding children board.

3. CHILD D's STORY

3.1 The main reasons for having a serious case review are to learn lessons and improve services for children. This executive summary will therefore concentrate upon those areas. However that will not make sense unless child D's story is outlined. This will be done briefly to protect the anonymity of the family.

3.2 Child D was a lovely young man but difficult to look after. His parents said that they were dominated by him and they found it hard to concentrate upon other areas of their lives. He had no sense of danger, would run away, would eat anything that he could get his hands on and break things, if left unsupervised. Child D attended a special school and a respite care unit; the professionals in those places also found him difficult to look after. He spent a week-end per month, for much of his life, with a family respite carer. With one to one attention she was able to look after him well and his behaviour, when with her, was different, much less challenging.

3.3 Child D did receive services throughout his life from different professionals. He attended one school, he was allocated an unqualified (and latterly a qualified) social worker, his case was reviewed every six months, occupational therapists visited his house and organised adaptations, children's social care provided staff who advised his parents about how to look after him and provided respite care in a children's home and in a family carer's house, various parts of the NHS provided assistance in all aspects of his physical and mental health and a private organisation took him out on trips. His sister too was provided with services from Barnardos.

3.4 Towards the end of his life children's social care and the police became involved with his sister who was being victimised.

4. ANALYSIS

4.1 Each IMR author was asked to answer a series of questions. This executive summary will summarise those answers and answer further questions.

Did professionals properly consider child D's welfare and safety?

4.2 Child D was loved by his family, but his parents and sister found it very difficult to live with him. This meant that his living conditions at home were not acceptable. However many professionals did not properly consider his welfare because they believed that home was the best place for him. A core assessment using the framework for assessing children in need and their families should have been used with particular reference to the parenting capacity domain.

Were appropriate single and inter-agency safeguarding procedures followed in respect of child D and his family?

4.3 Child in need and looked after children's procedures were followed correctly. Neither child was ever considered to be at risk of significant harm which meant that child protection procedures were not followed. Towards the end of his life there was evidence to suggest that child protection procedures should have been followed to ensure that he was safe at home.

Did appropriate consultation and information-sharing take place?

4.4 There were a lot of professionals from a variety of agencies involved in this family's life. On the whole they did share information well but this was not always the case and agencies sometimes failed to ensure that timely action was being taken following that sharing of information.

4.5 The panel was concerned about the failure of child D's sister's school to pass information onto the education welfare officer. At times police officers had information that should have been passed to children's social care.

4.6 It is positive that child D's care was reviewed every six months despite the fact that, legally, this was not required. However the reviews tended to focus upon whether his respite care was appropriate rather than considering the whole needs of child D and his family.

What assumptions were made by professionals working with child D in respect of his disability?

4.7 It was recognised very early in his life that child D exhibited autism and severe learning disability, this is to be commended. Professionals are left in no doubt about the extent of his disabilities and the constant communication between agencies about his behaviour confirms this view**.**

4.8 However most of the assessments undertaken directly with child D were made at the respite carer's home, the respite unit or the school. He was rarely seen at home. Some professionals involved in his care never saw child D.

4.9 Child D was not involved in his own care reviews. The panel members can understand why reviews went ahead without child D's presence as he would not have benefitted from the experience and would have been disruptive. However the fact that a child should not be invited to a review does not mean that his or her wishes and feelings should not be represented. There is no evidence of child D's views being represented at these meetings.

4.10 Panel members also accept that gathering information from child D's parents may have been difficult if child D was present but this ignores the fact that just observing can be an effective method of

understanding the child and their situation: Assessments should include direct observation as well as talking to people; they are not just about data collection.

The role and impact upon child D's sibling as a young carer?

4.11 Child D's sister was identified as a young carer at an early age and was referred to Barnardos Young Carer support service. At no point was a thorough assessment completed about her needs in her own right. With hindsight it was inappropriate that no professionals from the agencies involved considered that she may not be coping.

Do assessments and decisions appear to have been reached in an informed and professional way? Were actions identified by assessment carried out in a timely way?

4.12 Children's social care assessments took a long time and were focused upon services and tasks, not needs, risks or outcomes.

4.13 The education welfare service did not appear to have carried out an assessment.

4.14 The OT service and the adaptations team in Housing caused severe delay in adaptations being made to the home. This was not due to any negligence of individual workers but the backlog of work and lack of resources.

4.15 Health professionals produced appropriate assessments and within timescales but they were working in isolation from each other and other agencies. They would have benefitted from a joint health plan.

4.16 There are no records that indicate that a carers' assessment was ever offered to either parent or child D's sister, or that the use of the common assessment framework was considered to draw together what different agencies might be involved and how they could better understand and help.

Were more senior managers involved, or other organisations and professionals, involved at points where they should have been?

4.17 In general there were no particular reasons for senior managers to have been involved in this case except for the fact that there was no referral to the social care family support panel about the possibility of child D receiving a much higher level of care.

4.18 A serious omission of senior management overview relates to the management of the unqualified worker from children's social care. It is the panel's opinion that this worker was not experienced enough to manage this complex case and was not appropriately supervised.

When, and in what way, were child D's wishes and feelings ascertained and addressed?

4.19 Child D had major problems in communication and finding out his wishes and feelings was difficult. Nonetheless there was a failure to consider why his behaviour changed in the last few months of his life and there was no single person present at his reviews to speak up for him.

Parallel processes

4.20 This could be the key issue for this review if one considers the needs of both children. There is no evidence at any point that any professional thought about the needs of the family as a whole. This means that there has been a wholesale failure of integrated working amongst professionals. The failure to address the impact on the family of the behaviour of child D has been key to the fact that this family suffered so many difficulties.

Lack of performance management and use of unqualified workers in the children's complex health and disabilities team

4.21 The children's complex health and disabilities team allocate "stable" cases to unqualified workers. It is the panel's view that the worker should not have been expected to manage the complexities and risks involved in this case.

4.22 Allocating an unqualified worker would not be such an issue if the worker was subject to thorough and reflective supervision and a

performance management culture. By which I mean a more directive management style focused upon results, timescales and quality.

5. LESSONS LEARNED

All agencies

1) Professionals appear to be prepared to accept living conditions for disabled children that they would not consider to be acceptable for children who do not have disabilities
2) Staff focused upon one child in the family or the other but failed to assess the effect that each had on the other
3) Staff failed to recognise how at risk the children were because there were no particular events to trigger a child protection investigation
4) Neither child was listened to appropriately
5) Chase-up and follow through of referrals needs to be considered by all professionals to ensure that actions are implemented to protect children
6) The nominated key worker for complex cases should be appropriately trained and qualified
7) Regular safeguarding supervision is essential to ensure analysis of actions and interventions, reflection and critique of practice
8) The value of reviewing a disabled service user in person, meeting with that person, observing that person or visiting them in their home is essential in making an informed decision regarding their treatment and understanding that person in the context of their family
9) There was a sense of tunnel vision in looking to fit Child D's needs into the resources that were available
10) All agencies should report child protection concerns and need to be aware of the importance of seeing, speaking to and listening to the child in question
11) There was no recognition by agencies about the welfare of child D's sister regarding her caring for Child D when her mother was out at work
12) There needs to be clear recognition of the need for integrated working from all agencies
13) The common assessment framework could have offered opportunities for staff to come together to discuss the needs of the whole family

Adult social care

14) Delay in occupational therapy and housing adaptation services are severe but remain within the targets set by those services

Children's social care

15) Assessments in this case were task-led, not outcome-focused and failed to be completed within satisfactory timescales
16) Issues of safeguarding were not considered in this case
17) Carers assessments do not exist in the complex health needs and disabilities team
18) Families who access services from the complex health needs and disabilities team may not be routinely given information about the local authority's complaints procedures
19) Respite break reviews are focused upon services and not the needs of children
20) Unqualified workers need to have their cases rigorously reviewed to ensure that the case has not become too complex
21) Performance management was lacking in the complex health needs and disabilities team
22) Reviews were not appropriately challenging

Education

23) Education welfare officers were working in isolation to other professionals

Police

24) On two occasions, police officers failed to implement their own child protection policies

Housing

25) The current funding arrangements for housing adaptations over £1000 are not always appropriate to be administered via a Disabled Facilities Grant
26) It may not be appropriate to request funding via Housing Associations without an agreement protocol

Health

27) All children within special schools should have an individual health plan with clear care pathways and work should take into account the holistic assessment of children and families

6. CONCLUSION

6.1 This executive summary has sought to explain the author's assessment of the situation, represent the views of family and panel members, integrate the major lessons contained in the IMRs and show respect to child D and his family.

6.2 It is clear that the impact of child D's disability on his sister and family was not appropriately considered throughout their lives. This could have been done had the framework for the assessment of children in need and their families been followed, with particular regard to the domain "parenting capacity".

6.3 Significant change will need to occur to reduce the likelihood of similar failures to promote the welfare of disabled children in Bradford. This review's action plan is long and complex. However my experience during the process of this review is that all professionals, from those who were involved in the case, the IMR authors, the SCR panel members and the LSCB board members, have demonstrated a willingness to take these lessons to heart and to adapt and improve their services.

7. RECOMMENDATIONS

There are a number of single agency recommendations which are being implemented. The following are the recommendations that emerged from the overview report.

Supervision

1. To ensure that front-line supervisors are adequately trained and supported in safeguarding to enable challenge and to promote reflective practice. To all agencies.

Communication and Information-Sharing

2. To ensure that, between and during reviews, there is a formal agreed processes for information-sharing between agencies and independent reviewing officers with a single point of contact. To all agencies.
3. Bradford safeguarding children board will mandate independent reviewing officers to be able to challenge all agencies and hold them to account to ensure the child's needs are met. To all agencies.
4. Bradford safeguarding children board to review the guidance relating to lead professionals.

5. The issue of who has the right to be involved in reviews needs to be revisited by the independent reviewing team to ensure that all those who should be consulted are being consulted. To children's safeguarding and reviewing unit.

Review of Services

6. To chair of Bradford safeguarding children board: Bradford safeguarding children board will commission a multi-agency review of services for children with complex health needs and disabilities to:
    a. Consider how agencies statutory review process can be dovetailed.
    b. Develop integrated care plans and processes.
    c. Decide who are the most appropriate key workers.
    d. Explore opportunities for future integrated working and joint commissioning arrangements.
    e. Evaluate how all care plans are reviewed for children with complex health needs and disabilities within agencies.
7. To implement a rolling programme of multi-agency audits, concerning a sample of cases of children who have complex health needs and disabilities, to evaluate the quality of practice, the outcomes for children and the lessons to be learnt. To chair of Bradford safeguarding children board.
8. All agencies to ensure that plans about children are led by outcomes rather than inputs. To chair of Bradford safeguarding children board.

Failure to Attend Policies

9. All member agencies to review their failure to attend policies to ensure that these are reported back to the referrer, and reviewing processes are in put in place. To all agencies.

Assessment

10. All agencies to review and evaluate their assessment processes in terms of statutory timescales. Where there are no statutory timescales they are to develop Quality Standards to ensure completion. Issues of concern highlighted regarding the length of time taken to provide adaptations within timescales to be addressed. To all agencies/BSCB.

11. All agencies to review processes for ensuring that the views of all children are ascertained and recorded in the care plans and in annual reviews. To all agencies.
12. To ensure that formal assessment of children's needs must include evidence of professional observation of the child and family in different environments, especially home. To all agencies.
13. All agencies to ensure assessments are regularly updated, including risk assessments. To all agencies.
14. All agencies to ensure that holistic assessments are undertaken in families with children with complex health needs and disabilities, in particular to consider the needs of other children and young people in the household. This could be audited in the proposed multi-agency case audit. To all agencies.
15. Children's Services to evaluate how parent/carer assessments are promoted and publicised and used. To director of children's services.
16. All agencies to promote the value of early intervention and holistic assessment through the implementation of the common assessment framework and to embed it in practice through quality standards. To all agencies.
17. ESWs and EWOs will contact all agencies who may be involved with children to check whether or not they are, or have been, in contact with the child before criminal proceedings are commenced regarding non-school attendance

Training

18. Education Bradford to review training for schools on the statutory educational statementing process and invite other agencies to participate. Director Education Bradford.
19. Agencies to publicise and access Bradford safeguarding children board training on children with complex health needs and disabilities. To all agencies.
20. Bradford safeguarding children board training sub-group to review this specific training in the light of this serious case review, focussing on children with disabilities and safeguarding, with particular reference to neglect issues and to incorporate a '*Think Family*' approach. To chair of Bradford safeguarding children board.

Record Keeping

21. All agencies to review record keeping process systems and management practice through audit. To all agencies.

Management Oversight

22. All agencies to review their quality assurance processes for measuring outcomes for children and families. To all agencies.
23. Management oversight of practice to be reviewed in terms of accountability, supervision and quality professional standards and competences. To all agencies.
24. Social care's children's complex health and disabilities team should re-examine their use of unqualified workers, develop performance management systems integrated into those systems managed by the children's social care department. To director of children's services.

Serious case review process

25. Adapt the present guidance on SCRs to include
    a) the need for narrative in IMRs,
    b) separate questions for different IMR authors, and
    c) the need to adopt a more rigorous approach to IMR questions. (To Bradford SCB).