

**WAKEFIELD & DISTRICT**  
**safeguarding**  
**children board**

Wakefield and District Safeguarding  
Children Board

Executive Summary

Serious Case Review – Young  
Person A

December 2008

## **1 Introduction**

### **1.1 The circumstances that led to the Serious Case Review being undertaken.**

- 1.1.1 Young Person A died on 28<sup>th</sup> April 2008, after committing suicide. She was sixteen years old at the time of her death.
- 1.1.2 Working Together to Safeguard Children recommends that Safeguarding Children Boards should consider undertaking a Serious Case Review when a young person dies as a result of suicide. The Wakefield and District Safeguarding Children Board convened a Serious Case Review Panel to consider the circumstances of Young Person A's death, and subsequently concluded that a Serious Case Review should be conducted in line with Working Together to Safeguard Children. The aim of the Serious Case Review was to establish whether there were lessons to be learned about the way in which local organisations had worked together to support Young Person A and promote her welfare.
- 1.1.3 Following Young Person A's death, early information from agencies suggested that she was a young person who had been in emotional distress for some time, particularly during the last twelve months of her life.

### **1.2 Terms of Reference for the Serious Case Review**

- 1.2.1 The first Serious Case Review Panel met on 9<sup>th</sup> May 2008, to consider the circumstances of Young Person A's death and of agency involvement.
- 1.2.2 The recommendation was made by the Serious Case Review Panel to undertake a Serious Case Review, to establish whether there were lessons that could be learnt from this tragedy about the way in which local professionals and organisations worked together to safeguard and promote Young Person A's welfare.
- 1.2.3 Key issues within the scope of the Serious Case Review were identified as:
- Young Person A committed suicide and appeared to have been in emotional distress for a period of about 12 months prior to her death. She had experienced significant problems both at home and in school.
  - It was felt that the case could have implications for a range of agencies in terms of whether lessons can be learned about their intervention with Young Person A and her family.
  - Specific questions were raised as to whether agencies could have done more to engage with Young Person A, and offer her more co-ordinated support at critical times.
  - Agency thresholds and criteria for involvement need to be analysed.
  - Individual Management Reviews were to include both description **and critical analysis** of the agency's involvement, in order to establish whether lessons can be learned for the future. Actions to learn these lessons were to be clearly identified.
- 1.2.4 It was decided that the Serious Case Review should cover all information available from 2002 until the time of Young Person A's death.
- 1.2.5 The Serious Case Review Panel recommended that full Individual Management Reviews should be provided by:

- Young Person A's School
- Wakefield Health Community (including CAMHS)
- Family Services – Safeguarding and Family Support Directorate (this report should include information relating to the input of Adult social care services)
- West Yorkshire Police
- Barnardo's Wakefield District Young Carers Service

The Overview Report was authored by Gareth Sands (Governor at HMP New Hall) whose agency had not had any involvement with Young Person A or any members of her family. The Author has no management responsibility for any of the professional agencies involved in the case of Young Person A. The Author was therefore considered to have the necessary level of independence in line with Chapter 8 of Working Together to Safeguard Children.

#### 1.2.6 Members of the Overview Panel were:

- |                   |   |
|-------------------|---|
| • Dr Gill Pinder  | Consultant in Public Health Medicine NHS Wakefield District |
| • Jenny Goodchild | Senior Probation Officer – WY Probation Service             |
| • Joanna Burton   | Serious Case Review Officer – WY Police                     |
| • Jayne Robinson  | Service Manager (Safeguarding) WMDC Family Services         |
| • Ron Egan        | Schools Consultation Manager – WMDC Family Services         |
| • John Crosse     | Community Law Manager - WMDC Legal Services                 |
| • Janice Hawkes   | Assistant Director, Barnado's                               |
| • Richard Fawcett | WDSCB Business Manager                                      |

1.2.7 The Overview Panel met on four occasions during the course of the Serious Case Review to scrutinise Individual Management Reviews. It was agreed that Individual Management Reviews met the required standards in terms of quality, content and independence, and reflected the Terms of Reference of the Serious Case Review.

1.2.8 The Overview Panel felt that Young Person A's mother should be offered an opportunity to contribute to the Serious Case Review in order to obtain her views about the services and support provided to both herself and her daughter. A sensitive and supportive invitation was sent to Young Person A's mother in the form of a letter which invited her comments at a meeting which could be held at her home or at a venue which was acceptable and comfortable for her. A date for a response was given. Unfortunately, the date passed with Young Person A's mother having failed to make contact. Therefore, the report was finalised without the input of Young Person A's mother. It was not deemed appropriate to make further requests or to seek the views of other family members.

## **2 Chronological Summary of Key Events and Professional Interventions**

2.1 Young Person A's school had no significant concerns in relation to her until 2006, at which point, her attendance at school and her conduct within school began to deteriorate.

2.2 Young Person A's first contact with a non-universal service was in January 2003. A Health Visitor made a referral to the local children and families social work team, requesting support for Young Person A's mother. It was indicated that Young Person A's mother had physical disabilities, and that as a result both Young Person A and her brother were undertaking caring responsibilities.

2.3 As a result of this referral, a request was made to Adult Services for an assessment of the needs of Young Person A's mother, arising from her disabilities. This referral

led to a package of home care being offered to the family by WMDC Adult Services.

- 2.4 From February 2007, Young Person A was given a number of fixed-term exclusions from school, due to concerns about her punctuality and defiance towards staff.
- 2.6 On the evening of 7<sup>th</sup> February 2007, Young Person A's mother contacted the Police, after an incident in which Young Person A had tied a cord or wire around her neck, and appeared to have tried to jump out of her bedroom window. After this incident, Police Officers attended at the home. They concluded that Young Person A was not actually trying to harm herself, and felt that she was attempting to leave the house to see her boyfriend.
- 2.7 Young Person A's mother also contacted the Local Authority herself and requested support in relation to Young Person A. Social Care Direct recorded this referral, and swiftly transferred it to the WMDC Family Services Intensive Support Team. This team's role is to provide intensive support to adolescents and their families. The following day, the Intensive Support Team wrote to Young Person A's Mother offering her a place on the Parents Plus parenting course which was planned to start in March 2007.
- 2.8 At the request of Young Person A's mother, the school allocated Young Person A a Pupil Welfare Officer to provide direct support. This commenced on 12<sup>th</sup> February 2007. At the home visit on this day, Young Person A's mother informed the Pupil Welfare Officer of the problems she was experiencing in relation to Young Person A's behaviour. She also informed the Pupil Welfare Officer about the events of 7<sup>th</sup> February, and indicated that on 9<sup>th</sup> February, she had been assaulted by Young Person A, who had subsequently caused damage within the home.
- 2.9 On 12<sup>th</sup> February 2007, Young Person A and her younger sibling were referred to the Barnardo's Young Carers Service by the school's Education Welfare Officer in relation to their need for support, based on their caring responsibilities. Barnardo's responded quickly by sending a letter to the family on 4<sup>th</sup> February 2007 and a further letter on 14<sup>th</sup> February 2007.
- 2.10 After a short delay caused by an office move, and by difficulties in contacting the family, Barnardo's spoke to Young Person A's mother by telephone on 11<sup>th</sup> April 2007. During the conversation, their workers became concerned about the level of tension in the home caused by Young Person A's challenging behaviour, and after discussion with managers, contacted Social Care Direct to request provision of family support. They were informed by Social Care Direct that the Family Services Intensive Support Team was due to visit the family next week.
- 2.11 Between this point and October 2007, Young Person A was offered a wide range of activities, groups and excursions with the Barnardo's service. Although she indicated a desire to become involved, she persistently did not attend, and only attended one session with them, which she appeared to enjoy. Records show that staff at Barnardo's made significant efforts to engage with Young Person A and encourage her to become involved with their service. However Young Person A failed to attend more than one session, and was eventually discharged from the service in October 2007.
- 2.9 On 13<sup>th</sup> February, the Pupil Welfare Officer contacted the School Nurse, and requested that she make Young Person A an appointment to be assessed by CAMHS. This referral was made promptly, and received by CAMHS on 16<sup>th</sup> February.
- 2.10 After CAMHS made contact by telephone, Young Person A attended an initial appointment with them on 19<sup>th</sup> February
- 2.11 On 1<sup>st</sup> March 2007, the Pupil Welfare Officer contacted Social Care Direct to advise

them that yesterday, she had spoken to Young Person A's mother again. Young Person A's mother had been indicating a strong need for support.

- 2.12 Social Care Direct recorded this information on the Family Services information system. At this stage, there was still an open referral for Young Person A on this system, allocated to the Intensive Support Team for provision of a Parents Plus course.
- 2.13 On 2<sup>nd</sup> April 2007, Young Person A attended A&E with her mother with a minor jaw injury, following an alleged assault by two strangers.
- 2.14 On 5<sup>th</sup> April 2007, the Family Services Intensive Support Team wrote to Young Person A's mother offering an appointment at home on 17<sup>th</sup> April, to discuss the forthcoming Parents Plus parenting course.
- 2.15 CAMHS next became involved on 16<sup>th</sup> April 2007, to undertake an assessment of self-harm, after Young Person A was admitted to hospital following an overdose. She was offered further support, and attended appointments with CAMHS on 17<sup>th</sup> and 24<sup>th</sup> April 2007.
- 2.16 On 17<sup>th</sup> April 2007, records indicate that Young Person A's mother rang the Family Services Intensive Support Team and informed them that the support they had offered was no longer required, as Young Person A had returned to live in Ireland with her father. At this point, health records indicate that Young Person A was in hospital following her overdose the day before. On the basis of the information provided by Young Person A's mother, the Family Services Intensive Support Team closed their involvement.
- 2.17 At her CAMHS appointment on 4<sup>th</sup> May 2007, Young Person A did feel able to discuss a number of issues that were of concern to her. CAMHS records show that it was planned to explore this further with Young Person A in future sessions, and undertake further enquiries.
- 2.18 Young Person A then attended an appointment with CAMHS on 8<sup>th</sup> May 2007, during which she indicated that she had thought about self harming.
- 2.19 Young Person A failed to attend her next appointment at CAMHS on 17<sup>th</sup> May 2007. After a further series of three missed appointments, Young Person A was discharged from the CAMHS service.
- 2.20 On 2<sup>nd</sup> July 2007, the Pupil Welfare Officer made a referral to Social Care Direct again requesting provision of support for the family, based on her concerns about the information provided by Young Person A's mother during a home visit on the previous day. She reported that the relationship between Young Person A and her mother was extremely tense. Social Care Direct advised the Pupil Welfare Officer that she should use the Common Assessment Framework, in order to provide a co-ordinated, multi-agency response to Young Person A's needs.
- 2.21 On 18<sup>th</sup> July 2007, GP records show that at Young Person A's request, she was referred for a termination of pregnancy.
- 2.22 On 27<sup>th</sup> September 2007, CAMHS again became involved following Young Person A's second overdose and hospital admission. She did not attend an appointment on 3<sup>rd</sup> October 2007, so a further appointment was made for 17<sup>th</sup> October. Again Young Person A failed to attend, and she was then discharged from the CAMHS service on 8<sup>th</sup> November 2007.
- 2.23 Between this point and her death on 28<sup>th</sup> April 2008, GP records show attendances for minor medical matters. School records show a mixture of concerns related to truancy and defiance, but also several merits in certain subjects.

2.24 Young Person A died on 28<sup>th</sup> April 2008 as a result of suicide.

### **3 Analysis**

- 3.1 The Serious Case Review notes and accepts the recommendations made by individual agencies within their Individual Management Reviews, relating to issues such as the need for case recording and inter-agency communication to be improved across a number of agencies. The Serious Case Review would also like to highlight several areas of good practice, and also a number of areas in which practice could be strengthened in the future.
- 3.2 Young Person A was a young person in emotional distress for at least twelve months before her death by suicide in April 2008. The Serious Case Review has identified that this distress was known to a number of professional agencies, and therefore, has tried to establish whether agencies can learn lessons from the way they intervened with Young Person A and her family.
- 3.3 The Serious Case Review has identified a number of areas of good practice. For example, when she became involved with the family, the Pupil Welfare Officer quickly determined that further support for Young Person A was needed, and discussed the case with the school nurse without delay. She requested that the School Nurse make a referral to CAMHS in line with the CAMHS referral procedure. Again, the School Nurse acted promptly and made this referral in the correct manner.
- 3.4 CAMHS acted promptly to offer Young Person A a swift appointment after receiving the referral from the school nurse, and provided a suitable intervention until the point that Young Person A disengaged herself from their service. They became involved with her appropriately on two subsequent occasions, following suicide attempts, however Young Person A again failed to engage with the support offered to her, and was discharged.
- 3.5 There is evidence of good communication, discussion and liaison between key health personnel and between staff within the school.
- 3.6 In addition, PW1 made herself available to Young Person A for home visits, and also for individual sessions in school. Young Person A did not fully engage with this, however the fact that PW1 attempted to offer this support is very positive. PW1 also discharged her duty to promote Young Person A's welfare by referring her to Social Care Direct on two occasions, when her level of concern grew.
- 3.7 The Serious Case Review has also found that Barnardo's Young Carers Service responded quickly to the referral they received, and made significant efforts to engage Young Person A in a wide range of suitable activities, including social events and therapeutic groups for young people. However Young Person A continually resisted their efforts to engage with her, and ultimately, Barnardo's had little choice but to withdraw their service.
- 3.8 However the Serious Case Review has also identified areas in which lessons could be learned in order to improve practice in the future.
- 3.9 In relation to the Safeguarding and Family Support Directorate of Family Services, there were three opportunities for them to undertake a holistic assessment of need that would, with hindsight, have helped to build up a clearer picture of Young Person A's needs, and the needs of her family. These opportunities came in July 2003, in February 2007, and in July 2007.
- 3.10 In February 2007, Social Care Direct received and acted on the referral from Young Person A's mother. However the referral was assigned to the Intensive Support Team for provision of support, without the benefit of an Initial Assessment of Need. An Initial Assessment at this stage may have also identified a need for direct support

for Young Person A herself in a number of areas, alongside the support that was subsequently offered to her mother.

- 3.11 In July 2007, PW1 made a further referral to Social Care Direct, requesting support due to an escalation of tension within the home, and increased concern about Young Person A's behaviour. At this stage, Social Care Direct advised implementation of the Common Assessment Framework. If Social Care Direct had allocated the case for Initial Assessment of Need, it is possible that a higher level of need or concern may have subsequently been identified, leading to provision of more co-ordinated services for Young Person A.
- 3.12 Although advised by Social Care Direct to implement the Common Assessment Framework, this did not happen due to the school summer holidays. At the start of the new term, the home situation seemed to the Pupil Welfare Officer and other staff in school to have settled down, and with agreement of Young Person A and her mother, the plan to convene a meeting was withdrawn.
- 3.13 It is evident that CAMHS did make efforts to engage with Young Person A, and that they succeeded for a time. However during 2007, Young Person A's emotional distress seems to have heightened, and she made two suicide attempts. Support was offered again by CAMHS, however Young Person A did not engage.

#### **4 Assessment concerning the preventability of Young Person A's death**

- 4.1 The question as to whether or not the death of Young Person A could have been prevented is highly subjective and difficult to answer, even with the benefit of hindsight. Young Person A was clearly a young person with significant emotional need, but also one who persistently did not engage when appropriate services were offered to her by agencies such as Barnardo's, CAMHS and by the Pupil Welfare Officer in school. This Serious Case Review has found that an early, multi-agency assessment of Young Person A's needs may have led to the provision of a co-ordinated package of support to Young Person A and her family, however it is impossible to say with any certainty that this would have led to a different outcome.

### **5 Recommendations**

#### **5.1 Family Services – Safeguarding and Family Support Directorate**

- 5.1.1 It is recommended that the Safeguarding and Family Support Directorate undertake work related to the thresholds by which they agree to become involved with a child or young person. The Directorate needs to ensure that their thresholds for intervention are appropriate. The Serious Case Review also recommends that there is multi-agency discussion and "sign up" of the outcomes of this work by the Wakefield Safeguarding Children Board, to ensure multi-agency awareness and agreement.
- 5.1.2 It is also recommended that the practice of providing support services such as Parenting Courses without having first undertaken an Initial Assessment of Need is reviewed.
- 5.1.3 It is recommended that within the Safeguarding and Family Support Directorate, new guidance is issued to staff in Social Care Direct on responding to referrals, to ensure that when a referral is received concerning a child, full information is obtained, and consultation with partner agencies takes place, before a decision is made about how to respond.
- 5.1.4 It is recommended that in terms of the timeliness of service delivery, consideration be given to agreeing a set of standards about delivery of provision, to ensure that services are provided in a timely fashion that reflects the level of need.

- 5.1.5 Finally, it is recommended that guidance on case-recording be reiterated to staff, to ensure that records and referrals are entered onto the information system in a timely and accurate manner.

## **6.2 Wakefield Health Community**

- 6.2.1 It is recommended that guidance to General Practitioners on the need to keep clear records, particularly in cases of child concern, is reiterated quickly.
- 6.2.2 It is also recommended that guidance to General Practitioners about how to respond to cases of child concern is also reiterated and re-issued.
- 6.2.3 The Serious Case Review recommends that all health practitioners should accurately record the content of, and type of contact made for example telephone / face to face contact communications with other professionals, especially when there are child concerns. Guidance should include the importance of recording ethnicity on all client/patient records, and of practitioners clearly identifying risks, need, intervention, outcome and future plans of care.

It is recommended that guidelines are developed with regard to children and families who disengage or withdraw from services. These guidelines need to be written and shared with all agencies working towards supporting children and families in the District.

- 6.2.4 Trusts also need to raise the profile of young carers' and staffs' awareness of the additional needs of these children.

## **6.3 Schools**

- 6.3.1 It is recommended that guidance is issued to schools by Family Services, advising them how to manage situations where a referral is made to Social Care Direct, but declined, and where disagreement exists. This guidance is contained within the WY Safeguarding Children Procedures.
- 6.3.2 It is also recommended that schools be re-issued with guidance about the need for comprehensive and clear records, particularly about children who are the subject of welfare concern.
- 6.3.3 It is further recommended that in relation to the implementation of the Child Wellbeing Model (Common Assessment Framework), training and awareness raising continues. It is evident that this is happening already, however it needs to be certain that the messages are clear about when and how to implement the system. The Overview Panel understand that in all cases where Social Care Direct advise a referrer to implement the Child Wellbeing model, this is now being recorded and monitored by a co-ordinator, who is in a position to follow-up on the delivery of the model.

## **6.4 West Yorkshire Police**

- 6.4.1 It is recommended that the Police review their training provision, specifically in relation to working with children and young people. Training is available provided by Wakefield Safeguarding Children Board that may assist officers in responding and assessing risk.

## **6.5 CAMHS**

- 6.5.1 It is recommended that the process for discharge of non-attenders in CAMHS is reviewed, and that the outcomes of this are shared with the Safeguarding Children Board.

6.5.2 It is also recommended that at the time of closure, the level of risk to the young person is reviewed, in order to highlight the need to refer on. This discussion process should be clearly recorded.

**6.6 Barnardo's Wakefield District Young Carer's Service (BWDYCS)**

6.6.1 It is recommended that within BWDYCS, work is undertaken on their policy for how to respond to non-engagement following referral.

6.6.2 It is recommended that Barnados review the existence and quality of the feedback provided to referrers.

6.6.3 It is also recommended that within BWDYCS, all plans relating to young people that they are working with are regularly reviewed, particularly before closure of a case