

MILTON KEYNES SAFEGUARDING CHILDREN BOARD

**SERIOUS CASE REVIEW
EXECUTIVE SUMMARY
CHILD 'B'**

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**Report Author: Paul Kerswell,
Director of EadesKerswell Strategic Ltd**

Milton Keynes Safeguarding Children Board Serious Case Review Executive Summary

Introduction

This document provides a summary to an Overview Report which was commissioned by Milton Keynes Safeguarding Children Board under the requirements of 'Working Together to Safeguard Children' 2006. It was commissioned following the death of child B, aged 15 years and 3 months.

The report is based upon information provided, via the Serious Case Review Panel, from individual management reviews carried out by agencies that provided services to B. Individual Management Reviews (IMRs) were provided by:

- Children's Social Care, Milton Keynes Council
- The Children's Society.
- Health Services, Milton Keynes PCT.
- Thames Valley Police.
- Housing Department, Milton Keynes Council
- Education, Milton Keynes Council

Any conclusions and recommendations are based on analysis of the information provided, with the benefit of hindsight and produced in an Independent Overview Report compiled by Paul Kerswell, Director of Eades Kerswell Strategic Ltd. They are intended to assist in the application of 'best practice' for the future.

Purpose of a Serious Case Review

The purpose of a Serious Case Review is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- as a consequence improve inter-agency working and better safeguard and promote the welfare of children.

(Section 8.2 of the Department of Health document 'Working Together to Safeguard Children' 2006)

Serious Case Reviews are not enquiries into how a child died or was seriously injured or who was responsible. These are matters for Coroners and Criminal Courts. Therefore this report does not seek to apportion blame for the death of B.

This report examines the actions of the agencies that were involved with B and his family. It analyses individual agency policies, procedures and decision making and considers how agencies interacted with each other. The report provides recommendations that are intended to improve services and help to better protect children in the future.

Terms of Reference

The MKCSB SCR Panel has considered in this case the scope of the review and has drawn up agreed terms of reference:

- To cover the whole period of B's life, to include last CSC Core Assessment, triggered by B's death, and to also include information from A&E department (where B was taken by ambulance) and any other agency involved with the family in the week after B's death
- Reports should include when B was seen, and specify those occasions where he was seen alone
- Relevant information about B's siblings and parents to be included to form the family context
- **Revised timescales:**
 - 29 August - IMRs, chronologies and agency Action Plans**
 - 26 September - first draft overview report**
 - 3 October 2008 - final draft Overview Report**
 - 10 October - Final Report and Executive Summary to MKSCB**
 - 31 October - report to Ofsted/GOSE**
- **Second revision agreed January 2009**
 - 19th January 2009 - IMRs**
 - 26th January 2009 - first draft overview report**
 - 17th February 2009 - Final Report and Executive Summary to MKSCB**
 - 18th February 2009 - reports to Ofsted/GOSE**
- Status of case files - open/closed
- Decision-making - were decisions soundly based/recorded?
- Impact of agencies' response to neglect
- Impact of agencies' response to physical and emotional abuse
- Impact of agencies' response to domestic violence
- Impact of agencies' response to alleged sexual abuse of siblings, which may have impacted on the family
- Impact of agencies' response to mental health issues in the family
- Impact of agencies' response to bullying issues
- The Internal Management Reports will be owned by the agency concerned, with oversight by a senior manager, who will be

responsible for signing the report off and for overseeing the actions taken in respect of any recommendations made

Summary of the Case

1. Child B was born in 1992.
2. There were early indications within the family of alcohol misuse and domestic violence.
3. Over the years various supports were offered to the family and there were several periods when B's name was placed on the child protection register.
4. Early concerns were raised about B's delayed development and challenging behaviour and the special educational needs statementing process was initiated. He subsequently attended a special school.
5. Work was commissioned from a Children's Society Family Centre, where an holistic assessment of the family was undertaken.
6. B's childhood was typified by constant concerns about his dangerous and impulsive behaviour, and numerous incidents which were not always well reported or investigated.
7. He was later diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and prescribed Methylphenidate (Ritalin) at the end of 2002.
8. There continued to be many reported incidents during B's time at the special secondary school which he moved to in 2005. His mother particularly became concerned that during 2007/2008 he had a morbid interest in death. She also said he was very unhappy at school. There is at least one report of him saying he wanted to kill himself.
9. On 8th March 2008 B was at home with his father when he went to his bedroom. He was later found suspended from the bedroom door with a tee shirt around his neck. Sadly B never revived.

Analysis

The overview author's analysis explores, with the benefit of hindsight:

- A. The issues specified in the terms of reference and the interaction of agencies with B's family in situations which indicated that there were, over the years at various times, elements of domestic violence, physical and emotional abuse, mental health issues and bullying.

- B. The impact on B's life of the agencies responses to the difficulties faced by B and his family. In particular the child protection and family support phases, the identification and subsequent treatment of his ADHD, his experience at school and the impact of the findings of recent investigations into his secondary school. It considers the possibility of an adverse culture within the school and the education authority.
- C. It recognises the relatively long time period covered, the changes within that time period of both clinical knowledge and quality of practice, particularly in the areas of multi-agency working and an understanding of the child's perspective.
- D. It considers areas of good practice as well as those needing some attention.

Conclusions

1. B lived and grew up within a complex and chaotic family. There were many issues that impacted on the dynamics set up between the family and the professionals offering them help and support. Many of the aspects of this case have to be viewed within a historical context in that services have been continually improving over the last 15 years.
2. The child protection process (in the late 1990s) had the most chance of pulling the whole picture together and coordinating the support that the family was offered. There was confusion about the use of legal proceedings which indicated poor case management at the time. I note that there is now greater management capacity and a very clear process which includes the use of the Council's legal section to draw up agreements with families prior to the initiation of care proceedings.
3. Once the children's names were removed from the register and B had been diagnosed, input to the family became more reactive; responding to each immediate incident or crisis. The family's repeated failure to engage should have been seen as cause for raised concerns. Instead there was not a coherent multi-agency response; I note the references by both health and children's social care authors to the implementation of the common assessment framework (CAF) and the changes that will bring about. I also note that referrals and assessments within children's social care are quality assured and subsequent family support plans are now reviewed, monitored and audited; that a child protection coordinator is consulted before a family support plan is offered. I also note that there is now in existence a multi-agency Family Advice and Support Team.
4. B himself seemed to get lost in the melee around his behaviours and the difficulties they caused, both for his family and for professionals. I

note that it is now a requirement that children are always spoken to separately (dependent upon age).

5. Domestic abuse and violence was a significant factor in this family's history. This had an impact on mother's ability to protect the children, either by standing up to him or sharing information honestly and openly with professionals. The use of legal proceedings (in the 1990s) as a repeated threat can only have exacerbated this. I note that all agencies now have a much greater awareness of domestic violence and its impact on children.
6. The coroner took the view that he could not be clear either that B's death was an accident, or, not knowing what was in B's mind, that it was intentional. He accordingly recorded an open verdict. I think recent events cast doubt on the veracity of some of the evidence he heard in reaching that decision.
7. The following concerns emerge from recent investigations at B's School:
 - Children and young people were locked in classrooms whilst being taught.
 - Restraint was allegedly inappropriately used as a punishment.
 - There is no evidence of complaints of bullying being recorded or investigated by the school.
 - Child protection procedures were not followed by school staff.
 - Evidence was withheld by the head teacher from the Internal Management Review into B's death.
 - The head teacher of the school appears not to have been completely honest to either the inquest or the education IMR author.
 - The school had no anti bullying policy and there was no evidence of a child protection procedure being in place.
 - Senior Managers of that part of the local authority responsible for Education functions, failed on at least two separate occasions, in 2006 and 2007, to respond appropriately to complaints and concerns from parents and a wide range of professionals.

From this I infer that there was a culture of bullying and deceit within the school, perpetuated by the head downwards. It therefore seems extremely likely that B and other vulnerable young people were allowed to be bullied as part of the school regime.

8. Further, I would infer that there was a degree of collusion on the part of senior managers within the education department of the local authority in that they modelled and perpetuated the "closed loop"

which discouraged and actively prevented an open examination of practices within the school.

9. I note that once the Council found out, sometime after B's death, that classrooms were locked, it instigated a full independent investigation of the school, removing the head teacher and some other staff and installing a new regime. The new regime has as a priority sought to tackle bullying within the school. An Ofsted inspection in January 2009 has given the school a 'good' rating.
10. In addition to my concerns about this culture in the education part of the local authority, I would add the comments of the education IMR author about the delay in his appointment to the role; the lack of adherence to procedure in securing records; my own observations in the early stages of this review; and a disengagement from the process by those responsible for the education part of the local authority.
11. From this I infer a lack of engagement by that part of the local authority responsible for education at that time in the safeguarding agenda in general and in the partnership approach necessary to the work of the Local Safeguarding Children Board in particular.
12. Given the evidence now before us, and the manner in which it was obtained, I have no hesitation in concluding that the school had a significant problem with bullying amongst its pupils. However, there is not the evidence to indicate how great an influence this played in the tragedy of B's death. It must be seen as another factor in the world of a young man noted for his impulsive and dangerous behaviours.
13. It is not possible therefore to identify any one significant event or action by any agency, which if done differently would have changed the sad tragedy of B's death.
14. At a conservative estimate there were over 250 professionals involved with B and his family during the course of his life. Individual examples of good practice are recorded in the chronologies and agencies' IMRs.

Practice Issues

15. I commend the Milton Keynes Serious Case Review Panel for the open and transparent conduct of this review and their commitment to learning the lessons from B's tragic death. It is my view that the process which developed of allowing the overview author to meet with IMR authors and the SCR Panel during the compilation of the IMRs enhanced the outcomes of the SCR.

16. The benefits of the process were that emerging issues were discussed and the IMRs were therefore able to address all issues. The Terms of Reference were able to be updated and it was as a consequence of these meetings and the information shared that it was decided to request assurances from senior managers that appropriate services were available to the family after B's death. As Overview author the meetings also provided a forum for me to explore and make any recommendations for immediate action that may have emerged as necessary during the course of the review.
17. It is of concern to discover that there is no requirement for the Coroner to keep verbatim records of the evidence taken during the process of the inquest.
18. It is also of some concern that Ofsted had not picked up at least some indication of what was happening at the school in the course of their inspection and monitoring regime.

Actions arising

In line with the recommendations in the Independent Overview Report the following actions have been put in place and progress against them will be monitored by the Local Safeguarding Children Board:

1. The LSCB has required each agency to formulate an action plan in response to their Individual Management Review, which incorporates specific actions and timescales.
2. The LSCB has, within its Performance Management Framework, developed a mechanism for checking each agency response to IMRs and implementation of subsequent actions
3. The LSCB is actively promoting inter-agency working:
 - Modelling collaboration, communication, shared responsibility and joint planning.
 - Commission training which will clarify an inter agency outcomes approach, incorporating clear planning with shared stated objectives and making clear statements about safeguarding children within hard to reach and difficult to engage families.
 - Commission the development and implementation of clear standards, definitions and multi-agency responses to issues of:
 - Bullying
 - Domestic violence
 - Self harm and suicidal ideation

- Develop statements or standards which give professionals “permission” and mandate to meet and plan together, in an open honest and collaborative way.
4. The LSCB has required that part of the Local Authority responsible for education to develop and implement a culture change programme which addresses the issues raised by this SCR and will actively monitor and quality assure the process.
 5. The LSCB will review its procedure for serious case reviews to incorporate learning from this review.
 6. The LSCB will make representation to OFSTED about the development of national standards for the keeping of pupil records by schools and the monitoring of performance against them as part of the school inspection regime.
 7. The LSCB will pass on to the Home Office concerns raised re recording standards and practice at inquests.

Paul Kerswell
Director Eades Kerswell Strategic Ltd