Islands Child Protection Committee

Working Together for the Children of Guernsey and Alderney

ISLANDS CHILD PROTECTION COMMITTEE

SERIOUS CASE REVIEW
Executive Summary

CHILD X

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CONTENTS

1 INTRODUCTION

1.1 A child, known throughout this report as Child X, died whilst visiting his birth mother's home in the UK from Guernsey, in 2014. Whilst there will be an inquest to fully determine the circumstances of his death, the post mortem identified that there was evidence of mixed drug misuse but not alcohol and that he died of bronchopneumonia.

1.2 He was aged 17 years and 7 months.

1.3 The Islands Child Protection Committee ICPC is required to undertake a serious case reviews (SCR) in accordance with the local guidance when a child dies and there is concern about whether all agencies worked together effectively prior to the death.

1.4 All the agencies which were involved with Child X have collated sensitive and personal information about him with due regard for confidentiality. There were three different local areas involved with Child X during his life – Guernsey and Alderney, and two UK local authorities. The other two authorities have also considered the issues and have contributed to this review. The ICPC has balanced the need to maintain the privacy of the child and family, with the need for agencies to learn lessons in relation to practice identified by the case.

1.5 Child X's adoptive mother and his birth parents have contributed to the review. This has provided the reviewer with some additional information about their experience.

1.6 The ICPC has endorsed the recommendations of this review, and intends to implement them immediately and robustly to improve safeguarding practice.

2 THE REVIEW PROCESS

2.1 After the information about Child X's death had been shared, the Chair of the ICPC decided that a serious case review should be carried out.

2.2 The Serious Case Review Panel established by the Committee ensured that those involved were experienced, senior professionals who had no prior involvement with Child X.

2.3 The independence of the Panel and review process was established by the appointment of an independent Lead Reviewer, Amy Weir.

2.4 All the relevant partner agencies of ICPC as well as agencies in the other two areas were requested to undertake Individual Management Reviews or to provide

statements. They were asked to provide reports detailing their involvement with Child X and his adoptive and birth families.

3 THE FACTS / SUMMARY OF EVENTS

3.1 Child X was born in the north of England. There was a family history of domestic violence, drug and alcohol misuse and evidence that the children suffered neglect.

3.2 In 2001, Child X was removed from the care of his parents by the UK authority where he lived through a prolonged legal process.

3.3 In 2004, Child X was adopted in another area in the north of England. His adoptive parents supported Child X and made sure that he received the additional help he needed.

3.4 By 2010, Child X's adopters were struggling with Child X's behaviour. He was going missing, staying with his birth mother, taking drugs and not attending school.

3.5 In November 2011, he was taken into care by a local authority in England with the agreement of his adopters. He remained in care between November 2011 and August 2012. He continued to go missing, to refuse to go to school and to take drugs. In July 2012, he started spending time with his brother and moved in to live with him.

3.6 The local authority decided to discharge him from care in August 2012 but it was agreed that they would continue to support him as a child in need.

3.7 In September 2012, Child X left England and moved to live with his birth father in Guernsey. The local authority in the north of England informed Guernsey Children's Social Care (HSSD) that Child X was now in Guernsey but the liaison was not as strong as was required given his long history of concerns and his vulnerability. A visit was made to see Child X and his birth father. An assessment was not completed and there was no follow up.

3.8 In October 2012, his birth father sought out a school for him and he started to attend. However, by January 2013, Child X's behaviour had become problematic; he was staying out late, drinking and behaving inappropriately at school. In February 2013, he was arrested for driving a scooter under the influence of alcohol. Between March and June 2013, he committed several petty offences, he was missing school and there was evidence he was using drugs. A Youth Justice worker became involved. He told school that he was worried for his safety and was being bullied. In July 2013 he tried to fly to England but he was arrested at the airport as he was subject to bail conditions.

3.9 In November 2013, Child X was arguing with his birth father who said he was out of control. Child X was still wanting to return to England. He also asked about whether he could come into care but he was told incorrectly that his birth father would need to agree.

3.10 In January 2014, Child X was chased by some youths. There was a fight and he was arrested for affray and for having some white powder in his possession. He was remanded to prison though the Police advised that secure accommodation would be appropriate. He remained in prison till August 2014. During this time his birth father was arrested and imprisoned for a drug offence.

3.11 In July 2014, plans were made for Child X's release; his birth father was in prison; his birth mother was contacted to ask if he could go there. Child X decided he wanted to stay on the island. In August 2014, Child X was discharged to his birth father's address even though his father was in prison. Child X started a job and did well initially.

3.12 In September 2014, Child X went on a planned visit to the UK from Guernsey to see his birth mother. He was due back on 1st October 2014. That day he was found dead in his birth mother's home

4 KEY ISSUES

4.1 Child X came from a complex family and his birth parents struggled to care safely and consistently for him. His early behaviour reflected the impact of this. He was removed from his parents and adopted.

4.2 His adoption had broken down by 2011 after he sought increasing contact with his birth family – initially through social media.

4.3 Three different local areas were involved with Child X but despite his vulnerability, opportunities were missed to address his significant needs. It is clear that he was discharged from care in August 2012 with insufficient consideration of his vulnerability and risky behaviours.

4.4 In September 2012, Guernsey services were informed that he was on the island. There was no assessment or enquiry. The UK authority did not provide written information or follow up.

4.5 The Youth Justice Service worked with and supported Child X when he started offending.

4.6 Child X's offending escalated and he spent months in the adult prison with no alternative provision available.

4.7 In prison, Child X received and benefited from support and services. However, the plan for Child X's release was not robust enough and he remained vulnerable.

4.8 Three different local authorities were involved with Child X. At no time were his wishes and feelings fully sought or supported by statutory services or independently. The lack of independent process to listen to and represent his wishes, feelings and views was a critical omission.

4.9 Child X's birth parents did not have Parental Responsibility for him because he had been removed from their care. Neither in England nor in Guernsey was there sufficient consideration of whether his birth parents could now keep him safe. It is not clear on what basis he was discharged from care in 2012 when he was still very vulnerable.

4.10 In Guernsey, there was a lack of assessment of his needs and a lack of early preventative intervention with Child X as a vulnerable child; the response was to his challenging and offending behaviours rather to addressing his needs and vulnerability.

4.11 Child X was not seen as in need of safeguarding and protection because he was over 16 when he came to Guernsey. In the UK, his vulnerability was also underestimated.

5 PRIORITIES FOR LEARNING AND CHANGE

5.1 Each agency which completed an Individual Management Review as part of the Serious Case Review has identified a number of issues about their practice, and they are addressing these locally.

5.2 The recommendations relating to the agencies in Guernsey and Alderney will be robustly monitored by the ICPC to ensure that they are implemented within the agreed timescales and have the required impact upon local services for safeguarding children and young people.

5.3 In addition to these recommendations, the Serious Case Review has identified a number of key issues which need to be addressed by the ICPC as a whole. The ICPC will monitor regularly with partner agencies, the completion of these recommendations.

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Child X died following the consumption of a variety of different drug substances.

6.2 It is not possible to say conclusively that his death was either predictable or preventable. He had experienced a great deal of stress during his life and had, in his early years, not received all the care that he needed. He was not adopted until he was 7 years old and, by that time there is evidence that his emotional and behavioural development had already been affected adversely.

6.3 There is a great deal of learning in this case about the importance of consistent planning and follow through for vulnerable children.

6.4 ICPC Recommendations

6.4.1 **Review safeguarding practice with young people** to ensure that the needs of adolescents at risk are fully assessed, plans are in place and appropriate provision is in place to address those needs. A randomly selected multi-agency audit should be undertaken to focus on work with 16/17 year olds - particularly considering their vulnerability and legal status.

6.4.2 The provision needs to include **preventive and early intervention services**. The ICPC should monitor the Multi-Agency Support Hub's identification of high risk young people to ensure appropriate services are provided.

6.4.3 The ICPC should promote work to **divert young people from criminal prosecution** through monitoring the number of young people who are retained for prosecution rather than being referred to the Children's Convenor for the intervention they require.

6.4.4 The ICPC should promote multi-agency integrated working through joint training in how to **work with challenging and difficult to engage young people** – particularly older adolescents.

6.4.5 **Ensure assessments are completed** for vulnerable children who move to the islands. The ICPC should ensure that a system is in place for children's services (HSSD) to carry out thorough assessments of need and to chase up information about children in care, care leavers coming to Guernsey or any other vulnerable child.

6.4.6 The ICPC should host **a joint event** with the relevant LSCBs to share the learning.

6.4.7 **Promote cross authority / jurisdiction joint working** to safeguard children and young people in liaison with LSCBs.