Kirklees Safeguarding Children Board
www.kirkleessafeguardingchildren.com

A Serious Case Review in Kirklees (026):

Learning Lessons

)This briefing has been produced to provide practitioners and managers with the key learning from cases that have been considered and discussed at the Kirklees Safeguarding Children Board Case Review sub group.

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved and it is believed lessons can be learned from the way in which the local authority, their board partners or other relevant persons have worked together to protect the child.

Kirklees Safeguarding Children Board

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

What was the story?
In 2013 a fourteen-year-old male carried out very serious self-harm in what appeared to be a psychotic episode. The adolescent had been living with mother and a large number of siblings and they had been subjected to neglect for many years (at least 8 years). This serious self-harm was most probably precipitated through regular substance misuse (Cannabis and MCAT – Mephadrone, a stimulant) and alcohol, with long-term neglect also a contributory factor.

Background and case summary:

- The young person lived with mother and siblings, father having left before he was born although contact with father was maintained throughout. Contact and support from extended family appeared to be sound.
- The young person and his siblings had been the victims of considerable and sustained neglect over years.
- The mother and the young person consistently failed to engage or comply with requests, mandatory instructions or legal orders.
- There were a large number of agencies involved in this family and many interventions tried and applied.
- The adolescent abused drugs (Cannabis and MCAT – Mephadrone, a stimulant) and alcohol.
- This case was subjected to 'drift' for a number of reasons including long-term sickness of key staff and process/administrative/ICT failings including lack of management oversight.
- Several opportunities to address the young person's substance misuse were missed partly due to process failings and partly due to the non-compliance of the young person also the perception that referral would further criminalise the young person.
- There was a focus on the young person's lack of co-operation and failures to comply with processes and jurisdictions rather than the physical and psychological needs of the young person. Delays in psychological and paediatric assessments exacerbated this.
- There was agency focus on the needs of the younger siblings and the older child's needs, particularly emotional needs and presenting behaviours (substance misuse) were over-looked.
- In 2013 a psychotic episode probably borne out of the substance misuse together with the consequences of neglect resulted in very serious self-harm which may or may not have been a near-miss suicide.

Overview and Analysis

Strengths and Protective Factors

There was an extended family and an absent father that appeared to want to help and support the young person and recognised his needs

Risk/Harm/Danger

The young person's lack of engagement and compliance persuaded agency workers that this was a troubling child and not a troubled teenager.

There was a lack of management oversight and lack of regular quality supervision that contributed to drift and no proper case overview, reflection and analysis

Grey Areas

Non-attendance at school by the young person could/should have been a trigger for intensive early help and intervention that may have addressed the mental health needs of this young person

Poor appreciation of the necessity for professional challenge intra- and inter-agency may have contributed to delays in decision-making

Recent change in the chemical composition of available drugs make them more potent with unpredictable physiological and psychological effects

Complicating Factors

Assessments completed did not deal with holistic needs but rather on presenting issues at the time eg non-attendance at school and cannabis use.

Actions identified in plans were not SMART and there were no full and proper contingencies for non-completion/non-compliance

There was a lack of clarity over process and over which agency and which member of staff was responsible for which actions

Voice of the Child

The true voice of the child would have been heard through a full psychological assessment and evaluation of his emotional well-being rather than reliance on attitude and behaviours as a proxy indicator of his voice.

Workers admitted they did not know this young person well-enough

Analysis

This case is characterised by:

A focus on professional input and not outcomes (large numbers of agencies involved and interventions applied but the experiences of neglect for the child/ren changed little throughout all of this input)

Conclusion

Whilst the one-off psychotic episode that led to the serious self-harm (possible near-miss suicide) came on quickly (within 48 hours) and without warning and therefore could not have been predicted or prevented, there were many opportunities missed to evaluate the emotional well-being of this young person. Had these opportunities been taken early enough and with consistency, help may have been accepted by the young person and this could have countered the effects of the long-term physical and emotional neglect and reduced or removed his misuse of drugs and alcohol which probably jointly precipitated the psychotic episode.

Lack of management oversight in agencies, multiplicity of agency involvement and concurrent interventions and processes led to poor focus on the holistic, long-term effects of the neglect on all the children but particularly this individual child due to his age and his lack of compliance and engagement.

Poor adherence to established processes including timeframes for completion of effective assessments and SMART action plans with clear contingencies led to case 'drift' and exasperation for agencies that clouded decision-making.

Relevant Tools & Multi-Agency Responses for this case include:

- Protocol for Young People aged less than 16 years presenting to Accident and Emergency due to alcohol/drug excess or with an injury sustained as a result of drugs/alcohol use' – link
- Setting SMART Action Plans – link (Is there one?)

Learning for Professionals and Multi-Agency Working

- In a multi-sibling family, evaluation of all the individual children's holistic needs should be included in all case review
- Child substance misuse should always be referred to the Young Persons Substance Misuse Service
- Where there are large numbers of agencies and individuals involved in interventions with families, these need to be effectively managed and the impact and outcomes for the family of each of these should be regularly evaluated
- Assiduous and regular management oversight of cases and quality of practice is of paramount importance and should be scheduled and always carried out as planned; Management oversight should always include challenging of assumptions and perceptions; Regular, high-quality supervision of individual practitioners needs to be a priority for managers, scheduled and always carried out as planned

For more information about Serious Case Review and this case visit:

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

'Closing the loop'

Actions taken to address the learning

What has improved/changed as a result of the actions taken and how do we know?
What have the audits revealed and what has happened since?
What metrics have been presented in reports and what are the continued trends that are demonstrated?
Are we assured that learning has been embedded across all agencies?

Evidence of impact of these actions

How often is the evidence reviewed?
What happens if the evidence indicates no improvement or little improvement or things slipping back?