



**LONDON BOROUGH OF SOUTHWARK
SAFEGUARDING CHILDREN BOARD**

SERIOUS CASE REVIEW

'CHILD Y'

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07.09.18

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1 INTRODUCTION

1.1 TRIGGER EVENT

- 1.1.1 On 30.05.17 'Child Y' (a 5 year Black British old male) received life-threatening injuries from a 17 year old Black British male (J) with whom he lived at a Southwark address. According to other children who were present, Child Y had hurt himself in the course of play and J, possibly made anxious by it, sought to stop the crying by shaking him. Child Y and his twin brother were being fostered by a couple who had previously been granted a 'Special Guardianship Order'¹ for the then 16 year old perpetrator and his older brother.
- 1.1.2 The twins had been placed by Wandsworth Children's Social Care in late 2016. The foster carers had originally been approved as suitable for long-term care by the 'Fostering Foundation, an independent fostering agency (IFA) which in 2015 had been taken over by 'Diagrama'. J has a diagnosis of autism and is learning disabled. At the time of the incident, his carers were (in accordance with an agreed 'Special Guardianship Support Plan) in receipt of support services from Camden Children's Social Care (his borough of origin).
- 1.1.3 After extensive medical attention, Child Y is making steady progress. Based upon the observations of investigating police officers and informed by psychiatric opinion, it was concluded that J does not have mental capacity to understand the legal process and that there appeared to be no intent on his part to cause harm. The criminal investigation was therefore terminated. In the course of the post-incident responses by each involved borough, it was learned that J's behaviours at school had been becoming significantly more difficult to manage prior to the above incident.

CONSIDERATION OF A SERIOUS CASE REVIEW

- 1.1.4 In accordance with the 'Local Safeguarding Children Board (LSCB) Regulations 2006' and London-wide agreed procedures, the event and the context in which it occurred was debated in the relevant sub-groups of all three involved boroughs' Safeguarding Children Boards. Following consultation with the National Panel of Independent Experts (NPIE)² agreement was reached that the relevant criterion for conducting a serious case review was met³ and it was subsequently agreed on 03.12.17 that Southwark would take the lead and be supported by the LSCBs of the other boroughs.

¹ A SGO is a Children Act 1989 court order which grants the holder/s parental responsibility over a child until the age of 18; it enables the special guardian/s to make day-to-day decisions e.g. in relation to education

² The NPIE was established by government in 2013 to advise LSCBs on the conduct of Serious Case reviews

³ Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in Working Together to Safeguard Children HM Government 2015. A 'serious case' is one in which, with respect to a child in its area, abuse or neglect is known or suspected and either the child has died, *or* been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard her/him

- 1.1.5 The Department for Education, regulatory body Ofsted and the ‘National Panel of Independent Experts’ (NPiE) were informed of the above decision and the review was undertaken between February and July 2018 in accordance with the case-specific terms of reference reproduced in section 3.

1.2 PURPOSE, SCOPE & CONDUCT OF THE REVIEW

PURPOSE & SCOPE

- 1.2.1 The purpose of a serious case review (SCR) is to identify required improvements in service design, policy or practice amongst local, or if relevant, national services. The period of service delivery to be reviewed was debated by the SCR panel members who sought to establish a proportionate approach to the complex web of agencies involved with the foster family.
- 1.2.2 It was determined that the review should capture the period from the completion of an assessment of the suitability of the carers to care for the twins (June 2016), through to the trigger event and including early agency responses. The possibility of seeking reports associated with the granting of the SGO in December 2015 was considered, in case they made reference to the demand / risk J represented and scope for further placements. It was concluded that extending the scope of the SCR in that way – which would have required the carers’ explicit consent – would be a disproportionate and unjustified response.

CONDUCT

- 1.2.3 An independent report was commissioned from CAE Ltd www.caeuk.org and it was agreed lead reviewer Fergus Smith would:
- Evaluate submitted reports, develop and conduct a ‘briefing / consultation’ and subsequently ‘learning event’ with relevant professionals
 - Draft for consideration by the serious case review panel a narrative of agencies’ involvement and an evaluation of its quality, with conclusions and recommendations for action by Southwark’s Safeguarding Children Board, member agencies and (if relevant) other local or national agencies
- 1.2.4 Formal notification of the serious case review was sent by Southwark’s Safeguarding Children Board to the foster carers and to the birth mother of the victim Child Y and they were invited to contribute. By mid-June no response had been received and further attempts were made. Child Y’s social worker used a pre-arranged contact to encourage mother’s involvement and the author wrote to the carers. Neither action prompted a response.

PANEL MEMBERS

- Lead Reviewer (chairperson)
- Head of Social Work Improvement & Quality Assurance Southwark Children's Social Care
- Designated Nurse Southwark Clinical Commissioning Group (CCG)
- Head of Service Safeguarding Standards Wandsworth Children's Social Care
- Specialist Children's Quality Assurance Manager Camden Children's Social Care
- Agency Decision Maker (ADM) Diagrama Independent Fostering Agency
- Interim Named Nurse South London and Maudsley NHS Foundation Trust
- Review Officer Metropolitan Police Service
- Southwark Safeguarding Children Board Manager
- Administration Officer (minute-taker)

1.2.5 The panel's agreed draft is scheduled for presentation at Southwark's Safeguarding Children Board in September 2018. Following acceptance at that forum a copy will be sent to the Department for Education (DfE).

SOURCES OF INFORMATION

1.2.6 Reports (each sufficiently objective and proportionate to their respective levels of involvement) were provided by the following:

- Wandsworth Children's Social Care (care planning for twins)
- Camden Children's Social Care (support of J)
- Southwark Children's Social Care (post incident responses)
- Metropolitan Police Service (responding to trigger event and sharing of relevant background information)
- Named GP Southwark Clinical Commissioning Group (evaluating GP care provided)
- Diagrama (provider of foster carers)
- Croydon-based school (at which the twins were pupils)
- Special School (at which J was a pupil)
- South London & Maudsley NHS Foundation Trust (SLAM) (mental health services to J)
- Kings College Hospital NHS Foundation Trust (emergency and subsequent paediatric care in response to trigger incident)

TIMETABLE FOR REVIEW

Event	Target date
Decision to initiate case review & Ofsted, DfE & NPIE	December 2017
Author commissioned	29.01.18
Panel meeting 1: planning conduct SCR (methodology / scope)	27.02.18
Agency chronologies & reports required by:	13.04.18 & 30.04.18 respectively
Consultation / briefing event for involved professionals	17.04.18
Panel meeting 2: appraisal of reports received	01.05.18
Panel meeting 3: debating remaining reports & a 'draft 1' overview – further comments received by email	20.06.18
Submission of final draft overview	05.07.18
Agreement by SCR sub-group	06.09.18
Local Safeguarding Children Board debate of agreed final draft & consequent amendments	27.09.18
Learning event for involved professionals	tbc
Submission to LSCB, NPIE, Ofsted	tbc

2 SIGNIFICANT EVENTS

2.1 INTRODUCTION

- 2.1.1 Section 2.2 provides a very brief summary of the experiences of J and of the twins *prior* to the period under formal review. Section 2.3 describes and provides italicised commentary on services provided to Child Y and his brother during the review period (01.06.16 to the date of the trigger incident on 30.05.17).

2.2 PRE-REVIEW PERIOD

CHILD Y & HIS TWIN

- 2.2.1 As a result of prolonged domestic abuse and neglect, Child Y and his twin had been made subject of interim Care Orders to the London Borough of Wandsworth in 2011. The intention was to achieve permanency for them, though two placements had disrupted prior to placement in the foster home where Child Y was injured.
- 2.2.2 Child Y has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and is on the autistic spectrum. He has an 'Education, Health & Care Plan' (EHCP) in place and was in receipt of full time teaching support at the time of the trigger incident.
- 'J'**
- 2.2.3 J is understood to function at about the level of an average 2-3 year old; to have limited verbal communication and often use physical or tactile intervention to communicate or make wishes known. Because he is very tall and well-built, this can pose significant challenges.
- 2.2.4 J and an older brother (now 20) had been made subject of Care Orders to the London Borough of Camden and in 2003, about a year after the death of their mother, placed with the carers. The children had previously been exposed to extensive domestic abuse and parental substance misuse.
- 2.2.5 Just before Diagrama had taken over from the previous IFA, a troubled and challenging boy aged 8 had been placed with the carers. Minutes of the independently chaired panel of November 2015 make it clear that this was considered a poor match and the placement subsequently disrupted. Available records suggest that the disruption was more about the boy's intrinsic difficulties than any adverse reaction from J to his presence. A comment recorded by the registered manager that the carers '..are behaving inconsistently in their communication with different agencies' (they were providing different accounts to involved agencies about the support and management of that child) *may* though, have relevance to this SCR.

2.3 REVIEW PERIOD

FOSTER CARER APPROVAL PROCESS

- 2.3.1 Records provided by Diagrama provide confirmation that its re-assessment of the couple with whom the twins would later be placed was completed in accordance with regulatory requirements. It carefully considered all relevant issues, including the personal history and developmental influences of each carer, their success in providing long-term care of J and his older brother, and the potential for future placements.
- 2.3.2 The independently chaired panel of November 2015 noted that the carers were still coming to terms with the change of IFA and needed to be more trusting and transparent with staff. Their terms of approval were that the couple should be approved 'for 2 children aged 0-18 of either gender, emergency, short-term, long-term and respite'. Plans were spelled out to address a number of identified needs and the terms of approval and planned approach to support were subsequently ratified by the agency decision maker (ADM).
- 2.3.3 Nothing in the otherwise clear and comprehensive records suggests concern about any adverse response by J toward the existing very challenging, or any other younger child, who might be placed there.

REFERRAL FOR & SELECTION OF CARERS

Pre-placement meetings

- 2.3.4 On 24.05.16 a meeting of representatives of IFA Diagrama and Wandsworth Children's Social Care was convened and considered the suitability of the carers recommended by Diagrama. At an initial joint visit by SW3 and family finder SW2 on 27.05.16 the ongoing 'medical and development needs of J' were referred to but not considered to represent a risk, or to be an obstacle to placement. Indicating an appropriate curiosity about J's potential impact, were the placement to proceed, SW2 reviewed records provided by his school about J. They indicated lots of 'reward points' and no evidence of aggressive or dangerous conduct.
- 2.3.5 A delay ensued while the local authority explored the potential for a long-term placement with the twins' existing carers. Some direct work was undertaken with the twins during July focusing on the fact that their mother was expecting another child (subsequently born in early Autumn).
- 2.3.6 A second joint meeting was completed by SW3 and colleague SW2 at the carers' home on 03.08.16. This visit reinforced a sense of confidence that the carers were a good match – experienced, warm and caring with experience of autism in their decade-long care of J.

2.3.7 The view formed and supported by the social worker's team manager by 10.08.16, was that the couple could provide suitable long-term care. The significance of the older members of the family was not addressed in records retrieved for this SCR. A further joint meeting was held on 06.10.16 when a previous foster carer of the twins also contributed her experience and views.

Comment: failing to address the relevance to all parties of the older adolescents was clearly a significant oversight; drawing upon the experiences of a former carer in the latter meeting was though, good practice.

Permanency Planning / Approval of 'Match' by Wandsworth Children's Social Care

2.3.8 The manager of the independent reviewing section initiated a challenge over Summer 2016 concerned about delay in the permanence planning for the twins (by then in care for some 5 years). The existing carers had been concluded *not* to be a match for permanent care needs. No detail of any of responses to this challenge has been seen. Nor has evidence of a 'permanency planning meeting' been found.

2.3.9 Soon after the birth of her latest child, the twin's mother was caught shoplifting for the second time. Further research by Police revealed several aliases and previous offending. The event and subsequent Police enquiries had no direct impact on the local authority's planning for her sons' permanent care.

2.3.10 Originally scheduled for September, Wandsworth's independently chaired fostering panel met on 26.10.16 and formally recommended that the twins be matched in a permanent placement with the carers. The borough's records included a reference to 'J being good with younger children'. No checks were made with J's school nor with Camden (which retained a level of responsibility for J in consequence of the SGO application and later the SGO support plan). The recommendation for a permanent placement was ratified on 11.11.16 by the ADM.

Comment: thus, neither during the previous disrupted placement, nor in the planning process for the twins, was J considered to represent a risk to more vulnerable individuals; it seems likely that the school might by then, have offered a more objective perspective; its omission from the consideration of the twins' best interests was a missed opportunity.

Approval of 'out of area' placement

- 2.3.11 Regulations 11-12 Care Planning, Placement & Case Review (England) Regulations 2010 as amended, require in advance of the placement of a Child Y outside of the local authority in an adjoining borough, approval by its 'nominated officer'. Before granting such an approval, s/he must be satisfied that the:
- Child's wishes and feelings have been ascertained and given due consideration
 - Placement is the most appropriate available for the child and consistent with the care plan
 - Child's relatives (in this case, parents) have been consulted where appropriate
 - Area authority (Southwark) has been notified
 - IRO has been consulted
- 2.3.12 Insofar as the search for suitable carers had been extended to over 80 IFAs and that it been thought necessary to manage the challenge of ongoing contact with their birth family by means of a placement out of the area, it is unsurprising that the twins' selected placement was not within Wandsworth.
- 2.3.13 No evidence has been provided to confirm any awareness of the above regulations or that that the obligations within them were satisfied.

Comment: there can be no certainty but the involvement of the 'nominated officer' (and the borough has confirmed that its assistant director fulfils that role) might have offered a further perspective / proposals for further enquiries.

INTRODUCTIONS & PLACEMENT

- 2.3.14 Introductions were planned, commenced on 14.11.16 and involved 9 pre-placement visit including breakfasts and night times. On 23.11.16 both children were transferred to the carers' home.
- 2.3.15 Records from the twin's Croydon school (where they had been pupils since September 2015) refer to a meeting between staff and carers days before their placement, though no details of that have been seen. The IFA planned for the supervising social worker (SSW) role to be shared by SSW1 and SSW2.
- 2.3.16 Though its contents were presumably debated before placement, a Diagrama form dated 26.11.16 sets out a positive account of how the carers would be able to meet the developmental needs of the twins. Like the agency's risk assessment commented on above, the form is focused on the index child rather than the household in which s/he is living. Enhanced expectations and procedures consequently introduced following the trigger incident in 2017, render it unnecessary to formulate a recommendation.

Formal notification of placement

- 2.3.17 On 06.12.16 Wandsworth sent a belated placement notification to gaucp.admin@southwark.gcsx.uk The SCR panel understands that this address is incorrect though no evidence of a 'rejected email notification' has been located. The receiving 'area authority' was dependent upon the separate notification by the IFA. Diagrama's letter (posted on 24.11.16 to Southwark Council Adoption & Fostering PO Box 64529 London SE1P 5LX - the correct address) also failed to reach the relevant location. The area authority was thus denied the opportunity to check the proposed placement address and add the twins' names to the local register of placements.

Comment: it remains unexplained why a letter posted to the address above could not, if mis-routed, have been forwarded to the correct location; because Southwark anyway held no relevant information about the carers' or their home, this communication failure had only administrative consequences e.g. contributing to an underestimate of numbers placed in Southwark.

PROGRESS IN PLACEMENT

- 2.3.18 Diagrama completed a risk assessment for the twins on 28.11.16. The focus of the template then in use was the individual placed and her/his behaviours and vulnerabilities. Soon afterwards, the agency identified a need for improvement and revised the template in late 2016 and once again after it completed an internal review following the trigger incident. For these reasons and because the routine monthly supervision of carers now addresses the impact of fostering on all household members, no recommendation has been made.
- 2.3.19 Supervising social worker visits were completed on 8 occasions in the post-placement period and there was additional contact at training events. The visits were completed by either SSW1 or SSW2 and Diagrama has not indicated that the carers related better to, or trusted one member of staff more than the other.

Comment: the issue of trust and transparency had been identified at the point of Diagrama assuming responsibility and might have influenced whether / how they acknowledged or shared news of J's school-based conduct.

- 2.3.20 Material provided by Diagrama provided evidence that both the carers and in turn their supervising social workers, were provided with appropriate levels of supervision during the period under review.
- 2.3.21 At the first home visits on 30.11.16 and 15.12.16 household routines and interactions were discussed. The carer reported that J liked having the boys in the home. During the course of the latter visit Child Y was observed to have accidentally struck his the head on a table. His injury was later assessed at A&E as needing no medical intervention. No evidence has to date been seen to confirm that the correct GP Practice was notified of the A&E presentation, though Wandsworth was duly notified.

2.3.22 It appears that the twins were registered at the carers' GP Practice on 05.12.16 and that presentations were limited to a routine childhood issue on 27.01.17, for which treatment was prescribed and an appointment for an undisclosed reason on 05.05.17 to which Child Y was not anyway brought. On the former occasion, no record was kept of which carer presented the child.

Comment: the rate at which looked after children are moved renders it both more challenging and more important that their status is recognised and captured on medical records at the point of registration; it is also best practice to note which adult presents a child.

2.3.23 The need to better embed the recognition of vulnerable children at registration and to improve record-keeping had been highlighted in the last 2 'Primary Care Safeguarding Annual Reviews and, the panel was informed, progress is already being formally monitored. For that reason no recommendation has been made with respect to the following points that were relevant to this case:

- Ensuring that new child-patient registration forms captures the name / status of the adult registering the child, any named social worker (and if a 'looked after' child, seek previous records urgently from Primary Care Services England (PCSE)
- Applying suitable clinic codes so that the wider professional team (health visitors, Practice nurses, health care assistants) can contextualise any such involvement and share relevant information

Responsible Authority 'Placement Plan'

2.3.24 Regulation 9 of the Care Planning, Placement & Case Review (England) Regulations 2010 as amended, require a 'Placement Plan' to be completed by the placing / responsible local authority. This is preferably done in advance of the placement but anyway within a maximum of 5 working days. The plan should address an extensive range of day to day issues specified in Schedule 2 of those regulations as well as the important issue of the level and type of authority delegated to the carers. Though sought, no 'Placement Plan' has been traced and it must be assumed that none was completed.

Comment: whilst failure to complete a 'Placement Plan' is primarily a failure of the responsible authority, Diagrama should have pressed for its delivery and sharing with carers and, had that proved necessary, escalated the issue.

2.3.25 The carers presented Child Y at A&E, rather than the GP Practice on Christmas Eve where tonsillitis was diagnosed and treatment provided.

Statutory s.26 Children Act 1989: Review 1

- 2.3.26 On 22.12.16 the first of two formal reviews was convened. The twins were reported to be 'settled and happy'. The conduct of this review accorded with regulatory and professional expectations and records of it made no reference to, or any concerns about J.
- 2.3.27 Just after Christmas, an incident occurred in which J bit Child Y's brother (though did not break the skin). The incident was appropriately reported to Diagrama's supervising social worker and relayed to Wandsworth (the 'responsible authority'). This minor altercation was not regarded as a safeguarding issue.
- 2.3.28 On 30.12.16 Diagrama's 'Safer Caring Household' document was updated. It provided a fairly standard and generic summary of the (in themselves entirely appropriate) precautions being maintained by the carers in respect of their care of children. There was no specific recognition of any risk that J might be provoked or distressed by the behaviours of the 5 year old twins.
- 2.3.29 An unannounced visit by the supervising social worker on 28.12.16 when all were children present revealed no concerns. During early 2017, there developed a growing awareness that getting the twins to their school was difficult and tiring for the children and carers.

Comment: part of the government's rationale for requiring additional approval before a child is placed outside of her/his area was a recognition that it can threaten educational continuity.

Allegation by Child Y

- 2.3.30 On 23.01.17 an allegation against J's older brother was made by Child Y's twin that the young man had been smoking a 'big cigarette' and that he had helped him smoke it. With the agreement of the placing authority, this was internally investigated and concluded to have been a reference to the individual smoking a 'roll your own' cigarette outside of the home. There was no evidence that Child Y was with him or that it had involved any illicit drugs.
- 2.3.31 On 26.01.17 final Care Orders were granted with respect to the twins and the previously granted 'Placement Orders' (which had awarded the local authority the right to place the children with any individual concluded to be suitable to adopt) were revoked.
- 2.3.32 A useful joint visit (Diagrama and local authority) was completed on 08.02.17. Later that month the need for J's older brother to seek greater independence was discussed by supervising social worker and carer.

Comment: a recognition of the relevance of other household members is implied by that discussion.

2.3.33 The report submitted to this SCR by Wandsworth indicates that the IFA had not submitted to the case-accountable social worker, any of the daily diary notes that carers are expected to maintain. Further enquiries by the author have confirmed that this was because (in spite of repeated reminders) such records had not been submitted by the carers. This individual and organisational oversight had not prompted a response or complaint by Wandsworth.

Comment: this was a 'missed opportunity' for the IFA and placing authority to gain insight into the lived experience of the twins; insofar as the carers were visited regularly by their SSWs and allocated worker, it seems unlikely such records would have contained more explicit references to J's predominantly school-based difficulties, than the carers felt able to acknowledge and share.

Statutory s.26 Children Act 1989: Review 2

2.3.34 On 09.03.17 a second review was convened. Diagrama and carers had identified relevant issues and relayed them to the placing social worker. Agreement was reached that the twin's school needed to be changed to avoid a lengthy and tiring journey. The twins' health and education plans were also updated at this time. Some recent deterioration in Child Y's behaviour due to changes in support staff were noted by the school.

2.3.35 On 23.03.17 with the return of SSW2 from maternity leave, she resumed the supervising social worker role. Discussions a few days later centred around arrangements being put in place to facilitate transporting the twins to school.

2.3.36 On 24.04.16 for the first time, there is an account in SW3's records of (positive) interactions between J and the twins which she observed during a home visit.

Annual foster carers review

2.3.37 Standard 20 of the National Minimum Standards for Fostering requires an annual review of each carer's development and performance. This obligation was duly met on 24.04.17 and the 'Professional Development Plan' (which identified no issues related to J) was subsequently signed off on 03.05.17.

SUPPORT OFFERED TO J DURING PERIOD UNDER REVIEW

2.3.38 Because this SCR was commissioned by Southwark and is focused on the Child Y, commentary about professional practice with respect to J has been limited and included *only* when relevant to either of the twins.

‘No contact’ period

2.3.39 Material supplied by Camden revealed that because his needs for short breaks were being met, J’s case had remained unallocated to any specific team member from the late June 2016 until 10.01.17. Hence, in that period (which included the introduction and arrival of the twins) there was no communication between carers and Camden.

Comment: the above fact served (unintentionally) to reinforce the fragmentation of knowledge and concerns about J’s changing patterns of behaviour and its relevance to vulnerable others.

2.3.40 From January onwards efforts were clearly being made to facilitate transitional arrangements so that J could access suitable support after he attained the age of eighteen and his SGO support package ended.

2.3.41 On 20.03.16 Camden allocated senior practitioner SP2 to review J’s ‘Short Breaks’ package and advise / signpost the family on the pathway to Adult Services. At a home visit by SP2 on 28.03.17 the female carer acknowledged that J’s behaviour had become more challenging recently. A number of changes were identified. A record of the twins’ arrival ‘in the last couple of weeks’ is more likely to be a recording error rather than the carer failing to distinguish 2 weeks and 5 months.

Comment: records provided do not suggest any recognition that the conduct reported by the school could extend to other locations including home.

2.3.42 The foster carer later (20.04.16) reported to CAMHS that J had been aggressive towards the carer and his older brother e.g. tapping them on both shoulders, boxing / hitting. She also mentioned J having:

- Bitten one of the twins
- Tapped on someone’s shoulder in the supermarket
- Hit a child in the Centre he attended
- Laughed about the attention such incidents provoked

2.3.43 The carer reported supervising J 1:1 at all times and was concerned that J’s medication was insufficiently effective. She confirmed that the Camden social worker was aware of the current level of challenge.

Comment: the possibility of ‘1:1 supervision at all times’ seems remote and optimistic; this 60 year old female was directly responsible for 2 teenagers (both with significant, and one with severe learning difficulties), plus 5 year old twins (one with significant additional needs) and grandchildren, whom it is understood were frequent visitors.

School review

2.3.44 An annual school review of the EHC Plan was completed on 03.05.17. The female foster carer was advised that J required 1:1 supervision. Examples of J picking up and swinging other children (some as young as 5 years old), breaking toys and kicking and hitting others were cited. Other concerns included J displaying sexualised behaviours including masturbation and behaving 'inappropriately' touching female students.

Comment: J's school had, according to Camden Children's Social Care provided less than 24 hours notice of the annual review; had the carers been represented by Camden or CAMHS, it might have led to more substantive support e.g. more respite care.

2.3.45 The day after the above meeting the female carer reported to SP2 that the school had asked that an alternative education provider be found. The carers referred to the involvement of the 'Sunshine Service' (a specialist section within CAMHS). J had reportedly bitten another child at school on the day of the review.

2.3.46 SP2 promptly made contact with the school and the need for an urgent team around the child (TAC) meeting was agreed. SP2 also liaised with J's recently appointed volunteer buddy whose experiences did *not* match those reported by the school. On 11.05.17 SP2 completed a home visit and captured the following significant changes in J's recent home and school life:

- Arrival of the twins in November 2016
- J's brother having fathered a child born in November 2016
- The loss of J's brother when he had re-located some 3 days earlier, as well as the previous 'buddy' with whom over 5 years he had developed a close relationship
- There being a female teacher
- A changing peer group
- Being barred from PE lessons

2.3.47 The general reassurances provided by (especially) the female carer and J's 'buddy' contrasted sharply with the events described by the school. The possibility of completing a 'social story' with J and/or bereavement counselling (his mother had died when he was aged 3) was raised by the female carer.

Comment: it seems unlikely that J had the cognitive ability to make use of counselling.

2.3.48 An advocacy (easy read) questionnaire specifically for J and geared towards his feelings and actions at school was initiated.

Comment: the results of this commendable initiative, apparently available next day, revealed no new insights.

Team Around the Child (TAC) meeting

2.3.49 J's case was discussed at Southwark's CAMHS on 17.05.17 and it was concluded that contact should be made with the school and a suitable behavioural programme developed.

Comment: neither this agency or any other interpreted J's impulsive behaviours as representing a threat to the twins or other vulnerable individuals.

2.3.50 The TAC meeting was held on the same day and attended by school representatives, Camden's SP2 and an educational psychologist. CAMHS had not been invited. The meeting noted that J was already on the maximum recommended dose of his medication. A range of 'next steps' were agreed including the likely need for an alternative educational provider. The notes provided offer no indication that participants had identified any risk to other individuals in J's home.

Comment: had this meeting involved all relevant parties, it would have provided an opportunity for there to be developed a more holistic appreciation of the family context (a whole family approach) and the arguably unrealistic assumptions about the carer (especially female carer's) ability to cope.

2.3.51 A trainee psychiatrist ST6 from CAMHS spoke with J's school and foster carer on 18.05.17 and was briefed as to his increasingly challenging behaviours. Of particular relevance was that the carer reported no violence toward children in the family. At a team meeting though, the reported biting of one of the twins was interpreted as a safeguarding issue and the assessed risk to other raised to 'moderate'.

Comment: whilst a sensitive and proportionate response, the re-calibration of 'risk to others' did not trigger any specific action such as contacting the IFA or Wandsworth Children's Social Care.

2.3.52 Though descriptions of previous incidents had, it is thought, been shared with Camden's SP2, the school's more recent advice to the carer about the level of supervision that was thought to have become necessary was reportedly *not* shared with the IFA. The carers' view of these exchanges remains unknown.

Preparations for J's approaching adulthood & trigger incident

2.3.53 Earlier in May at a supervision session with the carer, the IFA's supervising social worker had been informed that J's older brother had completed a planned move to more independent accommodation (supported housing in Camden) 2 days before. The social worker and carer discussed the observations and concerns expressed by J's school. The carer indicated that J showed no signs of such challenging behaviours whilst at home or in his Saturday art class. The carer thought that some of J's behaviours e.g. swinging smaller children around, were being exaggerated or misunderstood. She reported that being swung was something that Child Y enjoyed. She also said *she* knew how to handle J in a manner that avoided conflict.

Comment: *the impression that emerges from records is that the female carer (possibly reflecting a long-standing commitment to J) diminished the significance of his conduct and its implications for vulnerable individuals.*

2.3.54 Camden meanwhile had identified the need to plan J's transition and engagement with local (Southwark) Adult Services. The case was formally allocated on 18.05.17 to Camden's SP2 who immediately followed up the previous day's meeting by phoning CAMHS.

2.3.55 SP2 was informed that the female carer had reported at the meeting of 17.05.17 that she had spoken with a CAMHS worker who had undertaken to ask the lead clinician to call her back and discuss a possible change of medication. CAMHS has confirmed a response was made and a phone conversation held between a trainee psychiatrist and foster carer. In response to a subsequent call to CAMHS by PS2, the recipient reported she was about to take maternity leave and a colleague would follow up. PS2 again contacted the carer on 26.05.17 and was told that there had been no further incidents at school.

Comment: *PS2 was clearly sensitive to the need to explore disparities between accounts of J at school and home.*

TRIGGER INCIDENT & REPORTED ORGANISATIONAL RESPONSES

2.3.56 Following the trigger incident described in section 1.1 a tri-borough strategy meeting was convened on 01.06.17. In accordance with regulation 36 of the Fostering Services (England) Regulations 2011, regulator Ofsted was notified of the incident on 02.06.17.

2.3.57 Accounts provided by the hospital and Wandsworth Children's Social Care of further responses differed significantly. Further searches of respective records and interviews with available staff enabled the production of the following composite narrative and critique.

Addressing immediate needs of Child Y

2.3.58 It would appear that:

- A follow-up strategy meeting was convened on 07.06.17 and the need (articulated by the hospital's neurology team) to better understand Child Y's developmental level and communication needs prompted a request for a copy of the last s.26 review⁴
- By 12.06.17 the above document had not been received and the 'neurology social worker' contacted a named Wandsworth service manager who advised her to contact the 'designated doctor' – meanwhile, the hospital occupational therapist called the twins' school and obtained information about Child Y's developmental needs

⁴ The material reportedly sought were the records of a formal independently chaired review which regulations require at prescribed intervals for every 'looked after' child.

- A conversation between the intensive care consultant at the hospital and the designated doctor for looked after children revealed that she had not been invited to either the initial or follow-up strategy meeting

2.3.59 The extent and nature of social work and other support of the carers differs according to which agency reports on it. It is clear that:

- Whilst the family home remained a 'crime scene' (on the night of the incident) Wandsworth Children's Social Care paid for a hotel for the remaining family members who needed it and J went to stay with his long-established respite carer
- Diagrama's chief executive, SSW and registered manager attend the hospital on the day of the incident
- SW3 attended the ward, spent time with Child Y and carer and conversed with ward staff on 4 occasions
- The carer was having to balance the care needs of the hospitalised Child Y with those of his brother (as well as managing ongoing contact with J)

Discharge planning

2.3.60 Communication about Child Y's discharge was also contentious. In the author's view:

- On Wednesday 14.06.17 Wandsworth manager was told that Child Y was fit for discharge, but that support for the carer with respect to the school run was 'still not in place' (deduced to have been debated at one or both strategy meetings) and perhaps reinforced by the carer's previously noted response to and influences on multi-agency work
- On 15.06.17, a response by SW3, promised by her manager had not been received

2.3.61 By Friday 16.06.17:

- An assistant team manager who received a call from the hospital reported that both SW3 and her manager were in court and thus unavailable to attend a proposed 'discharge planning meeting' (DPM) before 19.06.17
- Additional support for the carer was promised by a named senior social worker
- A paediatric consultant later spoke with the assistant director of Children's Social Care and agreed to defer discharge until the DPM agreed for 19.06.17

2.3.62 The delayed DPM required Child Y to remain (with a 2:1 staff ratio) in hospital over a weekend. At the DPM, only hospital records capture:

- Concern about the delay in receiving s.26 information
- A perceived insufficiency of support of the carer that would have enabled her to remain overnight with Child Y
- Delays in resolving school run support and the discharge

Comment: *the variation in agencies' initial accounts of the same events is of concern and a recommendation has been added to section 4.*

RETROSPECTIVE ACCOUNT OF SCHOOL-BASED INCIDENTS

2.3.63 A post-event assessment of J's needs drawn from documents supplied to the SCR reveal a significant rise in the school-based rate of concerning behaviours. During 2016/17 (until 30.05.17) there were 68 incidents. During 2014/15 there had been only 3, and in 2015/16 just 6 incidents recorded and shared with carers.

2.3.64 Within the last year of increased incidents, the monthly incidence rose steadily from December onwards. Aside from the characteristic challenge that 'change' represents to an autistic individual, it may be that hormonal changes associated with adolescence served to exacerbate mood swings.

3 RESPONSE TO TERMS OF REFERENCE & OVERALL FINDINGS

3.1 INTRODUCTION

3.1.1 Section 3.1 provides responses to the following italicised elements of the terms of reference and section 3.2 offers overall findings.

- *Clarity of 'Care Plan' ?*
- *Choice & support of foster carers ?*
- *'Placement Plan' ?*
- *Independent monitoring & review ?*

CLARITY OF CARE PLAN

3.1.2 Within the review period, the need to identify carers with the necessary attributes, experience and commitment necessitated a search well beyond the borough boundaries.

3.1.3 The twins' Care Plan was in itself clear and coherent, though (as described above) had not been offered for comment or ratification to the agency's 'nominated officer', nor supplied to the host borough.

CHOICE & SUPPORT OF FOSTER CARERS

3.1.4 A great deal of effort had clearly been expended in the search for suitable permanent carers. With the exception of a 'permanency planning meeting', all the routine processes had been followed by the placing authority and the decision to place with the chosen carers was supported by all those involved (social worker, her supervisor, the IRO, fostering panel members as well as the IFA by which the carers had been approved and recommended as carers for the twins).

3.1.5 At the time of the relevant pre-placement care planning processes (Summer and early Autumn 2016), the issue of the impact on the twins of the existing teenage boys (in particular the developmentally immature J) would have been more about 'best practice' than an evaluation of incidents. The level of co-operation and contact by the staff of the IFA and the allocated social worker was considerable and offered ample opportunities for the carers to share all relevant information.

3.1.6 As the *rate* of school-based incidents began to increase, the opportunity for the IFA's SSW and/or Wandsworth's social worker to be briefed about them, *theoretically* grew. In practice though, those professionals' appreciation of the origins of J's rapidly increasing impulsive outburst and the (probably unintended) risk of harm they represented were constrained by:

- A lack of direct information from school or CAMHS, both of which related exclusively to the carers and/or those Camden staff with a support role for J
- The carers' diminution of the scale and seriousness of J's conduct

PLACEMENT PLAN

3.1.7 No Placement Plan (as per Regulation 9 of the Care Planning, Placement and Case Review (England) 2010 as amended) has been located and it must be concluded does not exist. The purpose of the Placement Plan is to set out how any given placement will meet the needs of a particular child. It is fairly prescriptive in its requirements of content, *must* be completed with a maximum of 5 working days after placement and a copy *must* be left with carers.

INDEPENDENT MONITORING & REVIEW

3.1.8 Setting aside the unknown manner in which the challenge by the IRO section was met during early 2016, IRO2 was fully engaged and supportive of the placement. She conducted the initial and subsequent s.26 review in accordance with relevant regulations.

3.1.9 IRO2's appreciation of the whole picture was constrained for the same reasons as the practitioners.

3.2 OVERALL FINDINGS

3.2.1 The general context within which professionals were operating was characterised by an unhelpful fragmentation of information arising from (in order of its impact):

- Largely unconnected involvement with the family of 3 Children's Social Care agencies, an IFA, 2 schools and a specialist mental health provider - with the carers being the only common link
- Some non-compliance (seemingly through an unawareness of their existence) by Wandsworth Children's Social Care, with Care Planning regulations
- Insufficiently holistic practice by practitioners involved respectively with J and with the twins

3.2.2 The transition planning by Camden for J (which fell outside the scope of this SCR) appears unremarkable and included examples of good practice.

3.2.3 Essentially the implications for the twins, of J's increasingly challenging behaviours at school was not recognised by otherwise conscientious, able professionals because:

- Wandsworth's care planning including its formal independent reviewing process, was insufficiently informed about a steady and alarming increase in school-based examples of aggression / violence (this may have been a result of the carers consciously or unconsciously 'diminishing' the implications of J's behaviours)
- Camden's transition planning for J had been informed by psychiatric expertise but *not* by relevant contextual information from and opinions of, Wandsworth staff

WIDER LEARNING POINTS

3.2.4 There appears to have been, across involved agencies, a level of uncertainty about the status and significance of the SGOs that had been granted with respect to child J and his brother. Had they been 'looked after' children it is thought likely that the obligations of responsible authorities to liaise and negotiate any additional placements would have been fulfilled. In this instance, such liaison would probably not have revealed any contraindication to the twin's placement at the outset (though checks with J's school *might* have identified some concerns). What would have been established would have been a channel of communication that would have facilitated information exchange from December 2016 onwards as J's conduct at school became ever more challenging.

3.2.5 Though not articulated in such terms in records seen, there seemed to be a sense in which those subject of SGOs were rendered beyond even the level of consideration that would ordinarily be awarded birth children or other family members. The need and justification for *fully* evaluating the significance of any other resident SGO children is rooted in the following brief history of their developing use and associated concerns.

3.2.6 In the period 2010 to 2014 there had been a doubling of annual rates of SGOs being granted, probably because of the 2013 'Re B' and Re 'Be-S' Judgments (which ruled social workers must consider *all* alternative placement options before adoption). This served to raise the bar for adoption, making it less likely a court would approve an Adoption Order and caused an SGO to be an attractive alternative. In addition, budget reductions prompted local authorities to seek less costly ways of accommodating children in care.

3.2.7 In 2015, anxiety around this area of practice prompted the government to order a review of SGOs. By that time some 29% of SGOs made in 2014 had a 'Supervision Order' attached – suggesting that courts were concerned about the lack of post-order support available for special guardian families. A number of SCRs triggered by deaths or injuries of those living with special guardians highlighted their vulnerability and relative insufficiency of assessment if compared to those completed for the purpose of adoption or fostering.

- 3.2.8 The result of that review was to reform the assessment process for special guardians and with effect from early 2016, social workers were required to assess a guardian's capacity to parent a child until s/he was 18, while also considering their current and past relationship with the child. Government also later extended the 'Adoption Support Fund', making money available for post-placement support for those who had been granted an SGO.
- 3.2.9 Latest (2016/17) DfE figures indicate that the rate at which SGOs are being granted has reduced but it remains relevant for professionals to appreciate when working with those who have been granted an SGO, its status and the probability of ongoing vulnerability of one sort or another.
- 3.2.10 A further issue debated by the panel is the extent to which expectations were unjustifiably high. Whilst the carers had clearly coped well with the care of J and his brother for well over a decade, the additional demands of the twins, their combined impact (as well as support of the couple's grandchildren) appear in hindsight to have been more than many could manage. The calls latterly made to CAMHS suggest that the female foster carer *may* have been beginning (wholly understandably) to struggle with her many responsibilities.
- 3.2.11 Material made available for this SCR does not provide any confirmation of unreasonable expectations. Without the direct involvement of the carers, that possibility cannot be evaluated.

4 RECOMMENDATIONS

4.1 INTRODUCTION

- 4.1.1 In those instances where an involved agency has identified a need for and already introduced relevant changes, no recommendation has been made. The following recommendations are those considered the most strategic, and when implemented, should strengthen the effectiveness of service delivery in comparable circumstances.

4.2 SOUTHWARK & WANDSWORTH SAFEGUARDING CHILDREN BOARDS

- 4.2.1 Both Safeguarding Children Boards should seek formal assurances from respective member agencies that existing or planned training programmes include sufficiently clear advice and guidance about the status and significance (in terms of probable need and risks) of Special Guardianship Orders (SGOs) and associated SGO Support Plans.

4.3 WANDSWORTH CHILDREN'S SOCIAL CARE AND KINGS COLLEGE HOSPITAL

- 4.3.1 Both agencies should nominate relevant managers to meet and analyse what underlying influences can explain why such differing views of the same exchanges existed and what practical steps they will adopt to minimise the risk of repetition in comparable circumstances.

4.4 WANDSWORTH CHILDREN'S SOCIAL CARE

- 4.4.1 Wandsworth Children's Social Care should:
- As part of its 'matching process' for potential placements, complete (and update when circumstances change), 'need / risk assessments' about all children already living in substitute families (this should be informed by means of contact with at least one professional known to those children)
 - Address at home visits and at formal reviews, the 'lived experience' of relationships with siblings / other children and adults in the home
 - Identify the individuals and take steps to disseminate to all relevant staff the regulatory requirements for 'nominated officer' / 'director approval' with respect to 'out of borough' and 'at a distance' placements respectively
 - Seek to ensure that notification of placements to host local authorities include the child's details and Care Plan.
 - Update local practice guidance and procedures to clarify the above expectations

5 GLOSSARY: ABBREVIATIONS

Abbreviations	Meaning
ADM	Agency Decision Maker
A&E	Accident and Emergency Department
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
DPM	Discharge Planning Meeting
IRO	Independent Reviewing Officer
KCH	Kings College Hospital
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NPIE	National Panel of Independent Experts
SCR	Serious Case Review
SSW	Supervising Social Worker

RELEVANT BACKGROUND MATERIAL

- *Impact of the Family Justice Reforms on Front-line Practice Phase Two: Special Guardianship Orders Research report August 2015 Research in Practice*
- *Special guardianship review: report on findings Government consultation December 2015*

6 TERMS OF REFERENCE

PURPOSE OF THE SERIOUS CASE REVIEW

- 6.1.1 The purpose of the serious case review will be to cover the key areas of inquiry as set out in *Working Together* (2015) and to follow these principles. This is to identify improvements that may be needed and to consolidate areas of good practice.
- 6.1.2 Any findings from the review should be translated into programmes of action leading to sustainable improvements
- 6.1.3 The SCR should be conducted in a way which:
- Recognises the complex circumstances in which professionals work together to safeguard children
 - Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
 - Seeks to understand practice from the viewpoint of the individuals and organizations involved at the time rather than just using hindsight
 - Is transparent about the way data is collected and analysed
 - Makes use of relevant research and case evidence to inform the findings
- 6.1.4 The SCR will:
- Seek contributions from appropriate family members and keep them informed of key aspects of progress
 - Produce a report for publication available to the public and an action plan
 - Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances; establish how that knowledge contributed to the outcome for the child
 - Establish whether the respective statutory duties of agencies working with the child and family were fulfilled
 - Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).
 - Offer foster carers of twins and birth mother of the victim an opportunity to contribute their experiences and views

SCOPE

6.1.5 The review will focus on 01.06.16 to the date of the incident on 30.05.17 and the elements for particular consideration (when relevant to the agency submitting its report) are:

- Information about known need/s in referrals of twins
- Information provided by IFA in response
- Matching process / panel
- Notification by 'responsible authority' (Wandsworth) or 'area authority' (Southwark)
- Independent Reviewing Function involvement
- Monitoring by IFA of progress & difficulties in placement
- Evaluations during review period of needs, risks and mental capacity of J

FINAL