

**Executive Summary of the
Serious Case Review into the
services provided for young
person A and his family during
the period January 2004 –
February 2006**

**BROMLEY SAFEGUARDING CHILDREN
BOARD**

Introduction

This report on behalf of Bromley Safeguarding Children Board (BSCB) Serious Case Review Sub Committee is a summary of the overview report undertaken in relation to the death of A. The overview report was produced in line with the requirements of Chapter 8 of the *Working Together 2006* guidance.¹ This guidance sets out the arrangements for the local inter-agency review of cases through a Serious Case Review (SCR) involving the safeguarding of children and young people. The Local Safeguarding Children Board (LSCB) is obliged to hold a review when a child has died and child abuse is a factor in the death. In other instances the Safeguarding Board has the discretion to hold a SCR where a case 'gives rise to concerns about inter-agency working to protect children from harm'² and there appear to be important lessons for the local network of agencies with responsibilities in relation to the safeguarding of children. At a meeting on 6 September 2006 the LSCB decided that this case met this criteria and should therefore be the subject of a SCR. Particular weight was given to the fact that A was looked after by Bromley Council at the time of his death and that a number of agencies had worked with A and his family over a considerable period of time.

The purpose of this report is to summarise the outcome and findings of the serious case review to highlight any significant findings with the objective of improving local practice.

Background

The subject of the serious case review was A who was born in South London in March 1988. A died on Friday 24 February 2006 close to his 18th birthday. A's address at the time was a 'semi-independent' flat in the Somerset area where A had formerly been resident at a residential unit. He was also attending college in the area studying for a City and Guilds qualification. A was an only child and his parents live in Bromley, Kent.

On Tuesday 21 February A was admitted to an in patient psychiatric unit in Somerset, after he had been thwarted in the course of a suicide attempt earlier that morning. On Friday 24 February, A was transferred to another unit of the same health trust, which covered in its catchment area the town where A lived. A died at 6.30pm or shortly afterwards that day at the unit or on the way to Accident and Emergency. He had been found by nursing staff with his shoelaces tied around his neck attached to the door of his bedroom locker.

From the age of 8 onwards the psychiatric consensus was that A had Asperger's syndrome. At the age of 10 he was thought to have ADHD though this did not featured consistently in psychiatrists' opinions. From about the age of 12 he was believed to have had a relatively severe childhood

¹ Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to Safeguard Children*, 2006.

² See *Working Together to Safeguard Children*, 2006 paragraph 8.2

depression and was treated with a variety of pharmaceutical anti-depressants. At various points A was described as suffering from a psychosis and at times this was considered to be a possible side effect of other medications

On top of these overt psychiatric symptoms, A's records persistently refer to concerns about his low body weight and a preoccupation with weight and appearance on his part. It is not clear whether this was something secondary to his depression, a side effect of medication or an indication of an eating disorder.

As a result of these difficulties A had not lived at home since the age of 10 and had experienced five placements away from home, only one of which had been perceived as being successful and lasted for any substantial period of time. He had also been refused by a number of other potential placements, sometimes after initially positive contacts. He had not received mainstream schooling for five years despite having at least average educational potential.

Family and educational dislocation, together with repeated placement breakdown clearly add to the impact of underlying psychiatric problems and there is evidence that placement failures added to A's depression. There were times when A behaved in a very challenging way at home and was in particular hostile to his mother. Whatever the tensions at home, it is clear that leaving home to go to or return to placements caused A stress, right through to the end of his life.

Regardless of the complexity of his diagnosis and treatment, in purely practical terms the most significant difficulty for anyone living with or caring for A was his day to day behaviour. Over the years this had included:

- severe depression characterised by a repeated preoccupation with death and an extremely disturbing level of self loathing
- serious and persistent attempts to kill himself by strangulation – some of which were almost successful, before his final suicide
- a number of suicidal gestures through drug overdoses
- persistent less serious attempts at cutting and other forms of self harm
- flamboyant risky behaviour involving 'throwing himself' in front of trains and cars, often – but not exclusively - in the presence of his parents.
- repeated violent outbursts – particularly directed at his mother and staff caring from him
- a persistent interest in and repeated attempts to obtain and use illegal drugs

Terms of reference of the review

The Serious Case Review Sub Committee of BSCB agreed that the review would cover the time period from January 2004 when A moved to live in Somerset until his death in February 2006 and the Terms of Reference for the serious case review agreed as follows:

- 1 a) Were the arrangements made by Oxleas NHS Trust to provide continuing psychiatric care on A's transfer to Somerset adequate?
- 1 b) Were appropriate arrangements in place to ensure good information sharing between all those involved in A's care?
- 1 c) Were the clinical governance arrangements adequate in respect of T.W's psychiatric input

- 2) Somerset Partnership NHS and Social Care Trust considers that a fuller history should have been provided at the time of A's admission to a psychiatric unit in Somerset.
 - 2 a) Who was responsible for providing this history?
 - 2 b) Did the arrangements for managing A's care prior to his admission make the provision of such a history more difficult?

- 3) Was A's admission to an adult mental health facility suitable to meet his needs?

- 4) a) What risk assessments were undertaken to ensure an effective transition for A from Sedgemoor to alternative accommodation?
 - 4 b) How adequate were those assessments?
 - 4 c) Were adequate support services in place to support the transition?

- 5) What lessons can be learnt from the above for multi-agency working in the future?

Prior to consideration for the serious case review, the Somerset Partnership NHS and Social Care Trust Serious undertook an inquiry under their Untoward Incident Procedures and produced a report that made a number of recommendations arising from its review of A's care and treatment.

In addition the report also raised a series of possible concerns about working arrangements between agencies in Bromley and Somerset prior to A's hospital admission. The report was made available to the chair of Bromley Children's Safeguarding Board and informed the decision to hold the SCR. The concerns identified were incorporated in the Terms of Reference of the SCR.

Steps taken in producing the SCR overview report

Agencies involved

The following agencies who are members of Bromley Safeguarding Children Board provided chronologies and / or management reviews of their involvement: Oxleas Foundation NHS Trust, Bromley Council Learning Disability Transition Service (part of Adult Services), Bromley Council – Children’s Social Care, Bromley Council – Special Educational Needs service and Connexions South London.

In addition a number of agencies in Somerset also submitted reports. It did not prove possible to have any direct contact with the private psychiatrist who provided psychiatric care for A while placed in Somerset.

Family involvement

The chair of the safeguarding board met A’s parents to discuss the review in the context of their overall concerns about the services offered to A and the independent chair of the SCR met A’s parents twice during the preparation of the report

Conclusion and overall findings

This section summarises the findings of the overview report in relation to the areas identified in the terms of reference set by the LSCB.

Commissioning of psychiatric care for A

1. The decision by Bromley Council and Oxleas Trust to commission a private psychiatrist to provide psychiatric care for A as part of the package of care at Sedgemoor was sensible and appropriate in all the circumstances.
2. When the private psychiatrist’s contribution failed to match what was needed, there were no effective remedies to secure a full service because of the way the arrangements had been set up. Her specific responsibilities and accountability should have been much more tightly defined by the commissioners in Bromley Council, Oxleas Trust and the residential unit in Somerset.

Information sharing

3. In the early stages of A’s placement at the residential unit the sharing of information between all of the professionals involved was of a very

high standard. As the placement proved to be stable and successful some lapses in practice arose, though these did not prove to be critical from the perspective of A's welfare. Information sharing during A's time at the semi-independence unit was of a very high standard. The SCR panel did not find that prior to A's hospital admission greater sharing of information with the Somerset Partnership Trust or other agencies in Somerset was called for.

4. In the course of arranging A's admission to the psychiatric unit, the private psychiatrist provided a good deal of background information by phone. She should have confirmed her phone conversations with the admitting psychiatrist in writing and supplied copies of background reports. The worker from the semi independence unit acted appropriately in sharing information about A with the psychiatric unit.
5. Had the residential unit known that A had been admitted to hospital it could have shared very useful information with the psychiatric unit. However no contact was made.
6. A's social worker should have contacted the psychiatric unit by phone and should have sent the unit background written information from the social services records. It is clear that the staff in the unit were told that A was looked after and that Bromley Council were very involved and they should have attempted to contact the social worker.

A's admission to an adult psychiatric unit

7. A's admission to an adult unit as opposed to an adolescent unit resulted from a proper assessment and was an appropriate one in all the circumstances.

A's transfer from the Somerset residential unit to the semi-independence unit.

8. There was no detailed appraisal of the benefits or potential adverse effects of A's move to the semi-independence unit. However considerable thought went into identifying potential risks to A and then building safeguards into the placement arrangements to minimise or eliminate them.
9. Some of the discussions about the planned move to the semi-independence unit took place in a very negative environment because communication and explanation of options and parameters with A and his family about where A might live in future had been handled poorly.
10. It was a priority in planning A's move to semi-independence to ensure that if his mental health did deteriorate it would be recognised

immediately. Appropriate arrangements were put in place to ensure this.

11. Despite the initial concern about the level of risk to A in living in a semi-independence setting, the SCR panel found that the placement was a satisfactory one which met the overwhelming majority of his needs, particularly because of the additional resources and safeguards that were built into it.
12. On the basis of all of the accounts available, agencies and professionals involved responded in a timely and appropriate way to safeguard A once his mental health did deteriorate and in particular after his suicide preparations at Cannington College.

Other issues highlighted

11. The serious case review showed up weaknesses in the way in which staff dealt with the transfer of responsibilities, particularly that thinking began about the services needed after 18 began too late. Planning needs to begin much earlier and address as an explicit consideration the level of support likely to be provided by adult services. This needs to be discussed fully with service users and their families.
12. The case review highlighted many of the difficulties which arise when placements are made at a distance from Bromley. Managers responsible for such commissioning these services should review it and consider whether the findings point to any improvements that can be made in current practices.
13. The review highlights the shortage of good services for children and young people with Asperger's syndrome, particularly those where the condition is complicated by co-existing mental health problems.

10 Recommendations

1. Bromley Safeguarding Children Board	The full Safeguarding Children Board should endorse the recommendations of the SCR and adopt an action plan which identifies who is responsible for their implementation and timescales for implementation.
2. Bromley Safeguarding Children Board	Bromley Safeguarding Children Board should prepare a short executive summary version of the report which may be circulated should there be wider public or press interest in the case.
3. Bromley Safeguarding Children Board	Subject to any specific legal advice the Board should arrange for a copy of the overview report and the narrative of events in the case to be made available to A's parents and provide them with an opportunity to discuss the findings with a representative of the SCR panel.
4. Bromley Safeguarding Children Board	Subject to any specific legal advice the Chair of the Board should arrange to provide A's parents with an update on the progress made in the implementation of these recommendations on a date to be agreed but no later than 31 December 2007.
5. Bromley Safeguarding Children Board	<p>The LSCB should make a copy of the overview report and associated documents available to the following bodies and invite them to take any action they think are necessary in relation to the findings:</p> <ul style="list-style-type: none"> • Somerset Safeguarding Children Board • Somerset Primary Care Trust • Somerset Partnership NHS and Social Care Trust
6. Bromley Safeguarding Children Board	The LSCB should make relevant findings of the report available to Sedgemoor and Lazerpoint.
7. Bromley Safeguarding Children Board	Member agencies of Bromley LSCB should ensure that staff involved and their line managers are made aware of the findings and given access to relevant training and development opportunities if required to address any areas of concern identified in the report.

8. Bromley Safeguarding Children Board	Member agencies of Bromley LSCB should identify any wider groups of staff not directly involved who may benefit from learning opportunities arising from the findings of the report.
9. Oxleas NHS Foundation Trust	The Chief Executive of Oxleas NHS Foundation Trust should provide the LSCB with an updated report on the current and planned implementation of the Care Programme Approach required by the Mental Health Act 1983 and subsequent guidance in the trust as it applies to CAMHS services.
10. Oxleas NHS Foundation Trust CAMHS service	Where a Bromley young person is placed temporarily outside of the area covered by the Oxleas Trust and is receiving psychiatric care from other professionals, Oxleas must ensure that the working arrangement between the Bromley CAMHS service and the other provider is clearly specified, confirmed in writing and subject to a periodic supervisory or management audit.
11. Bromley children and family services management team	<p>Bromley should issue specific procedures instructing staff that when a child or young person for whom the council has a statutory responsibility (including a looked after child or a child in need of protection) is admitted to any psychiatric, substance misuse or learning disability unit for inpatient treatment, the social worker responsible for the young person must:</p> <ul style="list-style-type: none"> • Make phone contact to notify the unit of the service's involvement • Provide copies of written reports and assessments as appropriate within 3 working days • Give priority to attending at any planning or discharge meetings • Notify a manager or supervisor and agree if any other action is required.
12. Bromley children and family services Placement Panel and Commissioning Team	<p>Commissioning arrangements for children's services need to be reviewed to ensure that they set out clearly the responsibilities of all parties commissioned to provide services, including the following:</p> <ul style="list-style-type: none"> • Additional responsibilities of agencies who

	<p>are commissioned by Bromley when they in turn subcontract services to other professionals or agencies such as occurred in this case</p> <ul style="list-style-type: none"> • Information sharing arrangements between all the agencies involved in the case
13. Bromley children and family services Placement Panel and Commissioning Team	The service manager responsible for the panel and the commissioning team should ensure that staff and managers who attend the panel are made aware of the approach it expects to be taken in relation to assessing the benefits and potentially adverse effects of placement decisions on service users
14. Bromley children and family services Placement Panel and Commissioning Team	The service manager responsible for the panel and the commissioning team should review their current arrangements to increase the attendance of managers and supervisors at the panel and to improve the accountability and responsibility for supervisors and managers in relation to implementation of panel decisions.
15. Bromley children and family services Placement Panel and Commissioning Team	The service manager responsible for the panel and the commissioning team should identify whether other changes or developments are needed in the way the current arrangements for the service in the light of the experience of this case. This should take particular account of the findings of this review in relation to the arrangements for children and young people who are placed outside of Bromley.
16. Bromley children and family services management team	Guidance should be issued to all managers and to reviews of LAC reviews clarifying the respective responsibilities of the placement panel and looked after reviews for children.
17. Director of Children's Services Bromley	The Director of Children's Services for Bromley should formally bring the findings of the review to the attention of the Director of Housing and Community Care Services in Bromley and the Chief Executive of Oxleas NHS Foundation Trust and seek to establish joint work on the weaknesses in the current approach to transition to adult services in social care and mental health identified in this case.
18. Director of Children's	The Director of Children's Services should

Services Bromley	review arrangements for the transfer of cases from children's services to the Transition Team in adult services to ensure that all of the relevant information on the family is transferred to the new worker responsible.
19. Director of Children's Services Bromley	<p>The Director of Children's Services should bring the findings of the SCR to the attention of the local children and young people's strategic partnership which should consider what steps should be taken by all agencies working with children and young people in Bromley to promote the provision of better services for young people in the area who have Asperger's syndrome.</p> <p>As part of this process a meeting of relevant senior service managers and voluntary or parents groups who have an interest and experience in this topic should be considered.</p>

The overview report was accepted and endorsed by the serious case review sub committee of Bromley LSCB at its meeting on 27th March 2007.

An action plan arising from the recommendations of the SCR will be drawn up and monitored by the Executive Committee of Bromley LSCB.