SCR Child M

Overview Report

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1 ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

Introduction

1.1 This report was prepared for East Sussex Local Safeguarding Children Board (the LSCB) in order to fulfil the requirements of the statutory guidance *Working Together to Safeguard Children 2013*.[1] The guidance sets out the arrangements for the local interagency review of serious child protection cases. The LSCB is required to undertake the review in order to identify opportunities to improve the provision of services for vulnerable children. This report sets out the findings of the Serious Case Review (SCR).

1.2 In keeping with statutory requirements, the LSCB has published the SCR Overview Report in full.

Reasons for conducting the SCR

1.3 The SCR concerns the services provided for a child who is subsequently referred to as Child M. Child M was aged 17 in March 2013 when she died as a result of a drug overdose taken while in the company of at least one adult. This was the last in a series of overdoses that Child M took which had resulted in hospital admission and serious health concerns from May 2011 onwards. Child M grew up in Surrey and lived there for the majority of her life. In September 2011, when she was 16 years old, Child M moved to East Sussex. In December 2011 she was made the subject of an Interim Care Order and a Secure Accommodation Order. East Sussex County Council was granted a Care Order in April 2012 and Child M remained a looked after child in the care of the local authority at the time of her death. Between August 2012 and January 2013 Child M had been living in supported lodgings accommodation in Surrey. From late January 2013 until her death she had lived in Bed and Breakfast accommodation in Hampshire, a few miles from her original family home. Child M had a history of substance misuse which according to some agency records went back at least six years.

1.4 Child M had lived in Surrey and Hampshire for some months prior to her death, but because she was in care the responsibility to determine whether or not an SCR should be held fell to East Sussex LSCB. *Working Together 2013* provides statutory criteria setting out the circumstances in which an SCR should be held.[2] The LSCB is required to conduct an SCR when a child has died and '*abuse or neglect is known or suspected*' or when a child has been seriously harmed and there is '*cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child'.* The guidance also points to other specific circumstances in which a review must be held such as the death of a child in custody.

1.5 In reviewing the history of professional involvement with Child M, a number of matters pointed clearly towards the need to conduct an SCR:

- There were very serious concerns about the circumstances of Child M's death
- Child M was in local authority care at the time of her death and has previously spent a period in local authority secure accommodation

[1] HM Government (2013), *Working Together to Safeguard Children*, chapter 4
[2] LSCB Regulations 2006 (Regulation 5), *Working Together to Safeguard Children* (2013)*, page 68*

- A significant number of agencies had been involved in working with her in at least 6 local authority areas
- Child M had previously been detained in an inpatient psychiatric unit under both Section 2 and Section 3 of the Mental Health Act 1989
- There had been professional disagreement about how some episodes in the history had been handled
- The review offered the possibility of learning for agencies which might lead to improvements in services in relation to
    - children who abuse drugs and alcohol and are resistant to attempts by family and professionals to encourage them to change their behaviour
    - working arrangements in cases where services are being provided for adults and children (either by separate agencies or in some instances by the same agency)
    - work with children who move either in a planned way or go missing across local authority boundaries.

1.6 The recommendation to hold the SCR was made by the LSCB Serious Case Review Group on 3 May 2013. Cathie Pattison who was at the time the Independent Chair of the LSCB made the decision to undertake the SCR on 16 May 2013. Work began at that point to agree the scope and focus of the review.

<u>The scope and focus of the Serious Case Review bearing in mind the circumstances of the death and the involvement of agencies with other family members</u>

1.7 The purpose of the SCR is set out in *Working Together 2013.* It is to provide a '*rigorous, objective analysis*' of the services that were provided to the child and family '*in order to improve services and reduce the risk of future harm to children*'. The LSCB is then required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.* [3]

1.8 It is the responsibility of the LSCB to determine the scope and focus of the SCR. In its initial discussions, the SCR panel agreed terms of reference that addressed all of the issues that appeared to be of potential concern in the case history. These are included as Appendix 1 of this report. Agencies that had provided services to Child M and her family undertook a detailed review of all of these aspects of their provision. This report sets out the findings of those enquiries and focuses on the matters judged to be the most significant. As the work of the SCR progressed, the work of the review focused on a number of issues in relation to which there was the greatest potential for learning and to satisfy potential concerns about the provision made for Child M and her family. These are the themes set out at the beginning of Section 4 of this report and evaluated there.

<u>Findings and recommendations</u>

1.9 The SCR has made recommendations to individual agencies, to East Sussex LSCB and to other LSCBs where it identified priorities for service improvement. In some instances the SCR has produced findings which require further work of the LSCB and member agencies before deciding what action to take.

[3] *Working Together to Safeguard Children* (2013), 4.1 and 4.6

The time period covered by the SCR

1.10 The SCR has taken account of events during the period between January 2008 (when it was understood that Child M first showed signs of experiencing difficulties) and her death in March 2013. During the course of the review, additional information covering earlier events has also been taken into account.

Agencies involved

1.11 The SCR considered the work of the following agencies and contracted health professionals who had the most significant involvement with the family. The agencies cover six different local authority areas and include both adult and children's services. This is because the review has also taken account of provision made by agencies to an adult male (subsequently referred to as Mr C) who had a very significant involvement in Child M's life:

Agencies in East Sussex

- Crime Reduction Initiatives (CRI) – which provided substance misuse services and young people's employment and careers advice services
- East Sussex County Council
    - Education Services
    - Children's Social Care and Under 19s substance misuse service
- East Sussex Clinical Commissioning Group – in relation to GP services
- East Sussex NHS Healthcare Trust – in relation to acute hospital services and health services for looked after children
- South East Coast Ambulance Service
- Surrey and Sussex Probation Trust
- Sussex Partnership NHS Foundation Trust – in relation to the Child and Adolescent Mental Health (CAMHS) Service
- Sussex Police

Agencies in Surrey

- Catch22 - which provided substance misuse services for young people
- Frimley Park Hospital
- Surrey County Council
    - Children, Schools and Families Directorate
    - Youth Service, including the Youth Offending Team
- Royal Surrey County Hospital NHS Trust
- Virgin Care Services Limited (in relation to school health services provided by the previously contracted NHS Trust)
- Surrey Police
- Surrey and Borders Partnership NHS Foundation Trust

Agencies in Buckinghamshire and the Thames Valley area

- Berkshire Healthcare NHS Foundation Trust
- The OASIS Partnership – a substance misuse service
- Oxford NHS Foundation Trust – which provided mental health services
- Reading Borough Council Children's Social Care

- DAIS Reading – a substance misuse service
- Royal Berkshire Hospital NHS Foundation Trust
- SMART CJS – a substance misuse service
- Thames Valley Probation Trust
- Thames Valley Police

Agencies in other local authority areas and national agencies

- Hampshire Constabulary
- The Priory Hospitals Group – in relation to an inpatient psychiatric unit
- West Sussex County Council – which provided secure accommodation for Child M

All of these agencies prepared chronologies and individual management reviews or reports describing and evaluating their involvement with Child M and her family.

Parallel processes proceeding alongside the SCR

1.12 Thames Valley Police has conducted a criminal investigation into Child M's death. The SCR panel has been kept informed of relevant information gathered during the course of the investigation. The criminal investigation has not affected the conduct of the SCR; however, it may impact on the timing of publication of the report. In July 2014 two adult males were convicted of the possession and supply of illegal drugs.

1.13 The Inquest which will establish the cause of death of Child M is being conducted by the Coroner for Reading. There has been communication between the Coroner's Office and the LSCB during the SCR and factual information about the services that were provided to Child M has been made available to the Coroner in order to assist in determining how the Inquest should best be conducted. The Coroner has been made aware of the findings of the SCR.

Update Comment: Inquest was held in June 2016 and concluded that Child M died of a drug-related death. The SCR panel found no new information or significant evidence from the inquest that lead to any change in the conclusion or recommendations of the SCR. From the record of Inquest: [Child M] died aged 17 years on the 16th March 2013 at Frimley Park Hospital, Surrey from Morphine and Benzodiazepine toxicity. She was a vulnerable child by reason of her age, historical drug abuse, mental health and association with a male drug user who was 7 years her senior. She was subject to a Care Order from East Sussex County Council which also arranged a Child Abduction Warning Notice that was served on the male on 27th April 2012 to discourage him from associating with [Child M]. There was evidence that this notice had been regularly breached but potential evidence required to act on the breaches was not obtained. [Child M] denied associating with the male when challenged. It was known to various Authorities that [Child M] had been admitted to hospital on several occasions following drug overdoses, invariably when in the company of the male. These incidents were not acted upon. There were missed opportunities to hold one or more multi-agency strategy meetings, firstly, when [Child M] moved back to Surrey in August 2012 and then, on subsequent occasions when safeguarding issues arose giving concern for [Child M's] welfare. Information from [Child M's] parents to Surrey Police in January and February 2013 raised further concerns about her safety. While these were shared with relevant Local Authority Children's Services, there were two failures by Surrey Police to disseminate the information to

relevant Police forces, in particular Thames Valley Police, for investigation and potential action. The risks to [Child M] were underestimated. In part, this was because she moved between different Local Authorities and Police jurisdictions and the fact that she was approaching her 18th birthday when her Care Order would effectively lapse. Finally, from the evidence, it is not possible to say, on the balance of probabilities, that, if any or all of the available opportunities to take action had been taken, the outcome would have been different.'

Agreed extensions to the normal timescale for completion of the SCR

1.14 The SCR has taken longer to complete than the six months set as a guideline in *Working Together 2013.* This was largely due to the scale of the work required and the large number of agencies involved. The Independent Chair of the LSCB has been briefed about the progress of the review. Where it was possible to take action in relation to shortcomings in practice identified during the course of the review participating agencies have done so. The review could not be published before the conclusion of the inquest however this did not prevent the agencies implementing the recommendations.

Involvement of family members

1.15 The author of this report has met with Child M's parents on two occasions (on one occasion another family member was also present) in order to inform them about the purpose and arrangements for the SCR and to obtain their views about the services that agencies provided for Child M. They have also commented on their own involvement with agencies. The parents have raised a number of concerns about aspects of the provision made, as well as recognising the substantial amount of effort made by some of the agencies and by many individual professionals to help, guide and advise Child M. The views of the family are reflected at a number of points in the report and addressed in the evaluation in Section 4. The findings of the SCR were discussed with Child M's parents prior to publication of the SCR.

Agreement of the SCR findings and arrangements for publication

1.16 Drafts of the SCR overview report were discussed by the SCR panel and agreed after amendments. The findings of the review have been circulated to the contributing agencies via the LSCB in the areas where they are located. This has provided an opportunity for the findings to be discussed with staff and managers who had been directly involved. The scale of the review, the timescale and the large geographical area covered made it impossible for the SCR panel to discuss the findings directly with all of those who had been involved. The report was presented to East Sussex LSCB on 17 July 2014 and its findings were accepted by the Board.

1.17 Following the inquest in 2016 the Independent Chair requested the panel review the report in light of the inquest conclusions. The Independent Chair also requested that the SCR panel consider the report in light of the significant passage of time since the review was completed and the developments and better understanding of child exploitation. The report was updated in August 2016 agreed by the panel and re-presented to the East Sussex LSCB on 13th October 2016 and its findings were accepted. (Comments from the SCR panel review are apparent within this report and the SCR author was consulted about the changes).

1.18 Other documents prepared by member agencies and for or by the review panel, the notes of interviews with members of staff and the records of service users will not be published or disclosed.

2 REVIEW METHOD

The review process and methodology

2.1 *Working Together 2013* sets out the principles that should inform the methodology for SCRs. These are reproduced in Appendix 4 of this report. The introduction of this revised statutory guidance has given rise to the development of a number of methods of conducting reviews which seek to engage professionals who worked with the child and family more directly in the SCR.

2.2 Initial review of the records in relation to Child M showed that a very large number of professionals in agencies from different local authority areas had worked with her. It was felt that not to involve these agencies as full partners in the review risked compromising its work, but that it would not be realistic to expect staff from a wide geographical area to attend a series of meetings in East Sussex, such as would have been entailed in some of the alternative review methods.

2.3 As a result, the LSCB decided that it would conduct this SCR in line with the method of enquiry set out in the previous (2010) version of statutory guidance, based on the preparation and evaluation of individual management reviews from participating agencies.[4] This would enable the LSCB and member agencies to carry out a thorough review using a familiar approach rather than have to commit substantial additional resources to training

[4] HM Government (2010), *Working Together to Safeguard Children,* Chapter 8

participants in an untested review method and asking agencies to attend a number of additional meetings.

2.4 In order to comply fully with the requirements of current statutory guidance, particular care has been taken by member agencies to involve staff as fully as possible in the SCR. The panel asked for additional information from a number of staff members and one panel member additionally reviewed and discussed a number of the more contentious episodes with staff and managers from his agency. The SCR panel also arranged a full-day learning event where participants from all of the agencies that had known Child M were invited to discuss and develop the provisional findings of the review. This was considered to have made a valuable contribution to the process.

2.5 Dr Jeremy Leach, who is a member of the East Sussex LSCB representing Wealden District Council, acted as the Independent Chair of the SCR panel. His agency had had no involvement with Child M or her family. The LSCB commissioned Keith Ibbetson to write the SCR overview report. He is an experienced author and chair of SCRs. He had not worked in East Sussex before and is also independent of all of the agencies involved in the review.

2.6 A full list of the roles and job titles of SCR panel members is contained in Appendix 2 of this report. Panel team members are experienced clinicians or managers in member agencies or designated health professionals with substantial experience of safeguarding children. None of the panel members had had any previous contact with Child M or other family members.

2.7 The SCR panel team met on eight occasions in order to review the materials prepared by contributing agencies to evaluate the provision made by agencies and to discuss and agree a report to be presented to the LSCB. There was also a day-long workshop to which the authors of individual management reviews were invited.

2.8 The overview report findings were circulated to participating agencies for formal comment and agreement before being submitted to the LSCB for discussion and agreement.

<u>The framework for making judgements about the actions and decisions of professionals</u>

2.9 Self-evidently, there is value in reviewing the history of professional involvement with a child and her family, with an overview of events and knowledge of the outcome. However, along with the clarity that hindsight brings, the SCR has taken account of the danger of what is termed 'hindsight bias'. It arises when the evaluation is unduly influenced by knowledge of the outcome because '*looking back the situation faced by the clinician is inevitably grossly simplified*'.[5] It is easy to criticise the decisions and actions of professionals because they can now be seen to be part of a chain of events that had a tragic outcome. In the investigation of serious incidents in health services, air accident investigation and other high risk industries the dangers of this are recognised and review teams seek to avoid them by understanding how staff and managers reached the decisions they did, based as much as possible on their experience at the time when they were dealing with events.

2.10 If decisions and actions are judged out of the context in which they occurred, it is likely to reduce the value of the investigation. It may also be unfair to the individuals. More valuable learning can be obtained by seeking to understand and explain why decisions were made

[5] Charles Vincent (2010), *Patient Safety* (second edition), Wiley-Blackwell BMJ Books, pages 50-52

and actions taken, taking full account of the influences over professionals arising from the context within which they were working. The SCR has therefore sought to take advantage of hindsight whilst avoiding hindsight bias.

2.11 In keeping with this approach, judgements about actions and decisions take into account the information that was available to the professionals who took them. At certain points it is necessary to evaluate the overall service provision in relation to information that was known to the network of professionals as a whole or ought to have been available if relevant information had been shared.

2.12 The review has sought to judge the actions of professionals and agencies against established standards of good practice as they applied at the time when the events in question took place, rather than ideals that seldom exist in the real world. Nevertheless, if the actions of individuals, groups of professionals or agencies as a whole are found to fall short of established professional standards, this will be stated, together (where it is possible) with an explanation of why that happened.

An organisational or systems approach

2.13 As well as focusing on the actions and decisions of the individuals who were directly involved, the SCR has tried to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken. The additional focus on the team, the service, the agency as a whole and the collective actions of agencies together does not diminish the responsibility of individuals to act professionally and to work effectively. It explains the factors that sometimes make it harder for them to do so.

Recognition of strengths in professional practice

2.14 Research points to the value of identifying strengths in practice and ordinary things that were done well. Agencies need to learn from these and promote them as well as learning from shortcomings. When these are judged to be significant, they have been highlighted, either in Section 3 or in Section 4.19 of this report.

Recommendations and challenges to the LSCB and member agencies

2.15 The review has distinguished in its findings between the following:

- Recommendations that an individual agency has already or may swiftly act on to ensure compliance with an established procedure or professional approach or to achieve a straightforward improvement in its provision. These are largely set out in the individual management reviews provided by participating agencies.
- Specific recommendations that the participating agency or the LSCB has agreed to take, but which may take longer to implement.
- Areas where more information or research is required before the LSCB or the agency concerned can decide on what action to take.

3 NARRATIVE OF EVENTS AND KEY PROFESSIONAL CONTACTS

3.1 This section contains a narrative of the main professional contacts with family members and events reported to professionals from January 2008 to March 2013. In Section 4, key

episodes and themes arising from the narrative are evaluated in more detail where this assists in understanding important aspects of the provision made for Child M and her family or where it offers an insight into the wider working of safeguarding services. Within the narrative text, there is commentary on a number of practical or immediate findings about the case. When the agencies involved propose to take steps to remedy shortcomings in practice this is noted.

3.2 When dealing with events after April 2011, the narrative also highlights information about Mr C, an adult seven years older than Child M. For the most part, he is referred to in this report as her 'boyfriend' but clearly this was an exploitative relationship due to the disparity in their ages and that Child M was only 13 years old when they first met. That appeared to be how Child M saw their relationship. It is the term used in most of the professional records. It is clear that the professionals involved recognised that Child M's contact with this man placed her at a very high level of risk from substance misuse. At times it was also recognised that it was potentially emotionally and sexually exploitative. There is no evidence that professionals condoned the relationship; however, on a number of occasions some professionals became resigned to it continuing and so focused on reducing and managing risks to Child M and enabling her to make a more informed choice about whether to stay in contact with Mr C or not.

3.3 The contact between Child M and Mr C became known to some professionals in 2010 – 2011. Full details of Mr C were only recorded by professionals who knew Child M in April 2011 when they were arrested together. For some time, both Child M's parents and the professionals involved were uncertain about the extent of the contact that Child M had with Mr C, what the age difference was and how they had come into contact. Child M's parents now believe that Mr C originally came into contact with Child M when he was selling drugs in the vicinity of her school, though there is no professional record which states this.

3.4 The narrative section of the report also includes comments and information provided by Child M's parents to the SCR. When these are additional to or at odds with the records of agencies that were working with Child M this is noted so it should always be clear what information agencies held at the time.

<u>Information held by agencies about events prior to the period under review</u>

3.5 The SCR asked agencies to review earlier information about Child M and her family. There is no significant information in any agency record about any difficulties in Child M's early childhood. There were no concerns shared by the primary school on transfer to secondary school in September 2006 and indeed Child M had been identified as being 'gifted and talented' in one curriculum area.

<u>Services offering early help to Child M and her parents: January 2006 – April 2011</u>

3.6 During 2006 and 2007, Child M had occasional and relatively minor behavioural difficulties at school and in the community. The school recorded eight incidents causing low level concern during Year 7 and Year 8 (problems over uniform and appearance, lack of effort and skipping lessons) which were dealt with under the school behaviour policy.

3.7 Child M's family told the SCR that during this time she was bullied by other pupils and that the parents brought this to the attention of the school on several occasions. Child M's father also stated that there were occasions when Child M was less than fairly treated by teachers (for example uniform rules were implemented more harshly for Child M than for other pupils). The comments about bullying are consistent with comments made while Child M was at the Priory Hospital in mid-2011. The parents also say that she also struggled to fit in with peers who had more money than she did and treated casual access to drugs as part of their normal lifestyle. These matters are addressed further in Section 4.3 and 4.4.

3.8 Between September 2007 and July 2008, Child M's academic performance was below the expected level. She received detentions for minor behaviour issues. Until this point her problems would not have marked Child M out from many other pupils. In November 2007 Child M's mother took her to her GP as she had noticed that Child M had been cutting her arm. Following a further contact in July 2008 Child M saw a counsellor.

3.9 In March and July 2008 Child M was found very drunk in the street. In November 2007 and August 2008 she was given reprimands and warnings for minor thefts.

3.10 In October 2008 the counsellor based at her school referred Child M to the Child and Adolescent Mental Health Service (CAMHS) because of concerns about substance misuse and self-harm. The extent and nature of these problems is not well documented in the school records, though it is recognised that this may not be surprising as both are activities that children would want to keep from teachers. Child M and family members attended one CAMHS session before they stopped attending saying that the family's difficulties had improved.

3.11 In July 2009 Child M was discussed in an internal school meeting. As a result, the Surrey Connexions youth worker became involved and the school counsellor had further contact with Child M. School records indicate that Catch22 (the voluntary organisations commissioned to provide the young people's substance misuse service) became involved at that point but this is at odds with the organisation's own records which state that it worked with Child M from July 2010.

3.12 In 2009 there were further incidents of drunkenness. Child M received a further 'final warning' from Hampshire Police as a result of an incident at another school. As a result, in October 2009 the Youth Offending Team, part of a wider Youth Support Service (YSS) in Surrey, assessed Child M's circumstances and decided that at that time she had a 'low risk' of reoffending. Accordingly the service closed the case.

3.13 School records highlight 18 significant incidents of poor behaviour during Year 10 (September 2009 – July 2010). In July 2010 when Child M was 15 her parents highlighted their growing concerns about her misusing drugs, including ketamine [6] and associating with other drug users. At that stage, Child M's self-report was that she used 1-2 grams of ketamine 3 plus days per week, and 20 units of alcohol (roughly equivalent to two 14% 75cl

[6] On a website designed to provide reliable and simple information for substance misusers, ketamine is described as '*A powerful general anaesthetic which stops you feeling pain and it's used for operations on humans and animals. The effects don't last long, but until they wear off, ketamine can cause a loss of feeling in the body and paralysis of the muscles. It can also lead to you experiencing a distortion of reality*'. www.talktofrank.com

bottles to three 9% 75cl bottles of wine) approximately once per week. Her actual consumption may have been higher.[7]

3.14 In February 2010 Child M requested and received emergency contraception and she reported having a regular boyfriend aged 15. Child M and her mother were involved in discussions around contraception, which the GP thought were entirely appropriate. Subsequently Child M had a contraceptive implant.

3.15 According to the agency's own records, Catch22 became involved in July 2010 offering an assessment and the involvement of staff members to work with Child M and with her parents. Initially Child M engaged well in this service and she undertook educative work about drugs, advice on 'harm reduction' (avoiding the most serious risks associated with drug use) and advice on managing her anger, which was felt to be a concern.

3.16 Child M appears to have trusted the workers at Catch22 to the extent that in September 2010 she allowed them to make a referral to the CAMHS service citing concerns about self-harm, substance misuse, low mood, anxiety, and more generally 'finding it hard to cope emotionally' and a 'difficult relationship with her family'. The referral stated that Child M did not want her parents to be involved with CAMHS, but wanted Catch22 to help her attend CAMHS.

3.17 In September 2010 a CAMHS worker completed a full assessment interview with Child M noting gaps in knowledge about Child M's early history and development which could not be filled as Child M did not want her parents to be involved. Child M agreed to a program of individual sessions using Cognitive Behavioural Therapy (CBT) and the worker from Catch22 brought her to the sessions.[8] After four sessions the CAMHS worker discussed Child M with the team psychiatrist because she was struggling to make any progress with the CBT approach. The sessions continued and the advice at that time was not to prescribe medication. Correspondence with the GP indicates that on one occasion Child M reported hallucinatory after-effects from taking LSD or a similar substance.

3.18 A parenting worker from the substance misuse agency tried to engage with Child M's parents to provide additional support and advice but at that time the parents did not take up appointments because of work commitments. Later the parents had sustained contact from another parenting worker who was a member of the YSS.

3.19 In October 2010 (at the beginning of Child M's final school year) the school convened a Common Assessment Framework (CAF) meeting about Child M.[9] The school invited Child M who refused to attend and her parents (who did) along with the school counsellor. There is no record that the school invited Catch22, but the reasons for this cannot be established. Nor did it invite the CAMHS service, which had only just become involved as a result of a

[7] This pattern of alcohol consumption is considered high-risk binge drinking for adult females (six units or more per drinking episode) and is associated with increased health harms; it is also in excess of the daily sensible drinking guidance for adult females (2 – 3 units). There is no guidance relating to under 18s alcohol consumption.

[8] CBT is a counselling approach which seeks to enable the patient to think about and understand their circumstances and problems differently in order to enable them to try different ways of behaving.

[9] CAF is a framework for the coordination of early help for children and young people based on a shared (common) assessment framework. http://webarchive.nationalarchives.gov.uk/20130903161352/http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068957/the-caf-process

referral from Catch22. The school seems not to have been aware of the referral to CAMHS prior to the meeting. At that point the YSS was not involved with Child M.

3.20 The meeting noted Child M's lack of interest in education (attending school but missing lessons), her substance misuse, reports of episodes of self-harm since age 12 and the parents' reports of Child M's possible relationship with an older male. The school decided to try to keep her engaged in education (by modifying her curriculum by developing an Individual Education Plan). It was noted that Child M had regularly attended the army cadets and enjoyed this. Noting the involvement of CAMHS and Catch22, both the school and the parents agreed to continue to support Child M in attending these services. The school counsellor agreed to continue seeing Child M each week. The written record of the CAF meeting was limited. The notes of the CAF meeting were submitted to Surrey County Council. In line with the CAF procedures at the time, they were monitored by the local authority for service planning purposes and there should have been no expectation that the local authority would do anything as a result of the CAF being submitted. There was no follow up meeting by the school or recorded further coordination of the other services involved through this forum. Child M did not attend most of the proposed counselling appointments.

3.21 The arrangements for this meeting and its effectiveness as a means of coordinating early help to Child M are considered further in Section 4.2.

3.22 On 4 November 2010 Child M pleaded guilty to an assault on a young person. The assault was seen as being out of character and linked to Child M's drinking. As a result, she was made the subject of a Referral Order.[10] The YSS undertook its standard ASSET risk assessment.[11] This again produced a score showing a low risk of reoffending, but highlighted concerns about Child M's substance misuse and her emotional difficulties. The Referral Order panel meeting decided that work should be undertaken on Child M's victim awareness (the impact of the assault on her victim), consequences of offending (potential impact on Child M's own life), peer influence, the effects of prison on women (Child M was to attend a visit and meet women in prison) and alternative ways of dealing with conflict. It was agreed that there should be continued attempts to reduce alcohol and substance misuse. The aim of the Referral Order panel is to engage the young person but Child M was noted to have made a very limited input into the discussion. Noting the existing involvement of CAMHS and Catch22 substance misuse service, the YSS agreed to take a limited role meeting Child M every two weeks initially and liaising with the other agencies.

3.23 From February 2011 onwards, it was noted that Child M's problems became more serious and she was less engaged with the agencies who were trying to work with her. There were renewed self-reports that she was taking ketamine and she missed CAMHS appointments.

[10] A Referral Order is the generic punishment given for most first juvenile convictions. When a Referral Order is made, the Youth Offending Team and independent lay members of a panel design a package of services and measures to reduce the risk of reoffending and support the young person and their family.

[11] ASSET is a structured assessment tool used by YOTs in England and Wales on all young offenders who come into contact with the criminal justice system. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances, ranging from lack of educational attainment to mental health problems, which may have contributed to such behaviour. The information gathered from ASSET can be used to inform court reports so that appropriate intervention programmes can be drawn up. It will also highlight any particular needs or difficulties the young person has, so that these may also be addressed. ASSET will also help to measure changes in needs and risk of reoffending over time. www.justice.gov.org

3.24 On 8 February 2011 Child M attended a hospital emergency department and reported taking an LSD-like drug at home. This triggered a further referral to the CAMHS psychiatrist. He saw Child M in March 2011 because of her concern about symptoms of 'paranoia' and concluded that the best way to reduce her symptoms would be to continue making efforts to reduce her use of illicit drugs and that until this happened there was questionable value in providing any psychiatric medication.

3.25 Until April 2011 Child M attended an alternative learning programme arranged off the school site. Again the school recorded comments that Child M had made about her contact with an older male, though no specific details of his age or identity were noted.

3.26 On 7 March 2011 Child M had her last face-to-face meeting with Catch22. After this appointment she disengaged though the worker continued to try to work with Child M and kept in contact with the family, CAMHS and the YSS.

3.27 In later March 2011 the YSS reported positive contacts and Child M's mother reported that Child M seemed happier.

3.28 Section 4.2 evaluates the effectiveness of the early help that Child M was offered during this period, including the steps taken to coordinate provision between different agencies.

Additional information

3.29 The Surrey County Council Contact Centre screened and responded to potential referrals to the social care service. During the period from January 2008 to April 2011, it received eight notifications about Child M, from the police or other agencies involved. It decided on each occasion not to refer the circumstances to the area team which could have initiated an initial assessment in order to determine whether Child M should be considered as a child in need. This is considered further in Section 4.3.

3.30 Over this period the school nursing service received copies of a number of discharge notes made following attendances at hospital Emergency Departments. These were filed and archived and the service did not follow them up by liaising with the school or other health professionals. This was because there was limited capacity in the service and it was assumed that other professionals already directly involved with Child M would be aware of the incidents. Records of individual incidents were archived individually and so the school nurses involved were not able to see the sequence of events.

Comment
The current service provider, which did not manage the service at the time, has recognised that this response might leave other children in similar circumstances vulnerable and without relevant services and has made recommendations as to how this should be addressed in future.

3.31 At some point during this period (probably most likely in 2008 when Child M was aged 13), she started to come into contact with Mr C. Records about him during this earlier period have not been obtained but Mr C is now known to have had a troubled history of mental health problems and substance misuse dating from early adolescence. He was registered for higher education in Surrey but had dropped out. Child M's family believe that Mr C first came into contact with her when he was a student who was supplying drugs to local young

people, though this cannot be verified. Some agency records during this time refer to Child M having an 'older boyfriend' though she was not asked for his details and the extent of the difference in age between them was not clear to professionals until April 2011.

3.32 In March 2011 Child M was refused a place at the local sixth form college as she had not achieved the GCSE grades required. In April 2011 she applied for a place at a college in East Sussex which Mr C also planned to attend. The school was aware of her application, though other agencies in Surrey were not. The Surrey school provided references, written by a senior member of school staff. They noted that Child M was receiving a range of supports at the 'school action plus' level (where outside agencies are engaged as well as the school) and had had a 'difficult Year 11'. No further background information was provided. Most aspects of Child M's work and performance had been graded as good though her motivation was noted to be dependent on the subject. She was 'passionate' about art and related subjects. No explanation was provided as to why Child M was proposing to move from Surrey to East Sussex.

3.33 The significance of this only became clear later in 2011 (after Child M had been in an inpatient psychiatric unit) when Child M and Mr C tried to move to East Sussex and it became clear that he had already obtained a place at the same college.

Comment
The reference format made it clear that Child M planned to attend a college at some distance from her home. However, the teacher who wrote the references did not ask why this was, given Child M's troubled background. The school say she may have missed this because the college has a similar name to another college which is closer to the school. The references give the impression that the school was seeking to assist Child M in making a fresh start at college. This might have led the college to underestimate the extent of Child M's difficulties though by the time she took up her place later in the year the nature of these had become very apparent.

<u>Assessment of risk to Child M as a result of substance misuse and possible sexual harm: incidents during April 2011</u>

3.34 During March and April 2011 Child M appears to have had much more contact with Mr C. She became more unsettled, ran away on a number of occasions and placed herself at risk as a result of her misuse of drugs, including the risk of sexual harm.

3.35 The first significant incident occurred on 11 April 2011 when both Child M and Mr C took overdoses of a number of illegal narcotics in a hotel in Reading. This took place a short time before Child M's 16th birthday. Hotel staff notified the police who arrested both parties before arranging urgent hospital treatment and admission for Child M. The police investigated both Child M and Mr C for possession of Class A drugs. Mr C told the police that they had gone to the hotel to take drugs and have sex.

3.36 Agencies in Reading and the Surrey area became involved. The hospital referred Child M to Surrey (her home authority) and also to social care services in Reading. The police notified agencies in Surrey.

3.37 As Child M had been found in Reading, social care staff from that local authority liaised with colleagues in Surrey, convened a strategy discussion and then conducted child protection enquiries, interviewing Child M and her father. It was clear that there were substantial concerns about Child M's safety but the risks did not arise from the care she was being provided by her parents. As a result, Child M's father was encouraged to take her home, where he undertook to ensure that either her parents or her older sister would supervise her until the local services could assess the circumstances in more detail and agree how to proceed. The outcome of Reading's enquiry was a recommendation that Surrey social care staff should undertake a more in-depth core assessment of potential risks to Child M. Reading Council staff believed that a CAMHS appointment had been arranged to take place shortly after Child M's return to Surrey. This was not the case but a member of the CAMHS team did see Child M quickly.

3.38 Records from Reading's social care staff highlight disagreements between the two local authorities about how to deal with Child M and, in particular, refer to the unwillingness of social care managers from Surrey to attend the proposed strategy meeting in Reading. This is considered further in Section 4.5 of this report. It was one of a number of shortcomings in the provision made by Surrey County Council over the days that followed.

3.39 Child M was returned to Surrey but over the following two days she twice went missing again in the company of Mr C. On 14 April 2011 Thames Valley Police removed Child M from his home in Buckinghamshire and served him with a Warning Notice under Section 2 of the Child Abduction Act 1984 threatening arrest if the notice was breached. He was also reminded that he had bail conditions (imposed after the their recent arrests) that he was not to contact Child M. The Warning Notice had legal effect for less than two weeks because, under the legislation under which it had been issued, it only applied until Child M was 16.

3.40 No further warning notice could be issued until April 2012 when Child M became the subject of a Care Order to East Sussex County Council, at which point notices with a broadly similar objective could be issued under Section 49 of the Children Act 1989 (this is described at Section 3.146 below). The findings of the SCR about the value of such notices and the action taken by agencies when seeking to implement them are set out in Section 4.18.

3.41 On 15 April a social worker from the duty service in Surrey social care and a member of staff from the YSS who knew Child M made a home visit in order to undertake an initial assessment. During the course of the visit they spoke separately to Child M and her parents. Child M's parents told the SCR that they spent a considerable amount of time talking alone to Child M and that on this occasion and others she was never willing to say what her concerns were in front of them.

3.42 Prior to the visit, information had been obtained about the work that CAMHS, the YSS and Catch22 had undertaken and the social worker contacted the family GP. The YSS agreed that it would now undertake substance misuse work with Child M within the statutory framework offered by the existing Referral Order (described above) as Child M had stopped cooperating with the Catch22 service. Prior to the assessment, the CAMHS service had also reported its concerns to social care that Child M was at risk of death by accidental overdose and at risk of sexual exploitation by older men. There is evidence in the CAMHS records of

an email setting out the concerns which the sender was invited to send to the Surrey County Council Emergency Duty Team. However, there is no trace of it in the social care records, suggesting that it was never uploaded to the recording system linked to Child M's file. There is no explanation for this. At that point Catch22 had also expressed concerns that Child M's parents were either allowing her to stay with her 'boyfriend' or could not prevent her from doing so.

3.43 The outcome of the initial assessment was that the local authority would not allocate work with Child M and her family for further assessment of risk and need or offer services. Instead, reliance was placed on Child M and her parents cooperating with the services being provided by the YSS (including its substance misuse service) and CAMHS. In forming this view, the local authority had decided that Child M was not at risk of significant harm and that she did not need to be the focus of further assessment and action under the local multi-agency child protection arrangements. In the absence of local authority involvement, no agency saw itself as having a role in coordinating the provision that was being made.

3.44 The SCR has concerns about the judgements reached by the local authority at this point and their implications for the future course of work with Child M. These are set out in full in Section 4.5 of the report.

3.45 Other agencies in Surrey were concerned by this decision and as a result both CAMHS and Catch22 expressed their concerns in emails to the local authority. However these were not followed up by more senior managers in the services, nor were they reiterated when, over the next two months, Child M's difficulties worsened.

3.46 During the following two weeks Child M ran away and was reported missing again. She missed a number of appointments while at the same time complaining that no one was helping her. At the time there was no collective or shared view of the risks that Child M was exposed to because there was no mechanism in place to coordinate the sharing of information and action. However, drawing on the information that is now available to the SCR, it is clear that Child M was spending time with Mr C, and, according to her parents, with at least one other older, adult male drug user. According to her parents, the second male was present when they went to collect Child M from hospital on more than one occasion.

3.47 Child M disclosed greater drug use saying that she was now regularly injecting (as opposed to inhaling) ketamine in order to get a stronger effect. She complained of symptoms of depression, anxiety and some psychotic symptoms and said she wanted to have medication. On three occasions Child M spoke of suicidal thoughts and professionals checked out that she had not taken any action to self-harm and had no specific plan to seriously harm herself.

3.48 At this time Child M started to refuse to see other CAMHS workers but wanted to see the psychiatrist in order to obtain medication. It is not clear whether this was because she felt that taking medication would 'sort her out' and make her feel normal (as she sometimes stated) or because she was being prompted to seek access to a psychiatrist in order to obtain access to prescription medication to give or sell to others. It may have been both. It is now clear that Mr C had a long-established pattern of obtaining prescribed medications from different services, though this level of detailed knowledge was not available to those who were dealing with Child M at the time because, in the absence of child protection

enquiries and assessment, there was no formal framework for engaging all of the agencies and sharing information.

3.49 Professionals responded by offering Child M further appointments, including referral to the Early Intervention Psychosis Team because of her references to thoughts of paranoia and self-harm.

3.50 At the end of April 2011 the police charged Mr C with possession of class A and Class B drugs in connection with the incident in the hotel. No charges were brought against Child M. Mr C pleaded guilty to the offences in September 2011 and received a Community Order (to expire on 09/06/2012), a nine-month Supervision Order and a requirement to attend non-residential drug rehabilitation for a period of six months.

3.51 Mr C was subsequently supervised by probation services in East Sussex (between September 2011 and February 2012) and the Thames Valley (until May 2012). Probation service involvement with Child M and the liaison between probation officers and those working in children's services are evaluated in Section 4.12.

3.52 Child M's parents have asked why no sexual charges were brought against Mr C. However this is understandable as this would have required Child M to make a complaint and give evidence against him. The response of the local authority to this evidence of sexual activity between a minor and an adult male is considered in Section 4.5

Update Comment: In line with learning from national SCRs and practice development there has been significant improvement in police pursuance of criminal conviction even where the is no first party complaint.

Further attempts to provide assistance in the community: May – June 2011

3.53 During May and June 2011, agencies continued to try to offer support to Child M and her parents. Her behaviour was very mixed at this point. On a number of occasions she went missing and subsequently admitted injecting drugs. However, she also continued to attend some education and sat her GCSEs. Child M blamed her parents for interfering and wanting to control her relationship with Mr C.

3.54 On 7 May 2011 Surrey Police received intelligence that Child M had again been injecting ketamine and having underage sexual relationships with an older man. By that point she was 16. The information was referred to the local authority which again decided not to undertake a risk assessment.

3.55 On 11 May 2011 the YSS parenting worker began to work with the parents, with most of the sessions subsequently being with Child M's father. Child M's mother stated that she had found information in a diary kept by Child M showing that she had been misusing drugs since the age of 12. The parenting sessions took place regularly until late 2012, beyond the time when Child M's Referral Order had expired and she had moved away from Surrey. The parents were welcoming of this continued support.

3.56 On 8 June 2011 Child M told a YSS member that she was 'thinking of' applying for a college course in East Sussex (she had in fact already done so, as had Mr C).

3.57 During this time Mr C had appointments at the mental health service in Buckinghamshire, though he frequently failed to attend them.

3.58 On 20 June 2011 Child M was admitted to a hospital near Mr C's home address following a heroin overdose. She had been found in the street and the circumstances in which she overdosed could not be established. Records suggest that Mr C had also apparently taken an overdose or tried to kill himself. In hospital Child M was noted to have suicidal thoughts. Throughout this period professionals dealing with Child M had no liaison with those dealing with Mr C.

3.59 Child M was seen by a local psychiatrist who liaised with the Surrey CAMHS service. No consideration was given to involving the local authority. Child M was then collected from the hospital by her father. In Surrey the Catch22 worker, the YSS and CAMHS staff all became involved immediately. Child M was offered advice on harm minimisation (how to avoid overdosing and other dangers of injecting), as well as a further psychiatric appointment. Child M was largely dismissive of the advice given.

3.60 CAMHS staff sought advice from social care who initially indicated that no referral should be made pending an outpatient psychiatric appointment, but subsequently requested a referral.

3.61 Child M's condition and behaviour deteriorated and it was apparent to her parents that she had been back in touch with Mr C and had used drugs again. On 23 June 2011 she was taken to a CAMHS appointment, but judged to need urgent medical attention at A&E. After one night in hospital she underwent a psychiatric assessment which concluded that she was suffering from a depressive disorder, unhelpful coping strategies including self-harm and drug use. She was found to have psychotic symptoms most likely to be drug induced.

3.62 As a result, Child M was detained under Section 2 of the Mental Health Act (2007) and admitted to the Priory Hospital inpatient unit in East Sussex.[12] On admission, Child M was found to have some old and superficial cuts to her arms and cigarette burns on her hands. Child M was treated with benzodiazepines in order to calm her and reduce anxiety.

Care at the Priory Hospital: June – August 2011

3.63 This section of the report provides a summary of the key actions and decisions taken whilst Child M was a patient of the Priory Hospital between June and August 2011, by when it had been agreed that she should be allowed to move to East Sussex. The focus is on the assessment and management of risk to Child M and the coordination of provision between the Priory Hospital and services in Surrey and East Sussex, rather than on clinical judgements and medical or psychiatric treatment.

3.64 Shortly before the admission, CAMHS staff referred Child M to the Surrey County Council social care service but no action was taken once it was established that she was in hospital. None of the key decisions taken during this period were part of a multi-agency assessment of need or risk. The placement at the Priory Hospital was not commissioned or overseen as part of any multi-agency arrangement and the local authority in Surrey played no further

[12] Section 2 allows for compulsory detention of a mentally disordered patient for one month for the purpose of assessment and treatment judged to be required.

part in Child M's care from this point, despite a number of requests. These matters are considered further in Section 4.6.

Agency contacts with Surrey social care

3.65 Child M entered the Priory Hospital as a 16 year old child who had lived and was normally resident in Surrey. On 28 June 2011 Surrey CAMHS called the Surrey County Council Contact Centre to confirm that Child M was sectioned under the Mental Health Act (2007) for 28 days and is in the Priory Hospital in Ticehurst. The local authority took no action.

3.66 The records of Catch22 show that on 19 July 2011 the organisation wrote a lengthy email to the Surrey County Council social worker who had been allocated to Child M asking the local authority to allocate and assess Child M's case or, if not, to provide a clear account of the reasons for not doing so. Catch22 highlighted concerns that Child M was:

- not in education
- not engaging with support from professionals including substance misuse services
- had been repeatedly admitted to hospital because of overdoses but had been unwilling to take up harm minimisation advice
- presented risks of self-harm and suicidal ideas but was not engaged with CAMHS
- contact from the YSS would reduce or end when her order expired shortly
- there were risks associated with her involvement with an older man/boyfriend

The local authority confirmed its position that it would not take on the case as Child M had sufficient support from other agencies and that it would only become involved if risks increased.

3.67 On 11 August 2011 the Priory Hospital contacted the Surrey County Council Contact Centre stating that Child M was a patient and that she wanted to discharge herself. The hospital asked the local authority to provide a report for a forthcoming Mental Health Act Tribunal. The local authority did not undertake a further assessment but provided the hospital with a copy of the initial assessment of 20 April 2011. A Surrey social worker subsequently attended a network meeting at the hospital and confirmed that the case would remain closed as it was planned that Child M would remain in hospital and it could not offer a service in those circumstances.

3.68 On 25 August 2011 the Priory Hospital contacted the Surrey social work team to ask the local authority to provide a care coordinator for Child M. This was in keeping with the responsibilities (and using a terminology) that the hospital might have expected for an adult mental health patient. Surrey responded to say that it did not provide such a service.

3.69 Shortly before Child M's final discharge from the Priory Hospital, the Surrey County Council Contact Centre was contacted by the probation service to ask for information about Mr C and any risk assessment that the authority had done in relation to risks that he might present to Child M. The local authority social work team confirmed that it had never undertaken such an assessment.

3.70 During her time at the Priory Hospital, the other agencies in Surrey continued to liaise with one another to share information about Child M's progress and the parenting worker from the YSS continued to have contact with the parents. The YSS worker was also active in updating the probation service and the Thames Valley Police, being mindful of the important link to work with Mr C.

Decisions and actions taken while Child M was at the Priory Hospital

3.71 On admission, the Priory Hospital conducted its normal assessment, identifying the following potential risks: absconding, deliberate self-harm, suicide, non-adherence to treatment, aggressive behaviour, use and supply of drugs and alcohol and the risk of alcohol and drug withdrawal. Levels were fixed for minimum contacts with staff and arrangements for drug screening were put in place. At this point, Mr C was viewed as being a potential threat to the stability of the placement and Child M's treatment. In keeping with this, contingency arrangements were made should he be found on the hospital site.

3.72 The hospital updated this risk assessment on 13 occasions during the subsequent three months, either as a result of planned review or when circumstances and risks were perceived to have changed. The nature of the perceived risks changed little over this time. In general the level of acute risks diminished but the underlying danger of Child M falling back into alcohol and drug misuse remained a constant concern.

3.73 Child M's predominant reaction in the days following her admission appears to have been one of anger that she was not allowed to see Mr C. She had a number of outbursts which led to her being prescribed additional sedative medication. However, by 12 July 2011 it was agreed that she could be discharged from the Section 2 detention ahead of a planned Mental Health Act Tribunal hearing, having agreed to remain in hospital as a voluntary patient.

3.74 The Care Programme Approach (CPA)[13] meeting held on 13 July 2011 to plan care and treatment noted arrangements for brief unescorted leave into the hospital grounds and escorted leave out of the hospital in the care of Child M's parents. It was recognised that Child M was 'biding her time' until she could get back with Mr C and she was refusing to engage in any therapeutic work or group sessions. Child M's parents told staff that they were anxious about her safety and voiced their fear that if she were to be discharged, she would place herself in a dangerous situation again as nothing has been resolved or changed. They said that they would struggle to guarantee her safety at home.

3.75 Child M was to start on a treatment programme of antidepressant medication and medication to manage her anxiety symptoms. Child M was to remain a voluntary inpatient, though if she refused, consideration would be given to detaining her for treatment under Section 3 of the Mental Health Act 2007.[14] At that point, Child M was to be allowed to speak to Mr C once during each staff shift. A review was fixed for 16 August 2011.

3.76 On 21 July 2011 Child M was compulsorily detained under Section 3 as she was, according to the information provided to the SCR by the Priory Hospital, *'increasingly adamant about leaving and agitated at times; not open to any reason and showing no insight into the worries expressed about her by those who know her well in the community'*.

3.77 During this period Mr C was scheduled to attend sessions at the mental health service in his local area; however, his compliance was poor. At this time, photographs of Mr C in the

[13] A system for coordinating the care of mental health service users, including arrangements for discharge from hospital

[14] Section 3 allows for detention for the purpose of treatment and further assessment for up to six months. It is always subject to review and, if the patient requests it, an independent tribunal.

possession of substantial quantities of pills were passed to police services in Thames Valley and Surrey by the Surrey YSS worker but there is no evidence that any action was taken.

3.78 At the review meeting on 16 August 2011 it was agreed that Child M would continue on her medication. She had refused to attend occupational therapy sessions as she asserted that she would not be using any drugs in the community. Section 17 home leave was arranged on the condition that Child M would stay at her parents' house.[15] At this stage it was planned that HOPE (a community-based mental health and education service in Surrey) would see her. Child M remained subject to the Section 3 detention, but claimed this was not necessary as she 'did not need treatment'.

3.79 The following weekend Child M stayed with her parents and, as part of the agreed care plan, had up to six hours of unsupervised contact. The subsequent records show that she saw Mr C but that she had a negative drug screen on returning to the hospital.

3.80 Discussions between the Surrey YSS parenting worker and Child M's parents suggest that they felt this visit had gone well. Child M had been in contact with a member of the extended family with whom she had a very good relationship and was saying that she did not want to take drugs. However, these discussions also touched on possible educational plans for Child M should she return to live in Surrey, suggesting that the parents and the local agencies were not aware of how plans were for Child M to move to East Sussex had progressed. This became clear on 31 August 2011 when there was conflict between Child M and her parents and then between the parents and the Priory Hospital over the extent of planning that had already taken place.

3.81 By the time of the multi-disciplinary hospital team meeting on 30 August 2011 the care plan had changed. The revised plan centred on Child M having a series of brief trial stays with Mr C to establish whether she could remain drug free and live safely. Child M's parents were very unhappy about this and wanted the plan stopped. At this point it was noted that Child M would be applying for a course at an art college in East Sussex and the consultant would write letters to the college and the local drug advisory services and CAMHS team in East Sussex seeking accommodation and a support package in the community in East Sussex. As noted above, the local authority social care service in Surrey had no involvement. The social care service in East Sussex had also not been involved or consulted and only became involved when Child M was referred by local services.

3.82 Other than noting that this plan resulted from constant pressure from Child M and her insistence that it was what she was going to do, no specific rationale has been offered as to why or how this plan developed. Section 4.8 provides an evaluation of this period of service provision.

<u>Discharge from the Priory Hospital and establishment of a package of support services in East Sussex</u>

3.83 On 30 August 2011 East Sussex social care received a copy of the recent CPA meeting minutes from the Priory Hospital.

[15] Section 17 allows the doctor in charge of the patient's care to authorise periods of home leave to support the aims of the treatment plan.

3.84 On 2 September 2011 Child M was interviewed for a college place in East Sussex. She was presented as an ordinary student; it was left to Child M to tell the college that she was a psychiatric inpatient and had been escorted by two members of hospital staff. Child M acknowledged that she had 'severe anxiety', and agreed that the college could contact the hospital for more information. The college subsequently obtained a considerable amount of background information in order to be able to put appropriate support arrangements in place. At this point it was not clear to the college that Child M had a 'relationship' with Mr C who had already been offered a place at the college. Nor was it clear to the hospital or any of the other professionals involved that Child M's first contact with the college had been as long ago as April 2011.

3.85 On 6 September 2011 the Priory Hospital multi-disciplinary team agreed the plan for Child M to move to East Sussex. This was to commence with a trial period of one week's leave under Section 17 of the Mental Health Act at Mr C's address (also in East Sussex). A letter from the parents was read out in which they expressed concern that the plan would leave Child M at risk. The CAMHS worker from Surrey was also noted not to have been in agreement with the decision. It was agreed that referrals would be made to services in East Sussex. The targeted youth support service, social care and CAMHS representatives would be invited to the next planning meeting. Child M was expected to attend college and demonstrate that she could live independently. A member of the Priory Hospital staff inspected the accommodation and described it as 'appropriate', though it is not clear what this meant, and Child M agreed to contact the hospital every day and to undertake a drug screen on her return (which proved to be clear).

3.86 The following day the Priory Hospital referred Child M to East Sussex CAMHS which requested a full CPA assessment and risk assessment before it would accept the proposed transfer of care.

3.87 Child M had leave on 7 and 8 September 2011 in order to attend college. Subsequently she pre-empted attempts to seek more suitable accommodation and plan her discharge by failing to return to the hospital on the evening of 9 September. The hospital asked the police to visit her and consider removing her to a place of safety using powers under Section 136 of the Mental Health Act 2007. However this was not possible as this provision only allows for the detention of someone who is apparently mentally ill and an immediate risk to themselves or the public, whereas the police found Child M apparently 'safe and happy'.

3.88 On 9 September 2011 Mr C was sentenced to a Community Order for 9 months with a supervision requirement for 9 months and a Drug Rehabilitation Requirement for 6 months. He had pleaded guilty to four offences of possession of drugs, in connection with the incident on 11 April 2011. A psychiatric report prepared for the hearing had accepted Mr C's account that his offences had occurred during a period of relapse but that he was now abstinent from illegal drugs. The intention was that the low-intensity drug rehabilitation programme would focus on relapse prevention. He had previously been assessed for his suitability for a Drug Rehabilitation Requirement as part of the pre-sentence report being prepared by Thames Valley Probation Trust.

3.89 It appears that this recommendation was made without those concerned having knowledge of the plan for Child M to live with Mr C in East Sussex. Subsequently he barely attended

the college. The Crime Reduction Initiatives (CRI) substance misuse service in the local area tried to work with Mr C until 4 January 2012 when he ceased attending.

3.90 The Priory Hospital held a further planning meeting on 13 September 2013 attended by the full range of professionals who would be involved in assessing and managing risk once Child M had moved. Sussex Police provided information about Mr C's convictions. Further plans were made for support from substance misuse services and the local authority agreed to commence a core assessment to provide an overview of Child M's needs and potential risks. It was planned that Child M would attend college regularly and that this would assist in monitoring her well-being. The plan for her to move to East Sussex was not reconsidered. Child M was granted a further period of leave.

3.91 It was noted that a Mental Health Act Review Tribunal would be held in the next few days which might enable Child M to leave the hospital immediately. The tribunal discharged Child M's detention, but decided to defer her release until there had been further time for planning of services.

3.92 On 18 September 2011 Child M failed to contact the hospital and the police were asked to make a welfare check. Records show that she was found to be well and the Priory Hospital allowed her to continue her leave.

3.93 On 20 September 2011 Child M was admitted to the local District General Hospital in East Sussex for an overdose of an opiate-based pain killer which had been prescribed to Mr C. Evidence suggested that significant amounts of medication had been observed by ambulance staff on the premises with no arrangements for their safe storage. Child M was transferred back to the Priory Hospital on 22 September 2011.

3.94 Mr C gave an account of the circumstances of this overdose to his probation officer who felt that it 'lacked credibility'. The probation officer noted the need to obtain full details of Child M's 'partner' at their next supervision session. Her ability to respond effectively was reduced because she had not been involved in the multi-agency planning in relation to Child M.

Comment
The acute hospital treatment of Child M focused exclusively on her immediate medical needs at this point and on ensuring her safe return to the Priory Hospital where she was an inpatient. This meant that the safeguarding concerns about Child M and Mr C's behaviour (taking overdoses, considering where and how he kept his medication, consideration of whether agencies were aware of the age difference between Mr C and Child M and her potential vulnerability) were left to the Priory or other agencies to explore.

It is clear that at this stage, while Child M was in the process of being discharged from the Priory Hospital to services in East Sussex, there was no identified lead professional who could ensure that there was an overview of Child M's needs.

3.95 Child M attended college consistently for about two weeks. By the end of September, discussions were taking place about her poor attendance and her erratic behaviour which was in turn withdrawn and then aggressive.

3.96 On 2 October 2011 Child M's parents contacted the Priory Hospital to restate their concerns about Child M being discharged to unsuitable accommodation. It appears that

Child M's sister had visited the accommodation in East Sussex and, seeing how she was living, was very concerned.

3.97 On 3 October 2011 the probation officer contacted Surrey's Contact Centre formally seeking background information about Child M and Mr C and was told that there was no authority to share the information. On 5 October 2011 the officer followed this up with a faxed letter which was passed to the local social work team. In response, she was phoned back with the information that Surrey Children's Services had never carried out an assessment of the risks posed to Child M by Mr C.

3.98 The probation officer then completed an initial assessment on Mr C on the OASys system.[16] She identified that Mr C's girlfriend (then aged fifteen) had been present at the time of his offences and therefore that there was a risk of serious harm to her. The assessment noted that Mr C expected Child M would be moving in with him as soon as she finished her treatment at a rehabilitation centre. Their history of drug use together was noted, beginning with Mr C supplying Child M about a year previously. Mr C was assessed as being a 'high risk of serious harm to children' and to a specific person (Child M). The Risk Management Plan included reference to the history of sexual relationships with a minor (Child M), his admission of supplying drugs to Child M when she was a minor, his history of depression, anxiety and psychotic episodes (he was in receipt of medication under the care of the mental health team in Buckinghamshire) and his history of suicide attempts, including attempts made in the presence of Child M. The risk management plan included liaison 'with social services and police in relation to any future concerns regarding child protection/risks to partner'.

3.99 Section 4.13 of this report reviews the joint working of adult services, including probation services, and children's services.

3.100 Between September 2011 and January 2012 Mr C was viewed as having cooperated with his community punishment, attending 17 appointments with probation staff and a further 13 appointments at the CRI drug project. The probation trust says that '*while he did miss some appointments there were acceptable explanations for nearly all of these'* and that '*while he tested positive for opiates on a number of occasions, he explained that this was due to prescribed medication. Once this was changed by the GP the drug tests ceased to be positive'*. Mr C admitted to relapsing into heroin use for a short period in January 2012.

3.101 The effectiveness of the supervision and monitoring of Mr C is evaluated in Section 4.10 of the report.

3.102 The final CPA meeting on Child M was held at the Priory Hospital on 4 October 2011. It was attended by a college representative, East Sussex children's social care and CAMHS professionals from East Sussex, CAMHS and substance misuse professionals from Surrey and staff from the Priory Hospital. It was noted that Mr C's accommodation was not satisfactory and it was agreed that alternative accommodation would be sought at the Foyer (intensively supported and monitored accommodation for vulnerable young people).[17] It was noted that Mr C had been excluded from the college, but Child M

[16] OASys (a brand name) is the probation service's standard system for recording and monitoring risk assessments about supervised offenders

[17] http://foyer.net/about-us/#our-mission

continued to attend. Services from Surrey would cease to be involved. Child M agreed to remain a voluntary patient until suitable accommodation had been found but was later overheard telling Mr C on the phone that she would stay elsewhere for two weeks before moving in with him.

3.103 The social care core assessment was completed that day. In line with the plans made at the Priory Hospital, it identified the need for services which would assist Child M to remain in education, secure more suitable housing, re-establish links with her family and reduce risks from substance misuse and potential mental health concerns.

3.104 As Child M had not returned to the Priory Hospital and there was no practical way of making her do so, she was discharged from its care on 11 October 2011.

Comment
The social care assessment was very thorough and looked not only at Child M's current circumstances but at the history of concerns and the factors that might have triggered Child M's difficulties. In general, there is no evidence that lack of a proper overall assessment or knowledge of Child M's problems and needs contributed to any shortcomings in service provision in this case. At this point, the social worker and colleagues were placed in an unenviable position in that they had had no influence over the plan to allow Child M to live in East Sussex and, in advance of there being any firm evidence that it had placed Child M at risk, no power to disrupt it.

East Sussex: 11 October 2011 – 22 December 2011 (when Child M was admitted to secure accommodation)

3.105 This section of the report summarises the provision made for Child M and Mr C between her discharge from the Priory Hospital and her placement in secure accommodation in December 2011.

3.106 The care plan agreed on Child M's discharge relied on her being found more suitable, i.e. supported and supervised, accommodation. However she did not cooperate in this and throughout this period she lived with Mr C.

3.107 It also relied on Child M attending college. Between October and December her attendance amounted to approximately 30%. On 11 October 2011 Child M agreed a plan to improve her poor attendance, lack of communication and erratic behaviour. Child M agreed that she could not be on campus whilst under the influence of drugs or alcohol, that she would keep appointments with all agencies and that Mr C would not come into campus. Other agencies were made aware of the additional supports available and it was clear that if Child M did not implement the agreements made she risked losing her college place.

3.108 From mid-October Child M's attendance and engagement declined, so that none of the agreed targets were met.

3.109 Plans to provide support by the CAMHS service in East Sussex were hampered because of the way in which Child M discharged herself from the Priory Hospital. However, an assessment was undertaken after she moved to East Sussex and it was planned that Child M would have weekly contact with a CAMHS worker and a monthly appointment with the consultant psychiatrist who would review her medication. During November and December

there was a concern that Child M was taking irregular amounts of prescribed medication, and other drugs and alcohol that were suspected to have been obtained from Mr C.

3.110 On 21 October 2011 the CAMHS worker and the allocated local authority social worker discussed Child M and noted that she was offering minimal cooperation with services. Child M's parents continued to be in contact with services to express concern about how she was living.

3.111 From September 2011 Child M's case had been allocated to an experienced social worker. Both she and her line manager had substantial experience in working with young people with substance misuse problems. On 26 October 2011 the social worker discussed the need for a complex case meeting with her supervisor. Such meetings are convened under East Sussex multi-agency procedures in order to produce a shared risk assessment and action plan, usually for older adolescents who are causing high levels of concern.

3.112 On 14 November 2011 the East Sussex social worker saw Child M at home. In the room she noted evidence of beer cans, prescribed drugs and non-prescribed Diazepam which Child M reported taking (up to 60mg) at least three times per week.[18] The worker spoke to Child M about her history and reasons for taking drugs, the dangers of mixing drugs with alcohol and the dangers of overdose. Child M confirmed that she had met with a drug advisory service. After the visit the social worker sought advice and appointments for Child M with the Under 19s substance misuse service doctor because she was concerned about her risky injecting practice and use of ketamine.

3.113 The complex case meeting was held on 18 November 2011 chaired by a senior CAMHS manager and attended by professionals and managers from social care, education support services, the college, CAMHS, probation and drug services. It noted the undesirability of Child M living with Mr C and living in East Sussex. It recognised that the plan that had led to this outcome and the way it had been arrived at were both 'far from ideal', it would be unlikely that Child M could be persuaded to return to Surrey voluntarily and at this point there was no legal mandate that could be used to force her to do so. The meeting took a number of sensible, practical decisions to identify any additional risks to Child M, for example by undertaking basic police checks on those known to be living in Child M's house.

3.114 The meeting agreed that all of the agencies needed to continue to be involved, to gather background information from agencies in Surrey in a much more systematic way, to continue to share information about risks to Child M and work with both Child M and Mr C. The chronology notes an agreement to clarify which agency would be the lead service, comparable to being the lead professional, and subsequent notes show that the CAMHS worker had been allocated responsibility for coordinating work on the case.

Comment

This was a well-attended meeting which brought relevant agencies together to share and evaluate information and to identify gaps in knowledge. The only involved agency not invited was the CRI agency providing the substance misuse programme for Mr C. The meeting triggered a higher level of concern and inter-agency working. There was a clear professional perspective that Child M was a

[18] A normal adult dose for dealing with anxiety would be 2 to 10 mg two to four times a day http://www.drugs.com/dosage/diazepam.html

child who needed to be protected from an adult who posed risks to her, albeit that she needed to be engaged in services and to cooperate in order for that to happen. In general, and particularly after this meeting, the arrangements for information sharing between agencies in East Sussex worked well. Subsequently information sharing across agency and geographical boundaries proved to be more problematic. The reasons for this are set out in detail in Section 4.15.

3.115 From this point on, the level of information sharing between probation and social care about risks to Child M increased. However, it does not appear that any of the professionals involved made clear to Mr C or Child M how they were working together or the framework within which they were sharing information.

3.116 Professionals continued to work with Mr C and Child M separately but following a supervision session in December 2011 the social worker proposed a meeting involving Child M and Mr C and the probation officer to present them with a clear account of the concerns and the steps that might be taken to safeguard Child M.

3.117 On 21 November 2011 the local authority social worker saw Child M and explained her view that it was not in her best interest to be living with Mr C in East Sussex and that she should consider returning to be nearer her parents in Surrey. Child M became angry and threatened to disengage from services altogether. The social worker discussed Child M's overdosing and fear of dying. She felt sufficiently concerned about Child M's comments and feelings that she discussed the interview with her manager.

3.118 On 24 November 2011 the probation officer noted that she had still not received background information or a chronology of events from Surrey CAMHS or social care. This was because the trust was waiting for a written request. She liaised with the social worker to inform her that one of the individuals with whom Child M and Mr C were sharing accommodation was known to have serious alcohol problems, which was seen as adding to the risks to Child M.

3.119 On 28 November 2011 Child M threatened to break off contact with the CAMHS worker stating that there had been inappropriate information sharing between children's services and probation and that the services 'just wanted her to go back to Surrey'. She refused to consider moving to more supported accommodation. Child M's mother told the CAMHS service that she feared that Child M was self-harming.

3.120 The Sussex CAMHS records note that the service had still not received information from Surrey CAMHS and the service manager had to write to request this urgently. This suggests that there had been a misunderstanding on the part of the two services about what needed to happen in order for the information to be provided. This was one of a number of examples of services taking a long time to share information or copies of documents with colleagues in other local authority areas. This is discussed in Section 4.14.

3.121 On 5 December 2011 the college held a meeting, which Child M did not attend, to monitor her further deteriorating behaviour and attendance. During December Child M missed further meetings to discuss her continued attendance. On 14 December she withdrew from the college as an alternative to having her place withdrawn. It was agreed that before

signing on to any further programme she would need to provide proof of at least two clear drug tests.

3.122 On 7 December 2011 Child M took an overdose which led to her being taken to the local hospital Emergency Department. She absconded but was readmitted on 9 December 2011. Child M collapsed in the waiting room of the CRI drug treatment service being attended by Mr C, after using substances that had been in his possession.

3.123 Staff at the CRI project informed other agencies about the incident. Mr C gave the probation officer a misleading account of what had happened and denied that it had involved the use of his medication.

3.124 Social care and CAMHS liaised in order to undertake a risk assessment. Child M's mother was informed and requested her readmission to the Priory Hospital. The assessment identified a high level of risk because Child M appeared to be lacking any insight or motivation to stop using substances. A further mental health assessment was arranged to determine whether Child M should be dealt with by mental health or drug services. This established that Child M was not suffering from a mental illness but that there was a significant risk of harm through accidental overdose. Child M was judged to have the mental capacity to decide on her own living arrangements and lifestyle, even if her choices created a degree of risk.

3.125 Shortly after this, CRI identified that Mr C had been using the needle exchange and injecting heroin and ketamine. At this point the needle exchange operated a confidential needle exchange service so that even though staff in the same organisation were in contact with Mr C they did not know that he was an injecting drug user. This policy subsequently ceased. This raised immediate concern about whether Mr C was injecting Child M and also her ready access to large quantities of Mr C's prescription medications. From this point, there was sharing of information about the current risks between CRI and the social worker.

3.126 On 14 December 2011 a further complex case meeting was held, chaired by a senior manager from the local authority and attended by front-line staff and managers from Sussex Probation, CAMHS, the local authority U19s Substance Misuse Service, Community Mental Health Nurse, children's social care and the college.

3.127 There was a suggestion that the care plan at this point needed to include daily monitoring of Child M by social care and CAMHS in order to safeguard her. Subsequently, more senior managers in the local authority determined that given the previous overdoses the level of risk was too great to manage in this way and decided that an application should be made for secure accommodation. In order to facilitate this, Child M was taken into police protection, an emergency power under the Children Act 1989, and placed in the Secure Unit managed by West Sussex County Council.

3.128 A hearing for a Secure Order and an Interim Care Order (ICO) was held on 19 December 2011. Child M was legally represented and actively opposed the orders while her parents supported the local authority. The Secure Order was granted but not the ICO because of the court's desire to fully explore the different legal viewpoints that had been presented in court.

3.129 The ICO was made on 22 December and it was subsequently determined that Child M had been unlawfully detained for the intervening two days. This led Child M to be awarded a compensation payment of £7500 which she was due to receive at the age of 18. This proved to be an important consideration because Child M's thinking about her options as she approached her 18th birthday appears to have been shaped by her assumption that she would receive this payment in a lump sum and could make choices for herself without relying on the local authority. At the same time, the local authority was concerned that Child M might 'blow' this substantial sum of money if she received it in one go and at the time of her death was considering whether provision could be made for payment to be staged.

Secure accommodation: December 2011 – March 2012

3.130 Child M was detained in secure accommodation between 22 December 2011 and 6 March 2012. She was generally compliant with the unit's regime and engaged, albeit they felt superficially, with her social worker and the Under 19 service substance misuse worker during their regular visits. Discussions focused on her future care plan and the strategy of finding her supported accommodation and on her substance misuse, reducing the risk of taking drugs and, particularly, the risk of overdosing. Child M's request for contact with Mr C and his mother was refused.

3.131 On 4 January 2012 Mr C told his probation officer that he anticipated living with Child M when she left the secure unit. He moved back to live with his mother at the end of January 2012 and responsibility for supervision of his community punishment was transferred to the Thames Valley service. The transfer review stated that Mr C continued to be assessed as posing a high risk to children, namely his partner Child M, through the supply and use of Class A drugs. The timing of Mr C's move, a few weeks prior to the end of his community order, and delays in referral to services in the new area had a disruptive effect on his engagement with substance misuse services and, although he subsequently attended probation appointments in Thames Valley, he never properly engaged with the substance misuse service there.

3.132 Initially Child M refused education (though later she agreed) and she refused to go with escorts to attend a CAMHS session. In mid-January Child M's parents visited though the meeting did not appear to go well. The looked after child health assessment took place on 17 January 2012. Child M provided information about her health and use of drugs, much of which was at odds with other information that the doctor and nurse had available to them from agency records

3.133 On 17 January 2012 the County Court renewed the ICO and the Secure Order. At the hearing Child M made allegations of longstanding physical abuse and domestic violence in her family. Both parents denied this and have consistently done so. The court granted the Secure Order and Child M was transferred to the Secure Unit in East Sussex, where there was now a vacancy. There was a further health assessment, reviewing the range of medications that Child M was receiving and a care plan was agreed. At this unit Child M settled well and started to engage in the education provided.

3.134 In mid-February the social work team explored with Child M where she should move to on leaving the secure unit and referred her to CRI Connexions which explored further

education or training opportunities. CRI Connexions arranged for Child M to start another training programme.

Provision of support in the community: March – April 2012

3.135 On 5 March a Secure Order review, held by the local authority but chaired independently, determined that Child M no longer met the requirements to stay in secure accommodation and that arrangements for alternative accommodation should be made. Shortly after Child M moved to supported lodgings, i.e. semi-independent accommodation in the home of a very experienced carer. The intention was that Mr C would not know where Child M was living.

3.136 The social worker kept in regular contact and arrangements were made for Child M to begin an 'opt-in' part-time education programme in order to help her get back to more full-time education. She was helped to attend CAMHS appointments. Child M received further advice on substance misuse. It was agreed that she would be offered accommodation at the Foyer, which could provide independence with a good level of professional support at hand, if she could remain drug free for four months.

3.137 By mid-March 2012 professionals in East Sussex had concerns that Child M was using drugs again. It is now known that on 15 March 2012 Child M attended the needle exchange service in Reading, posing as a 19 year old and giving a false account of her history of heroin use. This attendance was not known to professionals in East Sussex.

3.138 After Child M had been reported missing, Thames Valley Police found her at Mr C's home address and returned her by train to Sussex. Her mother was again concerned and again asked for her to be readmitted to the Priory Hospital.

3.139 On 20 March 2012 Child M was arrested for being drunk in the street. No charges followed this incident. CAMHS and social care staff noted further signs that Child M had self-harmed by cutting again. Subsequently she went missing again and missed the first day of her planned education programme. She also missed social work appointments. She saw her CRI Connexions worker and complained that she was unhappy with aspects of the care plan, though these were not recorded specifically.

3.140 On 24 March 2012 Child M went missing again and was again returned by train. In a meeting with her social worker on 27 March 2012, Child M's request to have overnight stays with Mr C was refused.

3.141 In the 8 days following this Child M went missing on a number of occasions in order to spend time with Mr C and take drugs. She was returned to her placement after being found, usually by being given a travel warrant and put on the train.

3.142 On 3 April 2012 Child M and Mr C were arrested by Thames Valley Police in possession of significant amounts of diazepam. They appeared to have a prepared story that he was an addict, the drugs were his prescribed medication and any amount above that belonged to Child M. This account was accepted by the police having taken advice from a medical advisor that it was plausible. Child M was unwell and was taken to hospital. She tested positive for 10 different banned substances but refused to be observed or treated further in hospital. She was too incoherent to be interviewed by a social worker. As a result, Child M was taken into police protection and then returned to the care of East Sussex social care.

Given the level of risk, the Director of Children's Services agreed that she should be placed in secure accommodation for a period of 72 hours pending full consideration of the circumstances.

3.143 The legal advice of the local authority was that because of Child M's age there were limited grounds to seek a further Secure Order. Child M would shortly be 17 and such an order can only be made in relation to a young person of 17 if the person is already the subject of a full Care Order. In order to enable the Secure Order application to be made the local authority, with the support of the Children's Guardian and the parents, made an application for a Care Order.

3.144 On 11 April 2012 Mr C had an appointment with the substance misuse service in his local area. He disclosed being depressed since the age of 14 years and becoming a habitual user of antidepressants at age 16. He admitted an extensive history of substance misuse and a history of self-harm and suicidal gestures. Over the following months Mr C was in touch with both mental health and substance misuse services, attending some appointments but missing many others. He did not take up the treatments or advice given by either service in a consistent way. These services were unaware that his partner was under the age of 18.

3.145 On 16 April 2012 the Care Order was granted. The Secure Order application was adjourned for a week. Arrangements were made to transfer responsibility for Child M's case within East Sussex to an experienced social worker in the Leaving Care Team. This took place on 26 April. In the meantime, Child M missed a number of appointments with her existing social worker. After the court hearing there were further attempts to engage Child M in an education programme.

3.146 At the request of East Sussex County Council, Thames Valley Police agreed to issue Mr C a Child Abduction Warning Notice under Section 49 of the Children Act 1989. This informs the person that they may be arrested and prosecuted if they continue to associate with the child.

3.147 This was possible because this legislation is designed to prevent the removal from care of young people who are up to the age of 18 when the young person is subject to a Care Order. Other than allowing the court to consider the Secure Order application, this was the most significant practical change resulting from the granting of the Care Order. The fact that the court had not granted the application for the Secure Order meant that although East Sussex was legally responsible for Child M the authority did not have the power to detain her.

3.148 The Notice was served on Mr C by Thames Valley Police on 27 April 2012. Thames Valley Police noted that a warning marker was placed on the Police National Computer (PNC), though it was subsequently noted that the marker was only on Mr C's PNC entry. There were a number of administrative aspects of the way in which details of the Notice were recorded which made it harder in practice for the police to recognise and act on it. The terms of the Notice were comprehensive setting out in very specific terms that Mr C must not have contact with Child M at all and must, if she initiated such contact, refuse it and alert the police or social care staff.[19] This Warning Notice was breached on numerous

[19] The full terms stated that Mr C must not:

- *'Allow Child M to enter or stay in any other property you are present in*

occasions over the following months; however, no action was ever taken to enforce it. The reasons for this are evaluated in Section 4.18.

Provision made for Child M in the community in East Sussex: April – August 2012

3.149 Child M remained living in her supported lodgings until 13 August 2012 when, as part of an agreed care plan, she moved to similar accommodation in Surrey in order to be nearer to her family.

3.150 For some of this time Child M attended sessions at the college. There was concern that her return to college, arranged via CRI Connexions, had not been pre-arranged with the manager responsible for support services for vulnerable students who had dealt with her during her previous attendance. Once this became clear, a meeting was convened setting out the college's expectations about Child M's attendance and behaviour.

3.151 Child M saw her CRI Connexions worker until 21 June 2012, when she ceased keeping appointments altogether.

3.152 She did not engage with the CAMHS worker and the case was closed to the service at the end of May. Child M was invited to return to the service and provided with contact details, including the out of hours contact numbers.

3.153 She did however see the East Sussex Under 19 Substance Misuse Service worker who had been working with her for some time and during her stay in secure accommodation. She also kept appointments with her allocated social worker.

3.154 During April Child M went missing from her placement on a number of occasions. She claimed to have been staying with friends, including one named young woman whom she had met in a previous placement. She returned after these episodes and there was no evidence of her overdosing or showing adverse effects of substance misuse. As she most frequently went missing in Surrey or nearby, her parents often became involved in returning her to the supported lodgings.

3.155 There is no evidence that during this time Child M had contact with Mr C. Assuming that this is correct, and it is impossible to prove that she didn't, the reasons are not clear.

3.156 Mr C's last contact with Thames Valley Probation Service was on 23 May 2012 and he did not attend his planned final appointment on 8 June 2012. At this time Mr C was attending the substance misuse service in his local area. In late April he took an overdose and failed to comply with drug treatment arrangements which required regular collection of prescriptions. This pattern of contact with the substance misuse service continued throughout the period under review.

- *Allow Child M to enter or travel in any vehicle or caravan you own or are travelling in*
- *Meet with Child M or remain in her presence*
- *Telephone, text, email, write or communicate with Child M in anyway directly or indirectly*
- *Provide Child M with any food, drink, gift or any other item*
- *Mr C must refuse to allow them entry to the property or vehicle and ask them to leave or leave yourself'*

If Child M made contact Mr C was expected to

- *'Contact Social Services or the Police and*
- *Break off any communication*'

3.157 From mid-May onwards Child M attended fewer appointments in East Sussex and told a number of workers that she wanted to move back to Surrey. She missed her looked after health review and said that she would access her GP if she needed assistance or advice.

3.158 On 7 June 2012 Child M went missing for several days after an agreed overnight stay with friends in London. She returned to her lodgings well, but refused to say where she had been.

3.159 On 18 June 2012 Child M's GP saw her. She had taken her own discharge from a hospital Emergency Department where she had attended due to an overdose. It is not clear from the records whether the GP was aware that Child M was a looked after child and he did not communicate with her social worker. Child M told him that she was from Surrey and would be moving back there in August. The GP records contained little health information from the secure units, CAMHS or the Under 19s Substance Misuse Service.

Comment
The lack of feedback from specialist substance misuse services to GPs is a commonly noted concern, especially in relation to the progress of treatment and attendance.

3.160 At the end of June 2012 Child M's social worker sought information and advice from Surrey County Council about supported living schemes in Surrey. Information about the range of resources was provided.

3.161 During the preceding weeks Child M had been spending more time with members of her family, either on officially sanctioned visits or making contact with her family after going missing. Family relationships appear to have been better. The family were diligent in informing social care when they had had contact and by returning Child M to her placement after contacts. Child M also started to consider how she might find training or further education if she did move back to Surrey. In early July 2012 Child M went on a short family holiday.

3.162 On 11 July 2012 the looked after child (LAC) review meeting sanctioned the decision for Child M to move back to Surrey, in line with her strongly expressed wishes. Child M's social worker had made a referral to a supported accommodation provider in Surrey, having had discussions with his manager. Social care staff emphasised the need for Child M's behaviour to continue to be more settled in order for such a move to have any chance of success. An introductory visit was made on 31 July 2012. Child M also visited local accommodation, provided by the organisation Foyer, with a view to moving there in the longer term to assist a move to fuller independence.

3.163 On 13 August 2012 Child M's social worker helped her to move into the supported lodgings placement and an agreement setting out expectations about Child M's stay was signed with the provider. The records show that the social worker had a frank discussion with the service provider and her supervising support worker about the risks and potential concerns. No contact was made with the local authority in Surrey to notify the local authority of the placement, which should have happened as Child M was in care.

3.164 Subsequently the social worker made a referral with background information to the substance misuse service, Catch22, and to Surrey CAMHS, both of which had worked with Child M previously. Child M also registered with a local GP. The referral to Catch22 was

supported by information from the substance misuse worker in East Sussex which indicated the extent of Child M's substance misuse as being 'minimal drug use of ecstasy and alcohol' reflecting her known recent use and mentioned a history of heroin, depressants and other opiate use.

Service provision made during August 2012 to January 2013 while Child M was living in supported lodgings in Surrey

3.165 Initially Child M appeared to be settling well in the accommodation. Her parents were seen at the beginning of September 2012 by the parenting support worker from the Surrey YSS, who had continued to make periodic visits throughout the time that Child M had been living away from home. Child M was visited by her allocated social worker on 13 and 20 August 2012. The dates of further visits that Child M received from her allocated social worker are listed below. The frequency of these exceeded the statutory requirement, i.e. at least once every six weeks.

3.166 On 17 September 2012 Child M saw the Surrey CAMHS Psychiatrist. It was agreed that there would be further assessment, particularly of the need for further medication. Historical information was sought from the Priory Hospital. The psychiatric assessment was completed on 8 October 2012. Changes were made to Child M's medication and prescribing arrangements were made with the GP. Subsequently Child M attended monthly appointments to review her medication but she did not want to engage in any type of therapeutic support. Information received from the substance misuse worker in East Sussex reported Child M's current, believed to be low, level of substance misuse, rather than the historically higher levels.

3.167 The Catch22 worker was unable to contact Child M at this point because it appeared the service had incorrect contact details.

3.168 At the LAC review held on 28 September 2012 Child M expressed her wish to move into her own flat, but this was not agreed because the view was taken that she still needed a high level of support.

3.169 A further placement review was held by the social worker on 26 October 2012. It was noted that Child M was developing more of the skills required for independent living. It was not clear from the records, but according to Child M's parents, at this time she was volunteering in a local education project in the hope of getting a permanent job. However she found that she could not be given a job because of her criminal record. Child M was said to have been bitterly disappointed by this and then even more so when she failed to get a job in a fast-food outlet.

3.170 On 19 November 2012 Child M began attending a 12 week programme at the Prince's Trust, including a residential course and a number of work experience and volunteering opportunities. She was very motivated and had to get herself up at 7.30am every morning. Child M attended an average of 80% of the daily sessions and her attendance improved as the course progressed. Later enquiries by the social worker reassured him as to the improvement in Child M's condition because the project staff, who were seeing her daily, reported that there had been only one occasion when they had noted possible symptoms of drug misuse. Child M was popular on the programme and engaged in discussions about future career and training options.

3.171 On 27 November 2012 Catch22 closed their records as Child M had not responded to attempted contacts.

3.172 The following day Child M's mother phoned her social worker expressing her fear that Child M had been seeing Mr C again and that her sister believed that she could be using drugs. In response the social worker phoned Thames Valley Police to discuss the circumstances and recorded that he emailed a copy of the Child Abduction Warning Notice to the police on 29 November 2012. There is no record of this contact in the police records. This is evaluated further in Section 4.18.

3.173 On 30 November 2012 the social worker undertook a statutory visit to Child M who denied that she was seeing Mr C.

3.174 Thames Valley Police did not act on the update about the Warning Notice but did have contact with Child M on 8 December 2012 when Child M was found outside a club in Reading heavily under the influence of drugs. Child M's father collected her from the police station. This led to an information sharing report to the Reading Multi-Agency Safeguarding Hub on 10 December 2012 which was forwarded to Surrey social care and then on 12 December 2012 to East Sussex social care.

3.175 On 19 December 2012 a looked after review was held at Child M's placement. She again denied seeing Mr C. At the review it was agreed that she could spend up to three nights a week staying with friends as long as she provided a list of their names and addresses. The review agreed that there should be a risk assessment in place, that Child M would continue to develop her independent living skills and that the Pathway Plan needed to be completed.[20] Provisionally it was agreed that Child M would move into a flat in January 2013. It was noted that the Warning Notice was in place to prevent any contact with Mr C.

3.176 Child M spent Christmas with her family.

3.177 On 3 January 2013 the social care records contain reference to a discussion about two supported accommodation options, at the request of Child M. These were in a town nearer to her family home. They were not accepted by the local authority Operations Manager on the basis of cost and the fact that Child M would be 18 years of age in four months.

3.178 Following this there is an unusual three week gap in the chronology of agency contacts with Child M. However it has been established that for all of this time she was attending the Prince's Trust programme.

<u>Services provided to Child M between January 2013 (when she moved to live in Bed and Breakfast) and her death</u>

3.179 On 24 January 2013 Child M was brought by ambulance to the Emergency Department of the main hospital in Reading. She had taken an overdose of heroin and diazepam in the company of Mr C who had called the ambulance. Child M was assessed and treated overnight and referred to the adult mental health service which assessed her. She was adamant that the overdose had been accidental and that she had no desire to self-harm and no suicidal ideas.

[20] Each looked after child has a Pathway Plan to map the services that will support growing independence, normally drawn up at the age of 15 or 16.

3.180 The following day, after further consultation with the mental health service, Child M was discharged on the basis that she would be keeping a planned appointment with a doctor (possibly the Surrey CAMHS service though the details are not clear) later that day. The hospital notes also record that ward staff intended to contact Child M's social worker to notify him of the admission. In fact Child M did not have a planned appointment that day. The hospital staff did fax details of the admission to Surrey CAMHS but did not contact her social worker. He later spoke to the hospital once he had become aware of the admission.

Comment

Although the hospital could not have detained Child M if she had wanted to leave, it is a concern that the hospital discharge arrangements relied so heavily on her own assurances about the professional support network and that no attempt was made to contact the local authority before allowing Child M to leave. This is recognised in the agency's management report. The hospital did not establish that Child M was a looked after child. The reasons why the hospital did not take the course of action it had planned to are not clear. The SCR has commented in Section 4.15 on the vulnerability of adolescents who present at hospital away from their home local authority area and the need for professionals to be mindful of this.

3.181 By coincidence, the allocated social worker was making a visit to Child M's placement on the same day. During the course of this visit details of the overdose and admission emerged and Child M also stated that she had been admitted to hospital the previous weekend, i.e. 19-20 January, at a hospital in the town where Mr C lived. Details of this admission have never been established and the town concerned does not have a hospital with an A&E department. Child M may however have been admitted or treated elsewhere under a different name.

3.182 During the course of the visit it was reported that Child M had been staying away for more than the three nights agreed in her care plan. She admitted using heroin recreationally and she described injuries caused by a ligature round her neck. Child M said that these injuries had caused her admission; however the hospital had no record of them. Child M's social worker recorded that he had seen red marks on her neck but no convincing explanation was ever given as to how they had been caused. It was confirmed that Mr C had visited the accommodation in breach both of agreements made with Child M and his Warning Notice. It also emerged, though there are no specific details, that Child M had behaved angrily towards another resident who had a baby. During the course of the discussions Child M became very angry and started to smash items in her room, leading to the police being called.

3.183 After discussion with a senior manager, the local authority decided that it was necessary to end the placement. Taking into account Child M's refusal to return to East Sussex where it would have been possible to provide supported accommodation more quickly, the local authority decided to move Child M as an interim measure to bed and breakfast accommodation in a nearby town in Hampshire, while a new placement was identified. The notes state that a risk assessment was completed. This identified the risk of further contact with Mr C which would, on the basis of experience, lead to risk of further overdoses. Child

M's parents were informed of the events and decisions as were Surrey Police, the CAMHS consultant and the accommodation provider.

3.184 While reporting the incident, the social worker made Surrey Police aware of the background, giving details of Mr C, the recent events and the Child Abduction Warning Notice served by Thames Valley Police on 27 April 2012. Child M's father also contacted the police and was recorded as having provided a full account of her drug use and current heroin addiction. He also explained to the police that Mr C had been served a Child Abduction Warning Notice but that he feared that Child M was back in contact with him and that he was supplying her with drugs. Child M's father provided confirmation of the social worker's contact details. Child M's father was advised to keep a log of suspected contact with Mr C and told that the report would be shared with Thames Valley Police who could take action regarding the Child Abduction Warning Notice and that information would also be shared with the police in Sussex and Hampshire. They discussed the fact that Child M would receive her compensation payment once she turned 18. The officer involved and the father have differing recollections as to the advice given by the officer and whether the proximity of Child M's 18th birthday meant that risks to her were taken seriously.

3.185 The information was reviewed by a Surrey Police public protection unit supervisor and an intelligence report was compiled. It was not shared with the relevant police forces. Surrey Police have been unable to explain why what happened (because the staff and officers concerned process large numbers of intelligence reports each day and do not record the individual decisions). This has been acknowledged as an error. It is also clear that the police did not consider that it was possible to act on the Warning Notice. This is considered in Section 4.18.

3.186 Surrey Police did notify the local authorities in Surrey and Reading of these events using the normal arrangements for the notification of a young person or child at risk (known by agencies in Surrey as a form 39/24), linking Child M's current risk back to the first very serious incident in April 2011. Neither authority took any action as Child M was the responsibility of East Sussex, and was also no longer living or staying in either local authority area. The Reading local authority manager noted that law enforcement issues in relation to Mr C would need to be dealt with by the Thames Valley Police.

3.187 On 28 January 2013 Mr C attended the drug service in his local area, where he tested positive for opiates. This was the latest in a line of appointments with the service which Mr C had attended since early 2012. At these appointments he had been prescribed medication as part of treatment plans to which he had repeatedly failed to adhere. On this occasion he explained his positive opiate test by saying that he had used a pain killer 'accidentally'. He stated that he and his 'girlfriend', whose age he never mentioned, had befriended a family who did not use drugs. There is no evidence that any of this was true. This pattern of attendance at services without meaningful engagement or compliance in treatment plans continued until 5 March 2013, the last reported contact in the period under review.

3.188 The same day Child M was seen by her psychiatrist in Surrey. He noted that Child M was disengaging from services and that this would increase her level of risk. He shared these concerns with Child M's social worker on 31 January 2013. By then the social worker had

had a concerning phone contact with Child M during which she had stated that she wished that she and her family were 'all dead'.

3.189 The social worker consulted the Independent Reviewing Officer to arrange an early LAC review, but he was advised that this would not be necessary as there was no change in Child M's care plan.

3.190 When the social worker next spoke to Child M on 5 February she sounded in a much better frame of mind and talked about her training course at the Prince's Trust. This reduced his level of concern. On 7 February 2013 Child M's social worker visited her at the hotel. His judgement was that it was of a good standard, though it was recognised that it was not ideal that she was living in bed and breakfast accommodation.

3.191 On 11 February 2013 Child M missed an appointment with the CAMHS psychiatrist which was rearranged for 21st February. She attended this session and spoke positively about her plans to move to Bracknell. The only service that she wanted from the session was a further prescription. A follow-up appointment was scheduled for 31 March 2013.

3.192 On 15 February 2013 the allocated social worker emailed the local authority legal service in order to establish whether there was any means of delaying or staging the compensation payment due to Child M on her 18th birthday because of the risk of her spending it on drugs and the risk of overdose. This was not clarified before Child M's death.

3.193 On 17 February 2013 a specialist LAC Nurse in Surrey received an email informing her that Child M had been placed in Surrey. She ascertained that Child M's immunisations were up to date and, as there had been no request from the allocated East Sussex social worker for any health input from the LAC Team, Child M's records were returned to the child health department for archiving. On about this date Child M's mother discussed recent events and concerns with a Surrey police officer who she encountered socially. The officer completed an intelligence report which was processed by Surrey Police but again not shared with Thames Valley Police.

3.194 On 22 February 2013 Child M's attendance at the Prince's Trust ended. Child M contributed positively to the 'graduation' event. Mr C attended the event. This was not seen as significant by the programme staff because they did not know that the 'couple' were not supposed to be in contact. The course organiser understood that Child M planned to investigate whether she could return to college to study art again, though there is no evidence that she made any enquiries before her death.

3.195 On 6 March 2013 the local authority social worker had supervision with his practice manager and told her that he had been sent copies of recent photographs taken of Child M and Mr C together at the bed and breakfast accommodation, confirming the continuing contact and the risk of further overdoses. As a result, on 7 March 2013 the social worker notified Hampshire Police that Mr C and Child M were believed to have been in contact and asked the police to make a visit to check on her well-being. The social worker mentioned the existence of the Children Act Section 49 Warning Notice. Hampshire Police visited but were unable to locate Child M.

3.196 The following day (8 March 2013) the social worker had phone contact with Child M whose voice was noted to be slurred. She expressed concern that the B&B was closing. The social worker later phoned the Prince's Trust and recorded that Child M was at the project. He noted that the staff at the project believed that Child M had only appeared 'under the

influence' on one occasion during her regular attendance over the previous three months. Staff who worked with Child M at the Prince's Trust have no specific recollection of seeing Child M that day, but say that it was not unusual for students to return after programmes had finished to complete work or collect documents. The local authority social worker informed the police and later had further phone contact with Child M agreeing with her and her parents that she would visit the family home the following weekend.

3.197 The social care notes of the contact with the police indicate that by informing Hampshire Police of the existence of the Warning Notice the social worker was anticipating that some action would be taken. The police did not have this understanding and closed their current involvement as soon as it was reported back that Child M had been found and was safe.

3.198 On Monday 11 March 2013 the social worker contacted Child M's mother and also spoke to Child M who was still at the family home. The notes indicate that the weekend visit had gone well and Child M's parents appeared to be well informed about what was going on with her. Child M again stated her concern that she might have to move to different accommodation as the hotel where she was staying was planning to close on 1 April 2013. In the meantime, it was not preparing food for her and she was being given £5 per day in order to buy food.

3.199 The social work notes indicate that the hotel kitchen had closed. The social worker believed that because of planned building works Child M would be moving a short distance to another building. He did not record the need to take any action. This was his last contact with Child M as he took planned annual leave at that point.

3.200 There was no further recorded professional contact with Child M between this date and her death on 16 March 2013.

4 EVALUATION OF THE SERVICES PROVIDED FOR CHILD M AND HER FAMILY

4.1 Introduction

Focus of the evaluation and list of topics covered

4.1.1 This section of the report addresses the aspects of practice that offer the most important opportunities for learning and service improvement, as follows:

- 4.2 The provision of early help by agencies in Surrey from January 2008 to March 2011 and the coordination of the provision made
- 4.3 Allegations of bullying
- 4.4 Substance misuse in the community where Child M grew up
- 4.5 Safeguarding concerns reported to Surrey in April 2011
- 4.6 Admission to the Priory Hospital
- 4.7 Constraints imposed on professional practice as a result of Child M's age
- 4.8 Decision making and planning at the Priory Hospital
- 4.9 Risk assessment on Child M leaving the Priory Hospital
- 4.10 The role of probation services
- 4.11 Substance misuse services for young people
- 4.12 Substance misuse services for adults
- 4.13 Joint working between services focused on adults and services focused on children
- 4.14 Challenges posed by Child M's planned movement across local authority boundaries
- 4.15 Challenges posed by Child M going missing and unplanned movement across local authority boundaries
- 4.16 Use of secure accommodation
- 4.17 Possible use of other legal measures by the local authority
- 4.18 Use of Warning Notices under Section 49 of the Children Act 1989
- 4.19 Evidence of good practice that should be encouraged and supported.

4.1.2 Each section of the evaluation refers back to specific episodes described in Section 3 of the report. Some aspects of the evaluation focus exclusively on specific episodes in the case history. Others address more general themes that may have occurred across a number of episodes. For each aspect of practice, the report evaluates whether the findings are significant in relation to the outcome for Child M and also whether they are of potential importance in relation to the wider provision of services for vulnerable children.

4.2 The provision of early help by agencies in Surrey from January 2008 to March 2011 and the coordination of the provision made

Introduction

4.2.1 This section of the report summarises the findings of the SCR about the provision of early help to Child M and her family prior to March 2011 when very serious and immediate concerns about her safety were notified to local agencies. During this period at least six agencies were aware of different aspects of Child M's problems and involved at different points: her school, the CAMHS service, a school-based counsellor, the Youth Support Service (which fulfils the responsibilities of the Youth Offending Team) and Surrey Connexions Youth Worker, Catch22 and Surrey Police. The local authority social care service also received eight contact notifications. There is evidence of considerable effort being made and good individual work by the professionals involved with Child M. However, the lack of coordination made services less effective than they might have been.

Coordination of early help

4.2.2 The school records are limited and focused on behavioural and educational concerns. The school did make referrals to involve other agencies when problems were identified, particularly Child M's substance misuse. However, once more specialist agencies became involved there is little evidence that they fed back information to the school. As a result, the school did not know about the full extent of Child M's difficulties (or did not include that information in its records). Despite Child M's attendance remaining at a reasonable level until her final year, the school was not used as a focus for coordinating information about concerns or action to support Child M.

4.2.3 Information indicating that Child M was bullied at school is considered separately in Section 4.3.

4.2.4 Child M's difficulties were not straightforward. At times there appears to have been genuine improvement reported, such as a long period when she became very constructively engaged in a youth group; so on a number of occasions agencies (including YSS and CAMHS) did not get involved or agreed to close the case. With hindsight, it might be commented that it would have been better to offer a consistent intervention, but it is important to recognise that it is inherently difficult to know which of the large number of young people who have low level concerns and show some improvement will not sustain it. Inevitably some young people will have cases 'closed' but subsequently prove problematic.

4.2.5 The records show that there was only limited involvement of agencies with the whole family as interventions mainly took the form of counselling or support services for Child M. The Youth Support Service sought to engage Child M's parents in a parenting support group and continued to visit and offer support and advice to her parents for some time after her Referral Order expired and she had moved out of the family home. Although this was not required by guidance or procedures, it was valued by Child M's parents. Other attempts to work with Child M's parents were limited by the fact that she refused to have other members of her family involved, or during home visits, refused to speak in front of her parents.

4.2.6 Among the agencies involved, there was often good bilateral sharing of information between individual agencies, such as CAMHS and YOS, Catch22 and CAMHS, but no

systematic multi-agency sharing of concerns. In September 2010 the school convened a Common Assessment Framework (CAF) meeting as the symptoms of Child M's problems became worse. The process was not effective because the school had only a limited understanding of how the arrangements were meant to be operated and did not invite the two key agencies involved at that time, Catch22 and CAMHS. Given the overview now available, this appears to have been because the school did not know about all the other agencies who were trying to work with the family. After the meeting, no lead professional was appointed and no review or follow up meeting was arranged. The school say that it continued to meet with Child M's parents, though there is no record of the discussions. The overall effect was that the CAF appears to have been followed as a procedure, rather than a process that those working with Child M felt might make a useful contribution.

4.2.7 The SCR has noted that the CAF was not a new procedure during 2009 – 2010.[21] However, it is apparent that at that time its use was not well embedded in agencies in Surrey. The local authority, which had the overall responsibility to implement the CAF, had been required to place much greater emphasis on achieving service improvements in safeguarding services following earlier external inspection reports which had highlighted serious shortcomings in provision. The slow implementation of the CAF in Surrey was reflected in external inspection findings at the time.[22]

4.2.8 The timing of the CAF meeting was also unfortunate in that it took place a few weeks before the YSS started to work with Child M. However when that happened the YSS did not seek information from the school which would have highlighted this initiative.

4.2.9 If the shortcomings that were present in Child M's case persist, they would have very negative implications for wider groups of vulnerable children. The SCR has been told that since 2010 use of the CAF has developed in Surrey and that arrangements are now in place to implement a revised set of assessment arrangements to improve the provision of early help. Social care staff who were interviewed by a panel member were clear that arrangements had improved considerably since 2010, the number of CAFs undertaken in their district had increased as a result and that there was now a much more 'joined-up' set of working arrangements in place to ensure that social care staff knew about the CAFs that were being undertaken.

4.2.10 The SCR has highlighted that there was no lack of capacity or effort in the provision of early help to Child M, but that it was poorly coordinated. The SCR is not in a position to judge the effectiveness of current provision or the potential of current or proposed new arrangements. It will therefore recommend to Surrey LSCB that, as part of its responsibility to monitor and challenge the effectiveness of member agencies, it should be satisfied that Surrey's arrangements for the coordination of early help are as effective as they can be, paying particular attention to coordination of help to children of secondary school age. This should include, but not be limited to, those who have problems of substance misuse.

[21] Key national documents date from 2005-2006

[22] Ofsted (September 2011) stated that 'The implementation of the common assessment framework has been slow. Managers recognise the need for further progress in the ownership and consistent contribution of all key statutory agencies as well as in the quality of these assessments', *Annual unannounced inspection of contact, referral and assessment arrangements within Surrey County Council children's services,* page 3.

Role of the local authority Contact Centre

4.2.11 Between March 2008 and November 2010 the local authority Contact Centre received eight contact notifications, mostly from the police, relating to Child M's intoxicated state in public, being missing overnight, substance misuse, and two criminal offences. Some of these incidents, such as the minor theft, might legitimately be considered to be within the range of undesirable but 'normal' early adolescent behaviour. Child M was a victim of assault as well as being found guilty of one assault, an incident strongly linked to alcohol abuse, and it was agreed by everyone, very out of character. Some incidents, such as repeated public drunkenness, were outside of normal behaviour and potentially very concerning. The local authority Contact Centre treated the notifications on their individual merits and had no system for evaluating the accumulating picture of concern or recognising the complexity associated with the involvement of other agencies with Child M.

4.2.12 At this time the Contact Centre, which screened all notifications to the local authority social care service alongside other contacts with the county council was not overseen or managed by the social care service. That has been recognised as being a potentially serious flaw in the original design. Over the subsequent years, arrangements for line management and supervision of staff working in dealing with notifications in the contact centre have been gradually modified in order to provide proper professional scrutiny. The SCR has been told that Surrey has now relocated the initial contact service within its social care services in order to reinforce direct professional management by social care managers. The authority is also, along with partners, carefully exploring the viability of a multi-agency first response service.

4.2.13 Whilst these developments are reassuring, it is important to note that organisational and management change will not in itself solve the problem of repeat referrals and notifications that do not trigger an assessment. There are many examples of this type of difficulty occurring in other areas which operate a range of systems. That is because there are professional and practical reasons why this occurs as well as managerial and structural ones. For example, information systems may make it difficult to see the details of previous contacts or the timescales imposed for decision making on cases may militate against full review of previous contacts. Some multi-agency hubs have found that staff struggle with the mass of information that becomes available when 'everything' is shared.

4.2.14 Surrey LSCB will wish to be assured that potential difficulties such as these are addressed within new arrangements. The SCR has therefore made a recommendation on this.

4.3 Allegations of bullying

4.3.1 Child M's parents and her sister who attended the same school have been clear and consistent in telling the SCR that Child M was bullied at school, and also not fairly treated by some teachers in comparison to other pupils. Child M's father is adamant that he raised these concerns with the school on several occasions. The family have also reported bullying in the form of anti-social behaviour directed against Child M and other family members in the community, though the school might not have been directly aware of this. Surrey County Council undertook a review of school records and interviews with staff members

who knew Child M in preparing the management review commissioned for the SCR. This states that the staff members who were interviewed were 'fully aware' of Child M's circumstances and along with other senior members of staff 'met regularly to review Child M's education'. However there is no reference at all in this document to the reported bullying. A multi-disciplinary care planning approach meeting at the Priory Hospital in July 2011 does refer to bullying, which suggests that the claims have some veracity. No action was taken at that point because by then Child M had left the school.

4.3.2 It is possible that Child M did not talk to staff at school about this directly, but her parents are clear that they did. If the accounts of family members are true, it is surprising and disappointing that concerns about bullying did not feature in records and discussions at the school.

4.3.3 The 2009 Ofsted inspection of the school presents a very positive view of the school's approach to its disadvantaged pupils, stating that '*robust and effective procedures are in place for child protection, safeguarding of students, and dealing with bullying and the very few racist incidents that occur. The school's commitment to students' welfare is evident in the excellent support that it provides, its strong links with a wide range of other agencies, and the high levels of parental involvement. Support for children in public care is excellent and is personalised through careful mentoring by senior managers.*'

4.3.4 It is not the role of the SCR to determine whether Child M was bullied. However it is a concern that there is such a sharp contrast between the parents' perception of this individual case and the wider view provided by Ofsted. While the SCR would endorse the view of Ofsted that the school has '*strong links with a wide range of other agencies*', the evidence is that they did not lead to well-coordinated input in relation to Child M. The school has provided the SCR with a copy of its current anti-bullying policy and protocol, which is comprehensive and would, if consistently implemented, provide an effective response. The school says that its arrangements are now independently monitored by a school governor.

4.3.5 In the circumstances, the SCR believes that, in conjunction with its audit of agencies under Section 11 of the Children Act 2004, the Surrey LSCB should seek, 1) to understand better the effectiveness of the school's anti-bullying policies, and also 2) to understand the role that the school improvement and challenge function of Surrey County Council plays in assisting schools in this regard. The SCR has therefore made recommendations in relation to this.

4.4 Substance misuse in the community where Child M grew up

4.4.1 Child M's parents paint a depressing picture of the extent of habitual drug use among young people in their locality. So whilst the SCR can be clear that the way in which Child M misused illicit and prescription drugs from 2010 onwards (and particularly the fact that she injected ketamine and heroin) was unusual, it would appear that her earlier casual access to a range of illicit drugs and their misuse alongside alcohol was commonplace. The parents state that a number of professionals from the local substance misuse service who worked with Child M described they had contact with several young people who knew and referred to the same drug suppliers. The parents realised in hindsight that in Child M's case and

others there is a risk that other exploitative behaviour may attach itself to the supply of drugs to vulnerable young people.

4.4.2 The SCR does not have the mandate or the resources to investigate this issue further and it might be that this is well known and that the police and other agencies have strategies in place to address it. However, it ought to be a concern and possibly the subject of further research and requires a more concerted multi-agency harm reduction strategy. The SCR has made a recommendation to Surrey LSCB in relation to this.

4.5 Safeguarding concerns reported to Surrey Social Care in April 2011

4.5.1 This concerns events described in Sections 3.34 to 3.45 above. In April 2011 Child M went missing with Mr C over a weekend and they were found in a hotel room in Reading, having injected and swallowed enough of a number of illicit and prescription drugs to risk very seriously harming their health. The incident was initially managed by agencies in Reading which judged that it was safe to discharge Child M to the care of her father, who had undertaken not to leave her unsupervised until such time as there had been a fuller assessment by agencies in Surrey. The plan to keep Child M safe in this way was based on reasonable assumptions but it failed in that she soon absconded again.

4.5.2 Thames Valley Police dealt with the criminal aspects of this episode and as a result Mr C was charged with possession of banned substances. He had had previous convictions for supplying drugs and the police have given no indication as to whether consideration was given to charging him with supplying the banned substances to Child M who was at that time a minor. Mr C was subsequently made the subject of a community order. The steps taken to implement this are considered further in Section 4.10.

4.5.3 There was disagreement between social care staff at Surrey County Council and Reading. Social care staff and managers in Surrey were made aware of high levels of concern by colleagues in Reading. These concerns were reiterated by all of the Surrey agencies that were working with Child M over the following days. Four days after the overdose social care staff from Surrey undertook an initial assessment (along with a member of the Surrey Youth Support Service who knew Child M) and determined that it need play no further role at that point because Child M and her family were seeking to protect Child M and were already being offered support and advice by a number of local agencies.

4.5.4 The local authority was charged with making judgements at this point in relation to the following:

- the level of risk to Child M from substance misuse and possible sexual harm
- the responsibility of the local authority to carry out a core assessment under Section 47 of the Children Act 1989 and establish whether Child M had suffered significant harm
- how effectively the parents could protect Child M
- the possible need for a child protection conference and plan and more immediate measures to safeguard Child M
- how best the local authority should relate to other agencies and partnerships that were already trying to work with the family
- how effective the coordination of work with Child M and the family had been to that point

4.5.5 Based on the information that was available to the local authority at the time, the SCR found that the judgements made by staff and managers substantially underestimated the level of risk to Child M and overestimated her parents' ability to control her behaviour. They also wrongly understood the role that children's social care should have played in relation to the other agencies involved. Reliance should not have been placed on agencies, whose interventions had clearly not succeeded in protecting Child M, to continue to work with the family without the framework for coordination that the local authority could have provided for Child M, either as a child in need or as a child subject to a child protection plan. These concerns outweigh the positive features of the intervention by the local authority, i.e. that it was sensible for the social worker to visit with a colleague from the YSS who knew Child M well and that a lot of time was spent on this visit seeking to establish Child M's views, wishes and feelings.

4.5.6 This episode presented an opportunity for the local authority to review the range of concerns that there had been about Child M since 2008 and the impact of the interventions that the school, the Youth Offending Team, CAMHS and Catch22 had made. This episode brought into the open the nature of the contact and relationship between Child M and her 'boyfriend', since they were arrested together and identified. This was the first opportunity to assess properly the nature of the relationship between Child M and Mr C and the risks that he posed.

4.5.7 Independent evidence confirms that during the period under review shortcomings similar to those which occurred in Child M's case were occurring more widely.[23]

4.5.8 The local authority and the SCR have sought to understand how and why this happened, including interviewing and holding a group discussion with the social workers and managers involved. The key local manager who had overall responsibility for the Area Office has left the authority. She was invited to give her views, which she did in writing, although she did not take up the offer of a discussion with a member of the SCR panel.

4.5.9 There appear to be a number of separate issues and a number of factors which best explain events. The following paragraphs consider in turn:

- The overall assessment of risk
- The specific assessment of risk from substance misuse
- The expectations placed by social care on other agencies

4.5.10 The overall level of risk to Child M was underestimated. This is hard to understand because the basic facts of the way in which Child M had been found gave a very clear indication of serious risk of harm.

4.5.11 The staff involved believe that it is always more difficult to manage incidents that occur out of the immediate local authority area. The SCR accepts that this may have been a factor. Although Reading's social care team took all the steps necessary to communicate the facts to Surrey, it is possible that if Surrey had been dealing with the episode at first hand, with a

[23] Ofsted (September 2011), *Annual unannounced inspection of contact, referral and assessment arrangements within Surrey County Council children's services,* letter summarising the findings of the recent unannounced inspection of contact, referral and assessment arrangements within local authority children's services in Surrey County Council conducted on 9 and 10 August 2011

clear and direct account of events from colleagues in the police and health with whom they worked with regularly, they may have responded differently.

4.5.12 It has been suggested that the capacity of staff and managers to think clearly and carefully about the risk to Child M is likely to have been adversely affected by the pressure of work on the team and by the emphasis placed by the manager with overall responsibility for work in the area office on achieving work within the timescales which were at that point set out in statutory guidance. According to the local authority management review, one local manager felt that undue pressure was placed on staff '*by setting rigid and unrealistic goals such as no initial assessment or core assessment being out of date*. *This resulted in social workers and managers staying very late at the office to complete some of these assessments within time scale. Agreement to extend the timescale for the initial assessment in respect of Child M would not have been possible within this context.*'[24]

4.5.13 The local manager who is said to have been responsible for adopting this approach does not accept this, stating in her written submission to the SCR that it was for the Team Manager and Assistant Team Manager '*to review contacts, and referral pathways and ensure that the threshold of need and risk was applied appropriately*'. She adds that '*supervision was always available'* and that '*this was also a well-resourced team that was highly motivated and proud of their practice, performance and achievements'*.

4.5.14 The view put forward by the local authority in its management review is that the approach of this local manager was at odds with the stated policy of the local authority. It accepts that in 2008, following an unfavourable Joint Area Review of Surrey's social care provision, there had been a very strong drive by senior managers to improve the completion of initial and core assessments within timescales closer to national norms. However, the view of the local authority is that by 2010 there was a more balanced approach which placed equal value on the improvement of quality in assessments.

4.5.15 If the difficulties in dealing with Child M were caused solely by the development of a culture in which some staff believed that the overriding priority was to complete tasks on time, that could easily have been addressed by categorising Child M's case as a core assessment which would have extended the deadline for completion of the assessment to 35 working days. The fact that this was not done suggests either that the staff involved genuinely did not believe that Child M was at risk or that the local authority was trying to reduce the amount of work that the service had to take on. Evidence for this is provided by this episode and also by the response of the local team to contacts with agencies about Child M over the following four months when on a number of occasions social care staff responded negatively to requests from the Priory Hospital and other local agencies to become engaged with Child M.

4.5.16 It is clear that the level of risk associated specifically with substance misuse was not understood or addressed properly. The local authority contribution to the SCR indicates that the staff involved lacked training and experience in dealing with adolescent substance misuse. The SCR accepts that this is an area of practice in which newly-qualified social workers, and some who are very much more experienced, often lack specialist knowledge. As a result they may rely on the advice of others, such as substance misuse services and

[24] Surrey Social Care individual management review

CAMHS. However this explanation is of only limited value, firstly because of the serious and obvious risk to Child M and secondly because, having sought the advice of the more specialist agencies, the local authority paid little account to their views.

4.5.17 The responsibility placed on other agencies was too great. The local authority relied on other agencies to continue to work with the family, even though their interventions had not been successful in reducing risk. No one in the local authority considered the potential value of convening a child protection conference, either because it was a necessary response to the risk to Child M or because this was a setting in which an overall picture of risk could be obtained along with an honest account of why services had found it so hard to work with Child M. The fuller assessment in preparation for a conference would have offered the opportunity to explore the origins and extent of Child M's difficulties, something which had not previously been done. Whether the conference resulted in a child protection plan or a child in need plan it would have offered agencies the structure and framework to coordinate their interventions in a way which had not happened previously for the reasons set out in Section 4.2.

4.5.18 It is a concern that those involved and the local authority as a whole have very different understandings about a key aspect of service delivery and that there was at the time no means of achieving a shared understanding of the challenges of working in a very pressured environment and of how best to resolve them.

4.5.19 It is very important that when pressures build up in services, as they inevitably do from time to time, they are recognised and managed more sympathetically than they seem to have been in this instance. The SCR will therefore ask Surrey LSCB to ensure that all member agencies have effective mechanisms in place to identify and respond to pressures on services and that front-line staff are offered an effective means of expressing concerns to senior managers about the quality of service that is being provided by their agency. Surrey LSCB also needs to be confident that thresholds for assessment of cases involving difficult adolescents who are at risk of significant harm are now operating appropriately. The SCR has therefore made recommendations on these issues.

4.6 Admission under Section 2 of the Mental Health Act 2007 to the Priory Hospital

4.6.1 The episode evaluated here is described in sections 3.46 to 3.62 above. Between April and July 2011 Child M went missing several times. She kept few appointments with professionals, the main exceptions being with the CAMHS psychiatrist who was able to prescribe. She admitted injecting and took overdoses on at least two occasions, despite having received advice on how to inject more safely and avoid overdoses. There was little evidence of agencies communicating with one another as there was no established multi-agency forum through which this could take place. The local authority responded negatively to further requests to intervene until shortly before Child M was detained under Section 2 of the Mental Health Act 2007 and placed in the Priory Hospital in East Sussex. This admission preceded any local authority involvement and the decision to detain her was made by the mental health professionals in liaison with commissioners.

4.6.2 The decision to admit Child M was made as an emergency measure because it was judged that she could not be assessed or treated safely in the community and was a justified use of the legislation. As a result, social care staff did not become involved and there was no

shared responsibility for Child M and no joint planning for her care. The only arrangement to monitor the effectiveness of the placement was within the health service.

4.6.3 The Priory Hospital and other agencies made several formal attempts to involve Surrey's social care service but the local authority attended only one planning meeting at the hospital. There should have been a much more positive response to these because Child M was a Surrey child with a high level of identified need in a Tier 4 mental health placement. There was no procedural requirement to ensure that this happened and it was not part of the culture of the way agencies worked at that time.

4.6.4 Surrey County Council has accepted that any young person admitted to a Tier 4 inpatient unit should be the subject of joint planning, ideally before the admission or, if that is not possible, then immediately afterwards. This would normally be the responsibility of Surrey's HOPE multi-agency team which offers educational and social care input for young people with mental health problems and will undertake an assessment in order to consider whether the child should be treated as a child in need. The SCR has therefore made no recommendation to the local authority in relation to this; however it will recommend that Surrey LSCB challenges local agencies to demonstrate that they have a more successful strategy for joint working in such cases.

4.7 Constraints placed by Child M's age on the interventions that agencies could make

Introduction

4.7.1 Before proceeding further with the detailed evaluation of key events in the case history, it is useful to note some of the constraints and uncertainties created for professionals by the legal framework governing the rights and responsibilities of adolescents. These apply to a large number of areas where public bodies and adolescents come into contact, including general medical treatment (including mental health) and the right to confidentiality, limitations on parental responsibility, public law in relation to child welfare and protection and the criminal law.

4.7.2 The following paragraphs briefly set out some of the potential difficulties of interpreting the law and using it to protect an adolescent. They are not intended as a comprehensive guide because the law in each of these areas is complex and could be discussed at great length.

4.7.3 The legal framework governing the rights of adolescents derives from three main sources: the common law (an accumulation of judgements about individual cases), a large number of statutes (Acts of Parliament), and the statutory and professional guidance that derives from them. Referring specifically to the use of mental health legislation to determine whether it is right to treat a 'young person' without consent, the leading textbook on legal aspects of children's rights refers to '*the law's extreme complexity*', noting the way in which '*legislative changes concerning children have been grafted on to the common law … with little concern for clarity and coherence*'.[25]

4.7.4 In general, as children grow older the law assumes that they become more mature, that they should have greater autonomy and that they should be able to exercise greater

[25] Jane Fortin (2009), *Children's Rights and the Developing Law*, 3rd edition, page 172

control over their lives.[26] The right of parents and others to impose sanctions and restraints becomes restricted to very specific circumstances. Like parents, professionals are required to work within this general framework, recognising that the law is open to interpretation and requires the use of judgement case by case. Some aspects of the law and guidance apply at particular ages, most commonly but not always age 16 and 18, while others rely on judgements in the individual case about maturity and development.

4.7.5 From the age of 16 the civil law assumes that children are able to make major decisions about their lives, including the right to consent to or refuse medical treatment, unless there is clear evidence that they lack capacity, have a mental disorder or are placing themselves or others at serious risk.

4.7.6 In relation to medical matters, a child aged under 16 who is of sufficient maturity and is judged to have the ability to understand the consequences of their decisions has many of the same legal rights as a 16 year old.

4.7.7 If a person is judged to have capacity, the law allows them to make a range of choices about their lifestyle even if the choices made are not well informed or have a reckless element and lead to some risk. The legal thresholds for determining that a childs lacks capacity are necessarily high. The use of mental health legislation to detain a person for assessment or treatment for a mental disorder does not restrict his or her ability to act with capacity in other aspects of their lives. Detention under mental health legislation may last only as long as it is deemed necessary for the treatment of a mental disorder. It cannot be used to restrict a person's wider liberty just because they are behaving in a risky or 'undesirable' way.

4.7.8 Thus there were a number of occasions in late 2011 and 2012 when Child M's parents requested that she be admitted to the Priory Hospital because she was not complying with the agreed plan and placing herself at risk. While this might have been a very sensible course of action, it was not legally possible unless Child M had either consented or fulfilled the very strict criteria set out in mental health legislation.

4.7.9 Consistent with this wider framework, the law offers a child who has capacity the same right to medical confidentiality as an adult. This inevitably diminishes the effect of parental responsibility in relation to older adolescents because it is not possible to give rights to children without taking them away from someone else. A child may stipulate that information about their health should not be shared with their parent. Professionals may share information about children who are at risk, but they must be clear that the need to share the information outweighs the breach of confidentiality.

4.7.10 In Child M's case, professionals also needed to understand and work with the legal framework for public child care law. Some aspects of this, such as the provisions governing the making of care orders and secure accommodation orders, have additional complications when the child concerned reaches the age of 16 and then 17. Despite the fact that local authorities have legal duties towards children who have been in care which

[26] The principle was established in the case Gillick v. West Norfolk and Wisbech Area Health Authority where it was narrowly applied to competent young people's right to make decisions about contraception. It is now applied more widely and more usually referred to as 'Fraser competence' (op. cit., page 93)

persist until the person reaches the age of 24, they have few comparable powers to restrict or control behaviour of a 16 or 17 year old.

4.7.11 The law in relation to sexual offences reflects assumptions about the growing maturity of adolescents. Any sexual activity with young children is by definition abusive and illegal because of the age and assumed immaturity of the child. Definitions of sexual offences are closely related to the age of the victim. Sexual activity between an adult and a child, even if an older adolescent, such as Child M will only lead to a criminal prosecution, even when there are suspicions of exploitation or lack of consent, if there is a complaint and a willingness on the part of the child to provide evidence to support the prosecution.

Update Comment: In line with learning from national SCRs and practice development there has been significant improvement in police pursuit of criminal convictions even where the is no first party complaint.

4.7.12 From the age of 16, Child M was entitled to a significant say in where she lived and could only be encouraged and urged to consider the disadvantages of any plan, except when there was very clear evidence of a high level of risk which might lead a court to place her in secure accommodation. There is a very high threshold for the making of a Secure Accommodation Order.

4.7.13 The requirement to respect a child's rights is not just based in law. Sometimes there is a pragmatic aspect to the decisions that professionals have to make. For example, at the age of 14 Child M made it clear that she would not attend family appointments at CAMHS. In order to engage her at all this choice was accepted and Child M was given appointments on her own. This was clearly the only sensible way to proceed. Similarly, a parent, including the local authority, may strongly disapprove of an older adolescent's behaviour but would probably not wish to risk severing all links with the person by refusing to offer a degree of financial support.

4.7.14 For both adults and young people, activities such as possessing and using illicit drugs are impossible for law enforcement agencies and other professionals to prevent altogether, even though they contravene the criminal law. Public policy is tolerant of minor infringements, even when these are repeated. There are numerous grey areas in the law in relation to the chemical composition and legality of different substances. Public authorities often do not bring prosecutions in relation to the possession of small amounts of illicit drugs. It is particularly difficult for the police to bring prosecutions over the possession of prescribed medications, even when those who misuse illicit substances obtain and hold these in substantial amounts which would give rise to the suspicion that a person is also acting as a supplier.

4.7.15 These issues are relevant to the evaluation of services provided for Child M at a number of points during the remainder of her life. They are much wider matters of law and policy which will not be influenced by the findings of this SCR. Many features of the current legal and policy framework reflect the rejection over the years of unpalatable alternatives which society felt placed too many constraints and limitations on individual choices and the rights of the ordinary adolescents. It is, however, important for the wider audience of readers to understand the framework within which professionals (and parents) have to operate when

a child such as Child M is struggling to make choices that are not self-destructive. It leaves professionals largely dependent on their ability to develop a constructive and trusting working relationship with an adolescent to persuade them to change their behaviour. This is not always possible.

4.8 Decision-making and planning at the Priory Hospital from June to October 2011 and the impact of this decision-making on subsequent provision for Child M

4.8.1 The events evaluated in this section are described in Sections 3.63 - 3.104 above. In June 2011 Child M was detained at the Priory Hospital under the Mental Health Act 2007 because she was found to be suffering from a number of psychiatric symptoms and because she had placed herself at a high level of risk by taking a number of overdoses. Initially, the hospital barred Child M from having contact with Mr C and put measures in place to ensure that this did not occur. By the end of August 2011, the hospital multi-disciplinary team that was responsible for Child M's care had agreed to work towards a care plan whereby Child M should be discharged from the hospital to share accommodation with Mr C in East Sussex while professionals worked to try to reduce the risk of potential harm. This reflected her strongly articulated desire to live with Mr C and her refusal to consider any alternative.

4.8.2 This was tested and implemented during September 2011. Agencies from East Sussex were invited to multi-agency meetings at the hospital in order to coordinate a plan of support and monitoring, though these meetings were never intended to challenge the key elements of the care plan.

4.8.3 Child M initially complied with requirements of her leave from hospital under the mental health legislation and the evidence is that she remained drug free. However over the course of a series of short periods of leave Child M became less compliant. Within three weeks she had taken another dangerous overdose. By late September Child M had been discharged from her compulsory treatment under the Mental Health Act 2007 because she no longer satisfied the criteria for detention. From this point she agreed to comply with planned leave arrangements in order that the discharge plan could be implemented with the agencies in East Sussex, but she did not do so. In early October 2011 Child M refused to return to the hospital from an agreed period of leave. The hospital had made efforts to contact the police and the patient's GP and had also offered outpatient appointments. However at this point it felt that it had no alternative but to discharge Child M as 1) she could not be detained, 2) she did not want to be a patient, and 3) the hospital felt that it had no influence over her care or treatment.

4.8.4 Throughout this period Child M's parents were very strongly opposed to the plan for her to move to East Sussex and made several representations to the Priory Hospital over this. They told the SCR that some members of the medical and nursing team appeared to be sympathetic to their concerns, whereas others were not. The parents were not in practice able to influence the overall direction of the care plan though they may, through providing a consistent reminder of the potential risk, have made the hospital more cautious in the way in which it was implemented.

4.8.5 No one involved appears to have believed that this was a good plan or outcome. The SCR has sought to understand how this plan was developed and whether there was a viable alternative. The following factors are significant.

4.8.6 Surrey County Council children's social care attended one meeting at the Priory early in Child M's admission. Later the hospital reported to the local authority that Child M would 'not be discharged for some time' and the local authority decided that it did not need to be involved. Whilst it appears to have always been Child M's ambition to move away from her family, had there had been a more concerted intervention early in her admission there might have been more scope to develop a plan based on Child M returning to accommodation in Surrey, for example in supported accommodation or lodgings. This was limited because Surrey children's social care had chosen not to have a role in coordinating Child M's care or discharge to the community and did not subsequently respond to requests from the hospital to do so.

4.8.7 In part, this was because at the time the local authority's policy was not to be routinely involved in cases where children were placed in inpatient mental health units. There was also a breakdown in communication when the hospital asked Surrey children's social care to appoint a 'care coordinator' as this was a language, commonly used in adult mental health services, that the children's services did not understand or seek to clarify. The local authority now states that a similar case would be dealt with differently through its early intervention multi-agency mental health service (HOPE).

4.8.8 The mental health legislation under which she had been admitted only allowed Child M to be detained in hospital to enable the assessment and treatment of her mental condition, not to place more general restrictions on her, even if there was a strong possibility that she would behave in a reckless way when released. This meant that Child M had to be discharged from the initial Section 2 admission once she appeared to be willing to remain in hospital and accept treatment.

4.8.9 Once she had settled at the Priory Hospital, Child M was determined to move to East Sussex with Mr C and refused to engage in discussion of any alternative.[27] Given that she was aged 16, and not detained, the hospital had to be guided by the need to take a view of her as a competent patient with legal 'capacity' and, following from this, rights comparable to those of an adult, even though safeguarding law and policy would dictate that she be viewed as a child.

4.8.10 When Child M later withdrew her cooperation the hospital successfully sought Child M's detention for treatment under Section 3. It was a legal requirement to hold a Mental Health Review Tribunal.[28] When this gave consideration to the grounds for continuing detention in September 2011 the same overriding philosophy applied with the consequence that Child M was again at liberty to leave the hospital.[29]

[27] Professionals other than her school had no knowledge of this but it is clear that this plan had been developed between them for some months prior to the admission to the Priory.

[28] http://www.justice.gov.uk/tribunals/mental-health

[29] The Tribunal arrived at a compromise which was to discharge the Section 3 detention but to ask Child M to agree to stay and undergo a planned discharge. This appears to have reflected its own concerns about the possible risks. She agreed to do so but then reneged on the agreement.

4.8.11 In the absence of a legal framework which would have allowed the agencies to overrule Child M's wishes, the agencies were limited to a strategy of monitoring and minimising harm, without any meaningful long-term collaboration from Child M.

4.8.12 Through its participation in the SCR, the Priory Hospitals Group has reflected on its involvement. The hospital has noted that '*Child M's determination to live with her boyfriend was initially opposed by the clinical team here but then had to be worked with, albeit reluctantly as far as we were concerned'.* However, it has recognised that there were weaknesses in the way in which the discharge was planned and carried out, in that tasks identified at the final CPA meeting were not allocated to individuals or to agencies and that discharge information was not sent promptly to other health professionals. The SCR has found that the arrangements for monitoring Child M when she was on leave in East Sussex, and recording how she was and how she was functioning, were not sufficiently detailed and relied too much on Child M's own self-reporting.

4.8.13 Since it was planned that Child M was to be discharged to live with Mr C, this was also the first significant opportunity that professionals had to evaluate in more detail the nature of that relationship. The records give no indication that professionals involved attempted to work with Child M and Mr C to understand why their mutually dependent and obviously destructive relationship had formed and was continuing.

4.9 Assessment of risk after Child M's discharge to live in East Sussex

4.9.1 Once Child M was resident in East Sussex, effectively from early October 2011, the local authority allocated Child M to an experienced social worker who began a core assessment. This gathered and evaluated information about recent events and background historical information from all of the agencies that had worked with Child M, as well as from the probation and substance misuse services which were working with Mr C. This was the first time that there had been a systematic, collaborative assessment of Child M's needs which highlighted the nature of the risks to Child M, the length of time that there had been difficulties and the failure of previous attempts to address the concerns. The assessment was a good, thorough piece of work.

4.9.2 Plans were put in place for Child M to attend CAMHS and substance misuse services and to attend college and for signs of concern about her welfare to be monitored by all the agencies that had contact with her. Child M had agreed to move to supported accommodation rather than live with Mr C, but she refused to collaborate with the arrangements for this once she had been discharged from the hospital.

4.9.3 The monitoring of Child M and attempts to engage her in plans for her health, safety, reducing substance misuse and securing her with good educational opportunities continued throughout October and November 2011. By mid-November it was apparent that Child M was living in very unsatisfactory conditions because the household was chaotic, there were other residents who misused drugs and alcohol and Mr C left his prescription medication, as well as other substances, unlocked. Child M was at risk and could not be monitored because she was missing college and not keeping other important appointments. The response of the local authority to convene a multi-agency complex case meeting was the right approach to take. This led to a further gathering of information and agreements on how agencies would work together.

4.9.4 The SCR has considered whether there was a case that at this time Child M should have been considered as a child who was at risk of significant harm and dealt with under the local multi-agency child protection arrangements. In most respects, responding to Child M's circumstances within the multi-agency child protection arrangements would not have altered the actions of professionals or their impact.

4.9.5 The core assessment undertaken by Child M's social worker would have had the same content, which included historical information and information from other agencies. If it had triggered a child protection conference, that meeting would have happened sooner than the complex case meeting in mid-November 2011, but it would have brought together largely the same group of professionals to discuss the same information. The chair of a child protection conference would have been independent but of less seniority than the chair of the complex case meeting and possibly with less specialist knowledge. The plan made at a child protection conference would have been broadly similar to that which the complex case meeting made. Both meetings would have been working within the same legal framework and constraints. Whatever the format of the meetings held, the local authority would not have had grounds to use legal powers to protect Child M until December 2011, when the Secure Accommodation Order application was made.

4.9.6 Convening a child protection conference had two potential advantages, though whether they would have served as advantages in reality is impossible to tell. Child M, her parents (and possibly Mr C) would have been invited to participate, which would have strengthened the parents' involvement and possibly their capacity to exercise some form of responsibility for Child M. However, given the history, it is extremely unlikely that Child M would have participated alongside her parents in any such meeting. Attempting to engage everyone would have been extremely complicated and might have had a negative effect with no additional benefits.

4.9.7 The other possible advantage of holding a child protection conference is that it would have unambiguously focused attention on Mr C as the source of potential harm to her and provided a framework for maintaining arrangements to engage the agencies which worked with him. It would have led the police to provide a full list of his relevant criminal convictions to the local authority, which the SCR believes did not happen. The focus on the risk posed by Mr C was great between October 2011 and January 2012 whilst Child M was living in East Sussex but diminished once he moved away. If Child M had been made the subject of a child protection plan it would have been formally reviewed three months later.

4.9.8 It is unusual to make a 16 year old the subject of a child protection plan.[30] For the reasons set out above, it is unlikely to have changed the course of events in this case. However taking into account, 1) repeated research findings which highlight the vulnerability of older adolescents [31], and 2) concerns about the extent to which 16 and 17 year olds may be the victims of domestic violence and sexual exploitation, and 3) the need to counter the tendency in law and policy to treat 16 and 17 year olds as adults, it is important for the LSCBs whose member agencies were involved in this case to give a clear message that child

[30] In England some 2.6% of the 43000 children who are subject to child protection plans are aged 16 or 17 and it is very likely that many of those will have been subject to plans before they became 16.

[31] For example Ofsted (October 2011) *Ages of concern: learning lessons from serious case reviews, a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to March 2011*

protection arrangements apply in full for children aged 16 and 17 and that, in appropriate circumstances, a child aged 16 or 17 may need to be the subject of a child protection conference or plan. The SCR has made a recommendation on this.

4.10 The interaction of criminal justice agencies with Mr C and the effectiveness of provision made by probation services

4.10.1 Thames Valley Probation Trust provided a pre-sentence report on Mr C in September 2011 and the court sentenced him to a Community Order with a nine-month Supervision Requirement and six-month Low Intensity Drug Rehabilitation Requirement. This was the sentence for the incident in April 2011 when Child M and Mr C had been found in a hotel in Reading, leading to her hospital admission. The second component of the sentence was fulfilled by Mr C's attendance at a substance misuse agency. This is considered further in Section 4.12.

4.10.2 Mr C was supervised by Surrey and Sussex Probation Trust between September 2011 and February 2012 and by Thames Valley Probation Trust between February and May 2012. With the benefit of hindsight, it is useful to reflect on the relative merits of different sentencing options. The court's sentencing took account of a psychiatric report commissioned by Mr C's solicitor which indicated that a custodial sentence might jeopardise his recovery from a depressive illness. It is not clear whether the reports prepared for the court or the sentencing took account of aggravating factors, namely that Mr C, who had previous convictions for the supply of banned substances, had been in possession of significant quantities of drugs in the presence of a minor whose health had been seriously harmed.

4.10.3 Had Mr C been given a custodial sentence, it would at least have served to protect Child M from his influence for a short period. There is no way of judging what the long term impact might have been. The evidence is that the supervision and drug rehabilitation orders that were actually made had no positive impact on Mr C's continuing activity in using and supplying banned substances, though it is noted that he was not reconvicted during the course of the orders.

4.10.4 The probation service undertook an assessment of the factors that were considered likely to have contributed to Mr C's offending. It then provided individual supervision sessions and supervised participation in a range of programmes and exercises designed to reduce the risk of reoffending. Because of the circumstances of the offence, the initial risk assessment identified Mr C as posing a 'serious risk of harm' to children through the supply of banned substances and this assessment was recorded on the probation records. This risk level remained a constant throughout the period of supervision. Mr C was not subject to the multi-agency public protection risk management arrangement, known as MAPPA, because although he was judged to be a serious risk to children his offence was not one of violence or sexual violence and did not fall within the MAPPA criteria.

4.10.5 Mr C was supervised in line with the national offender management standards and expectations. He generally complied with the supervision requirements and any non-compliance was judged insufficient to merit a formal warning or breach. Formal reviews of the risk assessment took place but they were largely based on his self-reports. Without direct contact with the professionals who were dealing with Child M, probation supervisors

had no way of measuring or testing the actual impact of the offender's behaviour on Child M or other victims.

4.10.6 Prior to February 2012, when Mr C and Child M were both in East Sussex, the probation trusts offered input into the multi-agency meetings held to manage risks to Child M. The nature and the extent of joint working, and therefore positive impact on safety of Child M, were significantly affected by the proximity of the probation service to other agencies and the existence or not of a multi-agency forum in which to assess and manage risk. When all the professionals were in the same locality, the probation officer shared updates regularly and attended complex case meetings and discussions.

4.10.7 Thames Valley Probation provided a report on Mr C for the care proceedings for Child M in April 2012, but apart from that it had little direct contact with the professionals who were working with Child M. Between February 2012 and the end of the community order, there was much less evidence of contact between Child M and Mr C, and for part of the time she was in secure accommodation. Had Thames Valley Probation been invited to meetings to discuss risks to Child M, there is every reason to think that the trust would have attended.

4.10.8 Overall it is a concern that, despite following the required procedures and the efforts of members of staff (and the associated drug service input), the probation trust input had no discernible impact on the behaviour of Mr C.

4.11 Substance misuse provision for young people

4.11.1 Details of Child M's known substance misuse are set out in Section 3. Professional records indicate that she drank on occasion to excess from the age of 12 or 13. Her parents' accounts and the core assessment undertaken in East Sussex in 2011 suggest that Child M's drug misuse also began at age 12 or 13. Contemporary reports and referrals of drug misuse in the records of agencies in Surrey suggest that this started later.

4.11.2 Child M's family attribute her initial substance misuse to her unhappiness and experience of being bullied. At the Priory Hospital in mid 2011 she spoke of having suffered a serious sexual assault at the age of 13, though she did not give details or name a perpetrator, and made links between this and her drug use. On a number of occasions Child M referred to taking drugs as if it were medication in order to 'make things better'.

4.11.3 Child M's comments about the sexual assault were not reported to either of the local authorities that had contact with Child M or to the police and were not investigated further. The Priory Hospital has recognised that this was a failure on its part and has made an internal recommendation in relation to this.

4.11.4 Whatever the individual factors driving Child M's substance misuse, it was facilitated by the apparent ready availability of drugs in the community in which she grew up which her family and professionals involved were not able to combat. Child M met Mr C at about the age of 13 and he is believed to have supplied her with drugs from that point. Her attachment to him and to drugs overlapped and mutually reinforced one another.

4.11.5 Professionals who worked with Child M repeatedly recognised that she was intelligent, and could be forceful and articulate in one-to-one discussions. She produced copious amounts of artwork and often wrote about herself and her substance misuse in notebooks. These make it clear that she often enjoyed taking drugs, enjoyed the company of those who took

drugs and believed in the positive power of drugs to expand her 'consciousness' and enhance her life. For much of the time she did not appear to view substance misuse as a bad thing or a failing on her part. This made her unwilling to accept advice about the risks associated with taking drugs, either generally or in relation to the possible risk of overdose.

4.11.6 With one recorded exception, Child M was in the company of older more experienced drug users when she injected heroin or ketamine. Despite her repeated overdoses she appears to have been prepared to be guided about the risks by other drug users, rather than by professionals.

4.11.7 The role of Mr C is critical to her pattern of substance misuse. Mr C is known to have had psychological problems since early adolescence. It appears that as he grew older he developed a very high level of dependency on prescription medications and on other banned substances. His pattern of dependency and access to drugs led to him acting as a dealer as a result of which he had a number of convictions for the supply of banned substances. Services provided to Mr C are evaluated in Section 4.12. There is little evidence that when she was not in contact with Mr C Child M sought out other suppliers.

4.11.8 There is also evidence that when she found other aspects of her life fulfilling and satisfying, for example when she was involved with a youth group while at school or with the Prince's Trust activities when she was aged 17, Child M abstained from substance misuse for substantial periods.

4.11.9 With a small number of breaks, Child M received services from specialist substance misuse agencies and professionals from July 2010, when she was 15, until her death. The key agencies were Catch22 in Surrey, the specialist substance misuse worker from Surrey Youth Support Service, Priory Hospital Group Occupational Therapists and other professionals and the East Sussex Under 19s Substance Misuse Worker. She was also seen by professionals in CAMHS services in Surrey and East Sussex who sought to address her substance misuse, including psychiatrists who were able to prescribe. Child M also had contact with other walk-in services, including needle exchange services, where her identity may not have been known or false details given.

4.11.10 Professionals in all of these services made determined efforts to engage with Child M and to give advice. Catch22 lists the areas that it sought to address with Child M as follows: *'drugs education, harm reduction, general support, risk awareness, anger management and support to access CAMHS for presentation of anxiety type symptoms, and difficulties in managing her emotions'*. This seems to be typical of the approach taken by agencies. A substance misuse worker from the local authority in East Sussex told the SCR that he '*met with Child M frequently, especially when she was secured. His role … focused on harm reduction, trying to prevent accidental overdosing and managing the identified risks'*.

4.11.11 At times some professionals appear to have gained a degree of trust and confidence from Child M in that she attended appointments regularly and asked professionals for a degree of additional support. However the East Sussex substance misuse worker noted that she engaged only 'superficially'. Sometimes Child M missed appointments and appears to have used services in order to obtain prescription medication for her use or for Mr C's. In this she was adopting the approach of Mr C, whose main motivation for remaining in contact with health practitioners who could prescribe appears to have been to obtain medication.

4.11.12 In relation to substance misuse provision to Child M, the SCR has identified the following points for learning which may assist agencies and practitioners working with other adolescents. The majority of interventions appear to have been based on Child M's self-reported behaviour, including her substance misuse, and none of the services made contact with her parents or other family members to gather further background information. This may be the normal practice with services focused on adolescents; however, it meant that professionals may have missed important and useful information about the extent and nature of her difficulties. The interventions made appear to have been a series of standardised services and advice programmes, such as harm reduction advice, which were repeated as Child M grew older. It is recognised that if an adolescent does not want to discuss underlying problems there is little that can be done other than to try to make the child aware of the risks associated with substance misuse. However there is a case that a more individualised approach, which took account of Child M's specific reasons for taking drugs, her circumstances and her networks and her reasons for not heeding any of the advice previously given, may have been of greater value.

4.11.13 To be more effective, assessments carried out by substance misuse treatment services for adolescents should seek to understand family and social issues (family background relationships and tensions, domestic abuse, sexual harm or exploitation, schooling, offending, relationships with peers and other aspects of the person's lifestyle) alongside developing a clinical understanding of substance misuse and the correlation between the two. Subsequent intervention plans should address these concerns and seek to assist the child to develop an understanding of their rationale for substance misuse, historical and current, whilst addressing the immediate presenting concerns. The SCR has made a recommendation in relation to this. Information provided on the transfer of a case also needs to provide a full picture of past as well as current substance misuse.

4.12 Adult substance misuse and related mental health provision for Mr C

4.12.1 The SCR has identified that during the period under review Mr C attended a number of substance misuse and related adult mental health services. The two are addressed together here as, 1) it is apparent that since early adolescence Mr C had had a pattern of taking a range of prescription and banned substances to address his psychological problems, 2) he was often seen in parallel by mental health and substance misuse services, and 3) mental health practitioners often understood his psychological problems as being linked to addiction. The provision made is evaluated in distinct phases, relating to the different geographical areas.

<u>Buckinghamshire and the Thames Valley area</u>

4.12.2 Between January and September 2011 Mr C was a patient of mental health services in his home locality. He missed several appointments. He was referred to the adult substance misuse service for assessment but did not attend. He was then discharged from the mental health service.

4.12.3 Between July 2010 and April 2012 he was noted to be attending a drop-in drug service run by an organisation called OASIS. Attendance was sporadic. When Mr C moved back to Buckinghamshire in February 2012 he should have been the subject of a court-sanctioned

treatment programme, run by the same organisation, as a continuation of a programme he had attended in East Sussex. However it appears that he was not referred to that programme in time and the substance misuse aspect of his community treatment expired before he had attended.

East Sussex from September 2011 to January 2012

4.12.4 From September 2011 until January 2012, Mr C lived in East Sussex and attended the Crime Reduction Initiatives (CRI) programme as part of his court ordered treatment. During this time Child M overdosed on what was reported to be her boyfriend's prescribed medication, though it is not clear from the records which medical practitioner was prescribing to Mr C or how the medication that Child M gained access to was obtained. During his drug treatment programme Mr C repeatedly tested positive for opiates which he claimed were due to dental painkillers.[32] After his access to prescribed opiates was stopped, Mr C showed one opiate free drug test, but then reverted to illicit opiate use.

4.12.5 It is a concern that there was no evidence of liaison between the drug treatment service and the GP so that it took some months to rectify a pattern of prescribing led by the patient's demands but not ultimately likely to be conducive to a successful treatment outcome. Patterns of uncoordinated prescribing were repeated at several points in the case history.

Thames Valley area from February 2012 to March 2013

4.12.6 Between April 2012 and Child M's death in March 2013, Mr C attended a substance misuse service in Buckinghamshire known as SCAS and was prescribed medication to manage his opiate addiction. His attendance and engagement were limited and he repeatedly failed to comply with the drug prescribing regimes that he had committed to resulting in his substitute opiate prescribing being withdrawn and then recommenced on a number of occasions. In January 2013 he attended Oxford Health mental health services and was prescribed further medication. He remained in touch with the service until March 2013 when, after child M's death, SCAS Buckinghamshire took over the prescribing and review of all medications and requested the GP and the community mental health team to cease prescribing.

4.12.7 A number of concerns arise from the evaluation of substance misuse services in Buckinghamshire. It was often impossible to tell from the records how many professionals were prescribing medication, including drug services, mental health services and possibly GPs. As in East Sussex, it appears that GPs, drug treatment services and mental health services operated parallel prescribing regimes, even when Mr C was the subject of statutory orders and that this was only rectified after child M's death.

4.12.8 The arrangements for provision of substance misuse services in Buckinghamshire appear to have been extremely complex during the period under review with different services providing for aspects of assessment and treatment, but without effective arrangements for sharing of information either within or between agencies. This enabled Mr C to attend a number of different services and obtain prescribed medication. Had he wanted to use the

[32] This appears to have been an excuse well known to an experienced addict and supplier as basic tests do not distinguish illegal opiates from prescribed opiate-based medications. Challenge from professionals was very limited over this.

various services as a source of substantial amounts of prescription medication, he could easily do so. If, on the other hand, a motivated patient had genuinely tried to engage in help to tackle his substance misuse, he would have found the very fragmented nature of the provision confusing.

4.12.9 The SCR has been told by a member of the Drug and Alcohol Team for Buckinghamshire that since the period under review services have been re-commissioned so that it should now no longer be possible to receive prescription medication which has the effect of 'parking' a substance misuser without there being proactive assessment and review. The SCR will recommend that it is kept under regular and close scrutiny in order to maximise the effectiveness of any services provided.

Summary of findings on adult substance misuse and mental health services

4.12.10 Reviewing the information that is available about Mr C, it appears that he had embraced the use of a variety of drugs as self-medication for his long-standing problems in social functioning and his psychological difficulties. The nature and quantities of these drugs appear to have varied from time to time and records show him obtaining, either on prescription or through a variety of illegal means, substantial quantities of medication for his own use, for Child M and to supply to others. Prior to the death of Child M he had a number of convictions for supplying banned substances. Drug testing regimes offered little disincentive to this pattern of behaviour as Mr C had enough knowledge of the substances that he was taking to be able to explain away the findings of test results and buy himself enough time to find a different source of self-medication.

4.12.11 Mr C's contact with drug or mental health services appears to have been woven into his lifestyle, occasionally providing him with a proportion of his substantial daily drug intake, some limited medical monitoring and some professional attention. During the period reviewed by the SCR there is no evidence that any of the services had any lasting positive impact on this behaviour. In his case they can only be considered to have constituted a poor use of professional time and of public money. This vulnerability in service provision appears to arise from at least four contributory factors:

- Deliberate manipulation of services
- Lack of effective coordination of prescribing between one or more GP, substance misuse or mental health services
- Movement of the service user across geographical boundaries resulting in a 'start again' approach based usually on self-reporting rather than accurate records
- The large number of services involved and the pattern of commissioning and re-commissioning services, reducing continuity of knowledge and experience.

4.12.12 The recommendations made by adult treatment services in their individual management reviews seek to address these concerns.

4.13 Joint working between services focused on adults and services focused on children

4.13.1 Arrangements for sharing information and coordinating interventions were most effective between September 2011 and January 2012 when both Child M and Mr C were living in East Sussex and the local authority provided a forum through the complex case meetings where information could be shared and work with different family members could be coordinated. One adult agency which was working with Mr C (the probation trust) was

invited to this meeting but another (Crime Reduction Initiatives (CRI) substance misuse service) was not. It should be highlighted as a learning point from the SCR that all agencies working with relevant adults should be invited to relevant meetings.

4.13.2 Once Mr C moved to live outside East Sussex, services tended to work in parallel with some limited sharing of information but little practical impact on the case. The complex case meetings that were held after Mr C had moved away from East Sussex focused exclusively on Child M.

4.13.3 After the probation supervision of Mr C ended in July 2012, the substance misuse agencies working with him were largely not proactive in asking whether he had contact with a vulnerable young person or knew that he had a 'girlfriend' but showed no curiosity about her age or potential vulnerability.

4.13.4 This strongly suggests that joint working will be most effective when the local authority or another agency acting as lead professional on behalf of the child takes the initiative to coordinate information sharing, possibly through face-to-face contact with adult agencies. Adult agencies, including especially mental health and substance misuse services, should routinely ask for details of children who may be affected by the behaviour of a service user.

4.14 Challenges posed by Child M's planned placement outside of the local authority area

4.14.1 East Sussex County Council placed Child M in supported lodgings in Surrey in August 2012 at her request and as part of a care plan agreed by her Independent Reviewing Officer. This was rightly and understandably viewed as being a positive step in that the placement was in an area that was much more familiar to Child M and nearer to her family. During her time living in East Sussex, Child M had lived in shared lodgings with Mr C and in supported accommodation and she had spent four months in secure accommodation. She had not regularly attended education or engaged consistently with CAMHS or substance misuse services. She had little in the way of positive networks or support in East Sussex and no good reason to live there in the long term.

4.14.2 Research and the findings of a number of SCRs highlight the additional difficulties that arise for local authorities and other agencies when a young person in care is placed outside the local authority area, particularly if the placement is at some distance.[33] Typically provision for such children may suffer for a number of reasons:

- Existing professional contacts and networks can be disrupted
- Social workers from the home authority may have less contact with the child because of the additional time that it takes to make visits
- As a result, in many cases the level of contact defaults to visits at the statutory minimum level , i.e. every six weeks, and may not be in keeping with the needs of the child
- Social workers from the home authority are required to work with networks of professionals and services that they do not know

[33] HMI Probation, Ofsted and Estyn (2012), *Looked After Children: An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home* https://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/serious_case_reviews_2013_wda94557.html For example, Brent LSCB (Child H); Tower Hamlets LSCB (Child F)

- It is more difficult to respond quickly to developments and emergencies
- Information sharing and service planning become more complex, particularly if records move slowly between professionals in different areas.

4.14.3 Some of these factors did not apply in relation to Child M. For example, she did not have a good engagement with professionals or agencies in East Sussex and she was returning to an area where she was already known to a number of services. East Sussex was mindful of the potential risks of the move and made efforts to ensure that it was planned and well-coordinated. The supported lodgings were well researched and recommended by Surrey's leaving care service. Referrals were made to local CAMHS and substance misuse services, although Child M subsequently chose to have very little meaningful engagement with either. Child M's social worker visited more frequently than the statutory requirement.

4.14.4 The management review provided by East Sussex children's social care has noted that it would have been useful if there had been a face-to-face meeting organised involving Child M and the Surrey agencies who would be involved. Although this would have been time-consuming, it may have helped firm up the details of arrangements for local services and it would have been very useful for Child M and the carer in her supported lodgings to have direct contact with the professionals who would be involved. The SCR has previously noted the value added by the complex case meetings held in East Sussex.

4.14.5 It is common ground that the movement of a looked after child from one area to another can lead to difficulties in sharing information with professionals in the area to which the child is moving, particularly between health services. There are very often normal delays in the transfer of GP records between practices which affect the population as a whole. The transfer of GP records is always of importance for a looked after child and was particularly important for Child M as she was being prescribed medication by a CAMHS psychiatrist. On a number of occasions, CAMHS providers, the inpatient unit and community services in Surrey and Sussex, took some time to forward records of their involvement to colleagues who were taking on responsibility for Child M. Whilst the services may have been waiting for written requests or consent, more emphasis needs to be placed on the speedy transfer of records.

4.14.6 However, there are often differences in views as to how best to address these difficulties.[34] There is a strong case that health professionals need to take responsibility for sharing health information and coordinating health services. However, the health economy is now so fragmented that it is much more difficult to guarantee the coordination of information about a looked after child, especially one with complex health needs, from within the health service. It is often the case that the GP, who in theory stands at the centre of health provision, may not have an accurate overview of the health services being provided. GPs often do not know that their patients have left the practice until another practice asks for the records and it can take weeks to transfer records and weeks more for records to be summarised. If a child moves rapidly through placements health records may never catch up with the child. The system for looked after children's health assessments can at best provide an annual retrospective overview, often based on partial information.

[34] In the author's experience these are often manifest in discussions about the findings and recommendations of SCRs.

4.14.7 If the health service cannot be relied upon to coordinate health information then it may need to fall to the child's allocated social worker, acting as the corporate parent, to gather and hold information and to inform care providers such as foster carers, residential units and those who run supported lodgings with a full picture of the child's health needs and then ensure that this information is provided to the child's GP in the area to which the child has moved.

4.14.8 The SCR can identify and describe this area of potential vulnerability, but it is not possible to provide a simple recommendation as to how it should be addressed. The LSCB and its member agencies should however consider this further, taking into account the roles and responsibilities of placement providers, GPs, allocated social workers, providers of substance misuse services and the LAC health service.

4.15 Challenges posed by Child M's unplanned movement across local authority boundaries

4.15.1 On a number of occasions Child M went missing and was found in different local authority, health or police areas. This included times when she presented in hospital or was apprehended by the police because she was missing, suspected of offences or believed to be at risk. Details of these episodes are in Section 3 of this report.

4.15.2 In some instances, Child M's presentation 'out of area' was dealt with very thoroughly, correct decisions were made about how to assess and manage risk and information was shared with the 'home' authority so that further measures could be taken on her return.

4.15.3 On other occasions the response was not as thorough as it should have been because professionals assumed that she would return home to an area where she was already engaged with services. Because Child M was not always cooperating with services in her home area, and because sometimes she was not truthful, this approach sometimes hindered good service provision as it left gaps in information about events.

4.15.4 Inevitably, it is difficult to have completely reliable, prompt sharing of information when a child or child presents unexpectedly in different localities. Most agencies rely on local or in-house information systems and even police services which have some systems that operate across the UK, such as the police national computer, also maintain additional local databases and systems in order to support their local operations.

4.15.5 A number of the agencies that have prepared management reviews for the SCR have made specific recommendations as to how in future their response might be improved. The SCR suggests that there is a general lesson to be learned that professionals need to be cautious and risk averse when dealing with a vulnerable adolescent who has presented out of their home area and that they should seek as much background information as they can from professionals who know the child before making decisions. It is recognised that sometimes circumstances limit the time available to decide how to proceed.

4.16 Use of secure accommodation

4.16.1 Child M spent the period between late December 2011 and early March 2012 in secure accommodation as a result of an order made by the family court. It was later established that, because of a legal technicality relating to Child M's age and her legal status, the first two days of her detention were unlawful because the court had deferred making an Interim Care Order in parallel with the Secure Accommodation Order. Regardless of this, there is no

doubt that from the perspective of the professional responsibility to safeguard Child M both the application and her detention were fully justified and there was no viable alternative approach with which Child M would have cooperated.

4.16.2 There is a paradox about the use of secure accommodation. While a child is detained it is often impossible for them to continue behaving in the way that led to their detention in the first place. This was particularly relevant in Child M's case. While she was in secure accommodation she could not abscond, take drugs or place herself at risk of overdose with Mr C. Her behaviour in secure accommodation was always going to be a bad guide to her behaviour once she was discharged.

4.16.3 Statutory reviews of the continuing need for the use of secure accommodation are held after one month and then at least every three months. For the reasons set out in the previous paragraph there is always a strong possibility that a review will find that grounds for the continued detention do not exist. This makes it essential that the best possible use is made of the entire period of detention to plan for the future needs of the child and that this does not only happen in a hurried fashion once a review has decided to discharge the child.

4.16.4 The SCR considered whether better use could have been made of the period when Child M was in secure accommodation to understand the origins of her behaviour, to develop better working relationships with her, to understand more about her relationship with Mr C and to develop the best possible package of care for when she left. The evidence on this is mixed. Health trusts have recognised that much better use could have been made of this period to assess Child M's health needs, to collate and review records, to plan future provision and to make sure that professionals who would be dealing with Child M in future could do so with a full understanding of her needs. The notes of potentially important planning meetings held in the secure units were very limited. Social work and substance misuse service staff made visits to Child M but it is difficult to tell how intensive the work with her was. The local authority report notes that Child M engaged only 'superficially' and there is little detailed evidence of the work that was done with Child M when she was in secure accommodation. The CAMHS service could only offer appointments some distance from the secure unit.

4.16.5 It is impossible to make a general finding about the effectiveness of the use of secure accommodation from one case. The SCR believes that this is an opportunity for both of the local authorities that provided secure accommodation to Child M, one of which also held case responsibility for Child M, and the relevant health commissioners and providers of education and training to undertake a wider audit of the arrangements of the effectiveness of planning for children in secure accommodation.

4.17 Potential use of other legal measures by the local authority

4.17.1 The SCR has sought legal advice on the possible use of other legal powers, such as the use of civil injunctions, to consider whether they might have been used to protect Child M at any point. It is satisfied that East Sussex children's social care gave proper consideration to the range of legal powers that were available and that no other legal power offered a solution that was not considered.

4.17.2 The following section considers the use by agencies of the powers under Section 2 of the Child Abduction Act 1984 and Section 49 of the Children Act 1989.

4.18 Use of Warning Notices under Section 49 of the Children Act 1989

4.18.1 The SCR has considered the effectiveness of the steps taken by agencies under two legislative provisions which are designed to prevent risks to children arising from their removal from their home or from local authority care.

4.18.2 Section 2 of the Child Abduction Act 1984 enables the prosecution of a person who unlawfully removes a child from his or her parent or anyone else having 'lawful control' of the child. It applies to children under the age of 16 and was designed to prevent the abduction of children in contested custody cases, though its application is potentially wider.

4.18.3 Section 49 of the Children Act 1989 makes it a criminal offence for a person to knowingly and without lawful authority or reasonable excuse remove or keep a child away from the care of the local authority.[35] It applies to all children in care, up to the age of 18, and was designed to prevent parents from removing children from care, emergency protection or police protection. Breaching it may result in the court making a Recovery Order, a short term of imprisonment or a fine. It was intended to provide a disincentive to anyone to remove a child and a practical remedy to enable a child to be protected.

4.18.4 In recent years both of these provisions have been used more widely to seek to protect children and young people from a variety of difficulties, including substance misuse and sexual harm.

4.18.5 In April 2011 Thames Valley Police removed Child M from Mr C's home in Buckinghamshire. He was served with a Warning Notice under the Child Abduction Act 1984 threatening arrest if the notice was breached. The notice had legal effect for less than two weeks because it only applied until Child M was 16.

4.18.6 The provisions of Section 49 of the Children Act 1989 became relevant when Child M was made the subject of a Care Order in April 2012, and remained relevant until the time of her death. At the request of East Sussex County Council, Thames Valley Police served Mr C with a Warning Notice under Section 49 on 27 April 2012. The terms of the Notice were comprehensive setting out in very specific terms that Mr C must have no contact with Child M and that if she initiated such contact he should refuse it and alert the police or social care staff.

4.18.7 There is strong evidence in the contemporary records, supported by more recent discussions, that both the local authority and Child M's parents placed considerable faith in the existence of the Notice. The parents in particular believed that, while the Notice was in existence and until she was 18, it would mean that Mr C could be prevented from having contact with Child M, or that at the very least contact would lead to his arrest. It is easy to see why the detailed and apparently tough wording of the Notice would lead an ordinary person to believe that to be the case. In the event, although Mr C breached the Notice on

[35] The legislation covers a child who can run away by including in its definition, *keep a child away from care or induce, assist or incite a child to run away or stay away* from the placement made by the local authority.

numerous occasions, the police forces involved took no action to enforce it. There are concerns at three levels.

4.18.8 Firstly, there were administrative weaknesses in the way in which information about the Notice was held and processed by different police services which made it harder to notice and enforce. When it was served, Thames Valley Police placed details of the warning on Mr C's Police National Computer (PNC) entry but not on Child M's. As a result, contacts with her did not alert police officers to the existence of the Notice or prompt them to investigate whether she was in contact with Mr C. It was only when its existence was brought to the attention of the police by Child M's parents or by the local authority social worker that police became aware of it.

4.18.9 Secondly, there was a lack of clarity between police services as to how individually or collectively they should act on the Notice. In January 2013 Child M's father and the local authority told Surrey Police of evidence that Child M and Mr C had been in contact. Surrey Police processed this and stored it as intelligence for its own future use but did not bring the existence of the concerns raised by the family and the local authority to colleagues in Thames Valley Police, in order to prompt enforcement of the Notice. The staff and officers do not remember the reasons for their decision but it may be that they had little or no knowledge of the role that the Notice could play.

4.18.10 It is not clear whether the responsibility for oversight of the action taken in relation to the Warning Notice should have rested with Sussex (which in a general sense might be thought of as having a child protection responsibility towards Child M as she was in the care of East Sussex) or with Surrey (where she was resident and where some of the contacts had taken place) or to Thames Valley Police (which had served the Notice, where the person named in the notice lived and where other contacts had taken place).

4.18.11 Thirdly, neither legal provision was designed to be used in circumstances such as these. The provisions of the Child Abduction Act 1984 are designed to address the problem of children being abducted by their parents. The provisions of the 1989 Children Act are designed to prevent children being removed from care, usually by a parent or a perpetrator of proven abuse. It appears that some police forces have tried to be creative in the use of such Notices in order to assist in cases involving adolescents where there is an element of risk or sexual exploitation. Child M's case was complex and possibly not well suited to the use of a Notice as, at times, she actively wanted to be with the person named in the Notice. Advice given to the SCR is that before a Warning Notice is issued advice needs to be obtained from officers with specialist knowledge and the Crown Prosecution Service to ensure that the Notice is properly drafted and the actions of the police in serving and enforcing it maximise the chances of successful enforcement.

4.18.12 It would be wrong to understand these as individual errors by the officers concerned. Underpinning all of these difficulties is the fact that there is at present no proper national policy in relation to the use of these statutes and the associated Warning Notices and no agreed standard operating procedures for local police services.

4.18.13 There are examples of Warning Notices being used successfully where they relate to the possible exploitation of older adolescents but this has happened where considerable thought has gone into the development of local policy and practice. The SCR has been told

that the Child Exploitation and Online Protection Centre (CEOP)[36] is currently undertaking work to develop a coherent national approach on behalf of the police. This could use the shortcomings of the work undertaken in this case as an example of how not to implement a Warning Notice. If a national policy does not resolve the difficulties, legislation which is tailored more specifically to the circumstances of cases of exploitation of adolescents may be an alternative. The SCR has made a recommendation in relation to this.

4.19 Evidence of good provision and professional practice that should be recognised and encouraged

4.19.1 The previous sections of the report have focused on aspects of service provision where the SCR has identified some weaknesses or shortcomings in the provision that was made for Child M. It is also important to recognise that there were aspects of the services that Child M and family members received that were good and should be noted and encouraged. It is important to learn from the ordinary things that are done well, noting that many of the professionals involved were working under considerable pressure and that Child M often made it hard for professionals to help her.

4.19.2 Throughout the case history, a number of professionals, including social workers, CAMHS workers and substance misuse workers, made sustained efforts to engage with Child M, to understand her difficulties and to help her make better, safer choices. At times Child M made it very difficult to do this. Child M received very good clinical care on the occasions when she presented at or was taken to hospital having taken overdoses.

4.19.3 Child M's parents received good support and advice on parenting from the Youth Support Service in Surrey. They valued this and valued that it continued beyond the point where the statutory order on Child M expired and the service could have ceased to be involved.

4.19.4 From September 2011 onwards the social work assessment of risk and need were of a good standard. There was value in the efforts that were made to coordinate a network of support for Child M through the complex cases meetings.

4.19.5 East Sussex County Council was right to interpret its statutory duties by seeking both a Care Order and a Secure Accommodation Order on Child M, even though her age made this an unusual and complex step.

4.19.6 Child M's return to Surrey was generally well planned and coordinated. Once there, she gained a great deal from her involvement with the Prince's Trust while she was living there. The GP who treated her on her return was alert to her needs as a young substance misuser and mindful of the dangers of over-prescribing.

[36] A branch of the National Crime Agency

5 SUMMARY OF KEY EVENTS AND REVIEW FINDINGS

Summary of key facts and findings

5.1 This section of the report summarises key events and the findings of the SCR.

Overview of Child M's difficulties

5.2 From the age of about 13 Child M is known to have used alcohol, prescription medication and banned substances. This can now be understood as being behaviour that she claimed to enjoy as well as a form of self-medication for the problems in her life. There appears to have been ready access to drugs and alcohol in the community in which Child M grew up and in her substance misuse she was not alone among her peers.

5.3 Some of Child M's difficulties were the sort of ordinary problems that many adolescents face. Some, such as bullying, were difficulties which her parents and the adults in her life would have wanted her to avoid or help her to resolve. Child M may have had much more serious difficulties. There are indications in the records that she had been the victim of a serious sexual assault at the age of 13, though she never gave more information about this and was not willing or able to seek help from the adults around her.

5.4 At about the age of 13 Child M's use of alcohol and drugs led her to be targeted by Mr C, an adult who was seven years older than her whom she came to view as her boyfriend. Whilst being considerably older than Child M, this individual also had psychological and mental health problems and a chronic pattern of addiction. Mr C had convictions for the supply of banned substances and he repeatedly sought Child M's company and supplied her with drugs.

5.5 Under the influence of this man and possibly other adults, there is evidence that Child M actively embraced substance misuse, believing that it added to the quality of her life. When this was the major driver in her life she paid no attention to information, advice and warnings given by her family and professionals.

5.6 At other times, the evidence is that she could live drug free, able to focus on positive activities, keen to find fulfilling employment and capable of sustaining contact with friends who were not a destructive influence. It is always difficult for a troubled adolescent to sustain positives. Faced with setbacks such as being required to leave her lodgings and finding it hard to gain employment, Child M fell back into contact with drug users and suppliers. Child M's death, which was shortly before her 18th birthday, was particularly tragic as it came after what had appeared to be a positive time for her when she had completed training and activity programmes with the Prince's Trust and had also spent positive time with her family.

Identified strengths and weaknesses in service provision and professional practice

5.7 Professionals offered additional support to Child M in relation to her behaviour and underperformance in education from 2008 onwards and, from July 2010 until her death, in relation to the risks associated with her substance misuse. There were points during this time when she sought the support of professionals, cooperated with the services that they provided and followed advice given. However, for the majority of the time Child M posed a severe challenge to the professionals who were trying to work with her because her priority was to be with the adult that she viewed as her boyfriend and to take drugs. When this

happened she paid little attention to the advice and information provided about the risks associated with substance misuse, despite overdoses that repeatedly caused her serious harm. In general, this pattern of behaviour became more entrenched as Child M grew older and she became progressively harder to reach.

5.8 A number of professionals tried hard to form the kind of trusting relationship with Child M within which she might be more amenable to receiving advice, but without any lasting success. There was much that was good in the work that professionals did with Child M and it was valued by her parents and family.

5.9 Whilst appreciating the efforts of professionals and the very real difficulties that there were in working with Child M, it is important to recognise that her behaviour had features in common with that of many other children. The review must therefore seek to learn lessons and improve services for other children, noting weaknesses in the provision made as well as the strengths.

Key episodes and learning

5.10 Child M's school and a number of other agencies made efforts to offer her early help in Surrey during the period between 2008 and 2011. There was no lack of capacity but the impact of professional efforts was hampered by the lack of coordination. The SCR has been told that Child M was bullied at school during this time, but no evidence has been provided of this being noted in school records or help being provided.

5.11 In early 2011 Child M's health was placed at serious risk through the first of a series of drug overdoses. The children's social care service in Surrey seriously underestimated the potential level of risk to Child M at this point and did not take the required steps to bring agencies together to evaluate and manage the risks to Child M or to coordinate the work of the agencies that were already working with her.

5.12 In the months following this incident, Child M's substance misuse continued and she showed signs of anxiety, depression and self-harm. The risk of psychiatric illness and a further overdose led to her compulsory detention under the Mental Health Act 2007 in an inpatient psychiatric adolescent unit in East Sussex. Her stay in hospital lasted for about four months. Child M was now aged 16 and during this time professionals struggled with the conflict between their desire and responsibility to safeguard Child M from risks posed by her behaviour and her own wish to live with the adult male whom it was feared would expose her to further risks.

5.13 At this point and on a number of later occasions professionals were required to grapple with the complexity of the legal frameworks which apply to the rights and responsibilities of 16 and 17 year olds. This is extremely permissive in some regards, offering adolescents who are judged to be competent many of the same rights and responsibilities as adults but at the same time placing safeguarding responsibilities on professionals. The review has identified important learning in relation to this, though it offers no easy solution.

5.14 In October 2011 Child M moved to East Sussex to live with Mr C. The local authority was extremely concerned by the risks of this arrangement and by Child M's refusal to cooperate with aspects of the plan that had been put in place to reduce risk to her. It coordinated the work of the professionals involved but could only act when there was clear evidence of harm and future risk. The actions of the local authority in obtaining interim orders and then a Care

Order and also an order to place Child M in secure accommodation were unusual steps in relation to a child of 16 and 17 years of age but they were fully justified by the risk that she posed. The Care Order provided the local authority with parental responsibility for Child M and in theory enabled it to determine where Child M should live. In practice, it was only possible to do this through persuasion and gaining Child M's trust. The approach taken was only partially successful.

5.15 Child M spent four months in local authority secure accommodation between December 2011 and March 2012. Importantly, this protected Child M for that period from the risk of overdose though it did not alter her long-term pattern of behaviour. The SCR has asked the local authority and the agencies that provide secure accommodation to consider whether more positive and intensive use could have been made of young people's time in secure accommodation in order to maximise the potential benefits. This period of respite also offered an opportunity to ensure that all aspects of service provision, including particularly health services, were as well coordinated as they could be. More could have been done at this time.

5.16 Between April 2012 and her death in March 2013 Child M was in care (on a Care Order) to East Sussex County Council. The local authority placed her in supported lodgings in East Sussex and then, in order that she could be nearer to her family, in similar accommodation in Surrey. For the last two months of her life Child M lived in bed and breakfast accommodation as a result of having been forced to leave her supported accommodation because of her aggressive and difficult behaviour. During this 13 month period Child M's behaviour and mood fluctuated. There were periods when she engaged positively with professionals and others when substance misuse and her relationships with other drug users became the main drivers in her life.

5.17 In theory, Child M was barred from having contact with Mr C during this period by a Child Abduction Warning Notice issued by the police under Section 49 of the Children Act 1989. Her parents and the local authority set great store on this, but its effectiveness was undermined by a lack of clarity on the part of the police services involved as to how to enforce it. This stemmed in the main from the lack of national policy and agreed procedures. It is unclear whether this measure, which was not designed with circumstances such as those of Child M in mind, could be used effectively to protect a vulnerable child from the risk of exploitation, or whether wider legal changes are required in order to make this possible.

5.18 Between 2010 and 2013 professionals in a number of young people's substance misuse services offered Child M considerable input and advice. Ultimately, the success of their work relied on Child M making the decision that she wished to live more safely, which she was unable to do.

5.19 Adult drug and mental health services were sporadically involved with Mr C throughout the period under review, but they had no positive effect on his behaviour or substance misuse. He appears to have been adept at appearing to cooperate without consistently keeping appointments or following treatment suggestions.

5.20 Mr C was also subject to probation service supervision for a nine month period between September 2011 and April 2012. He was supervised in line with the national standards and complied with appointments sufficiently to satisfy the requirements of the order. He was not

reconvicted during the period of supervision; however, the order had no positive impact on his substance misuse and did not reduce the risk he posed to others.

Recommendations for action

5.21 Section 6 of the report sets out recommendations made by the SCR overview report which draw on the material provided by all of the agencies involved with Child M. These propose actions to be taken by the LSCB and member agencies to improve services for other vulnerable children.

> *Update Comment: There has been significant practice development and understanding of CSE since the date of Child M's death. It is of significance that many agencies referred to Mr C as 'boyfriend' when this was an exploitative relationship and posed a risk to child M. There needs to be a further recommendation that the LSCB requires all agencies to give greater regard to the use of language and the impact it can have on perception of risk.*

5.22 These stand in addition to the recommendations already agreed by the individual agencies that have participated in the review. The 28 agencies from several local authority areas and regional agencies that contributed to the SCR have between them made some 70 recommendations. These deal largely with important local aspects of practice and procedure within individual agencies and are focused on the following areas of service provision:

- Better sharing of information at the point of referral and case transfer
- Improved risk assessment, including the recording of risk assessments
- Policy and practice in relation to young people who repeatedly go missing
- Information sharing about vulnerable students in schools and colleges
- The response of acute hospitals to contact with young people who overdose
- Health provision for looked after children
- Improving responses to the needs of children who are being treated in Tier 4 psychiatric inpatient units

5.23 The implementation of actions arising from these recommendations will be monitored by East Sussex LSCB and the LSCBs in areas where contributing agencies are located.

Could Child M's death have been predicted and if so could it have been prevented?

5.24 Between April 2011 and her death nearly two years later Child M repeatedly injected ketamine and heroin and she overdosed on a number of occasions. She paid little attention to the guidance of her parents and other family members or to the professional advice that she received about the risks of this and how they might be avoided and chose instead to place her trust in other drug users.

5.25 Child M's pattern of behaviour placed her at a very high level of risk and there were only limited steps that the professionals involved could take to prevent her from overdosing. Had Child M not died in March 2013 it is highly likely that she would have overdosed again and at some point she is very likely to have done herself lasting, serious harm or killed herself. Professionals made substantial efforts to safeguard Child M including steps, unusual in the case of a 16 and 17 year old, to place her in care and in secure accommodation. Ultimately, only Child M could make the choice to stop behaving in a self-destructive way.

5.26 There were weakness in the services that were provided to Child M and her family which have been set out in detail in Section 4 of this report. However the SCR cannot point to any specific episode or episodes where it can be said with certainty that a different course of action by professionals would have prevented her death.

Update comment: The conclusion of the inquest stated that 'from the evidence, it is not possible to say, on the balance of probabilities, that, if any or all of the available opportunities to take action had been taken, the outcome would have been different'. Whilst the weaknesses in services identified potentially could have led to different outcomes if a better response had been provided, as with any circumstance, the SCR panel concurred with the conclusion of the Coroner.

6 RECOMMENDATIONS FROM THE OVERVIEW REPORT

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
Children's service provision in Surrey				
1.	4.2.10	Early help in Surrey was poorly coordinated and the CAF was not well understood. Since this time procedures have changed and professionals in Surrey say that this case would be dealt with differently. Nationally there are often concerns about coordination of help for secondary school age children.	Surrey LSCB has a better knowledge of early help in the county, including to children with substance misuse problems. This enables it to challenge local agencies.	As part of its responsibility to monitor and challenge the effectiveness of local children's services, Surrey LSCB should satisfy itself that arrangements for the coordination of early help are as effective as they can be, paying particular attention to coordination of help to children of secondary school age. This should include, but not be limited to, those who have problems of substance misuse.
2.	4.2.14	The repeated referrals and contacts to the Surrey County Council Contact Centre were not treated collectively. Since this time procedures have changed and professionals in Surrey say that this would be dealt with differently. There are to be new arrangements with a multi-agency hub and a different management of the Contact Centre.	Agencies in Surrey respond effectively in future when there are cumulative small concerns.	Surrey LSCB should ensure that the new multi-agency contact and referral arrangements identify and respond to repeated contacts which do not individually trigger an initial assessment but which might cumulatively merit action by social care.
3.	4.3.5	Parents allege that bullying of Child M in the school was not addressed. The school has reviewed and updated its anti-bullying protocol and procedures.	The school should respond effectively to future instances of bullying.	Surrey LSCB should ensure that school responses to bullying are challenged through the Section 175 audits that the board carries out. It should also ensure that the school improvement and challenge function of the local authority properly assists schools in combatting bullying.
4.	4.4.2	There is evidence from the parents of Child M of the widespread and easy availability	A safer environment for young people in this and other	The relevant Surrey Community Safety Partnership or similar body with local

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
		of prescription and banned substances in the home town of Child M.	localities in Surrey.	responsibility for commissioning young people's substance misuse services should consider whether this is a wider concern and take the action it considers relevant.
5.	4.5.19	Front-line services in Surrey children's social care performed badly in this case because they were under high levels of pressure and more senior managers played no positive role in recognising and responding to what staff perceived to be impossible demands.	When any agency is under high levels of pressure senior managers should know about this, accept responsibility for the problem and respond positively.	Surrey LSCB should ensure that all member agencies' front-line staff are offered an effective means of expressing concerns to senior managers about the impact of pressures on services on the quality of services. The LSCB should monitor the effectiveness of the steps taken by member agencies.
6.	4.5.19	Thresholds for initial and core assessment were too high and did not recognise important risk factors.	Agencies across Surrey operate thresholds at appropriate levels and the LSCB can monitor their implementation.	Surrey LSCB should take steps to establish that thresholds for assessment of cases involving difficult adolescents who are at risk of significant harm are now operating appropriately across the county.
7.	4.6.4	Child M received very limited provision from agencies in Surrey when she was an inpatient and had no allocated social worker. Surrey County Council and partner agencies now treat any young person admitted to a Tier 4 inpatient unit as a child in need who is the subject of joint planning, ideally before the admission, or if that is not possible, then immediately afterwards. Allocations are made to the multi-agency HOPE service.	There should be an appropriate level of service provision for children and young people from Surrey who are admitted to a Tier 4 inpatient unit, including input from the local authority and allocation as a child in need where this is appropriate.	Surrey LSCB should consider how best it can monitor and challenge the work of member agencies in relation to young people who are placed in Tier 4 psychiatric provision, especially those placed outside Surrey.

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
Child protection policy and practice				
8.	4.9.8	Child M's age impacted negatively on the provision made for her in that some professionals were less willing to use child protection procedures because she was 16 (or nearly 16) or 17.	There is better protection for children aged 16 and 17 and the use of child protection procedures when it is necessary.	All the LSCBs whose member agencies were involved in this case should give a clear message that child protection arrangements apply in full for young people aged 16 and 17 and that in appropriate circumstances a young person aged 16 or 17 years may need to be the subject of a child protection investigation, conference or plan.
9.	5.21	It is of significance that many agencies referred to Mr C as 'boyfriend' when this was an exploitative relationship and posed a risk to child M.	All agencies give due regard to the use of language and the impact it can have on perception of risk.	All the LSCBs whose member agencies were involved in this case should ensure that there is a policy and practice change in relation to the use of 'adult who poses a risk' as opposed to 'boyfriend' or 'girlfriend' when working with cases of child sexual exploitation.
Substance misuse services				
10.	4.11.13	Substance misuse services to Child M usually offered standardised programmes and interventions, rather than tailored approaches that related to her particular reasons for taking drugs and her overall needs as an adolescent.	More effective work with young people who misuse substances, based on more holistic assessments which take account of the background of a young person and pertinent current problems such as domestic abuse and sexual exploitation.	As well as offering standard programmes and advice, agencies providing substance misuse services should consider carefully how to tailor their services to the needs of individual young people, taking into account their motivation for misusing substances, their personal histories and pertinent relationship difficulties, such as domestic abuse and sexual harm, where these are relevant.
11.	4.12.5	At times Mr C had simultaneous contact with mental health, GP and substance	Properly coordinated prescribing and better liaison	Commissioners of substance misuse services and the NHS Local Area Teams should ensure

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
		misuse services. On occasions there was evidence of simultaneous prescribing. Information sharing between services was limited.	between GPs, mental health services and specialist substance misuse services.	that there are coordinated prescribing arrangements and information sharing protocols in place in relation to patients who misuse substances. This should include substance misuse services, GPs and mental health services. Agreed protocols should be monitored to ensure compliance.
12.	4.12.10	Substance misuse services provided to Mr C were ineffective.	Substance misuse services for adults in Buckinghamshire are more effective.	The Drug and Alcohol Team for Buckinghamshire should ensure that its services are kept under regular and close scrutiny in order to maximise the effectiveness of any provision, paying particular attention to, 1) the coordination of prescribing, 2) liaison between mental health, substance misuse services and GPs, and 3) more challenging review of services where service users are repeating patterns of behaviour, making no progress towards achieving pharmacological stability reducing associated drug harms, and remain resistant to engaging in recovery interventions.
13.	4.13.4	Adult substance misuse services showed no curiosity about the age or circumstances of the 'younger partner' Child M.	Vulnerable adolescents linked to adult substance misusers are identified and helped.	Adult agencies, including especially mental health and substance misuse services, should routinely ask for details of children and young people who may be affected by the behaviour of a service user. This should apply to substance misusers whose behaviour may impact on the well-being of adolescents as well as obviously vulnerable young children.

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
Interagency working				
14.	3.159	GP records across the case history show a lack of feedback from specialist services.	The GP should be at the heart of service provision and GP records should capture all health involvement.	LSCBs should remind specialist agencies, including specialist substance misuse services, of the importance of working closely with GPs in order to obtain relevant background information, coordinate care and prescribing and ensure good continuity of care after discharge and when a patient moves.
15.	4.14.8	On a number of occasions CAMHS providers (the inpatient unit, and community services in Surrey and East Sussex) took some time to forward records of their involvement to colleagues who were taking on responsibility for Child M. Whilst the services may have been waiting for written requests or consent, more emphasis needs to be placed on the speedy transfer of records.	Timely information sharing about CAMHS patients when they move location.	CAMHS services should be reminded of the need for prompt responses to information about former patients.
16.	4.14.8	The continuity of health provision between agencies was made more difficult when Child M moved between local authority areas. Systems for the coordination of health care for looked after children are vulnerable when they move placement.	Better coordinated health provision for looked after children who move across local authority boundaries.	Through the corporate parenting group, the East Sussex LSCB and its member agencies should consider how it can improve the continuity and coordination of the health care provided for looked after children when they move placement, especially to a different local authority area.
17.	4.15.5	Child M sometimes did not get a good service when she presented in an	Young people who go missing or are found outside their	The LSCBs involved in the SCR should remind all professionals of the particular

	Section in the report	Concern or learning point	Desired outcome	Recommendation or finding requiring action for further consideration
		unplanned way in other local authority, health or police areas. The SCR suggests that there is a general lesson to be learned that professionals need to be cautious and risk averse when dealing with a vulnerable adolescent who is found out of their home area and that they should seek as much background information as they can from professionals who know the adolescent before making decisions. It is recognised that sometimes circumstances limit the time available to decide how to proceed.	home area receive a safer service and information is shared appropriately with the home authority.	vulnerability of children who go missing or present in a different local authority area and the challenges that this poses. They therefore need to be cautious in their decision-making about such children.
Use of Warning Notices Children Act 1989 and Child Abduction Act 1984				
18.	4.18.3	There were important weaknesses in the work undertaken in relation to issuing and enforcing Warning Notices in relation to the Children Act 1989 and the Child Abduction Act 1984.	There should be effective, properly coordinated implementation of Warning Notices by police forces and all professionals involved in safeguarding understand their value and how to work with them.	East Sussex LSCB should report the findings of the SCR to Child Exploitation and Online Protection Centre (CEOP) in order to inform national policy work on Warning Notices. The LSCB should highlight the findings of the SCR to the Department for Education and the Home Office in order to underline the need for national policy work on Warning Notices.

APPENDIX 1

Terms of reference of the SCR

1. Were practitioners aware of and sensitive to the needs of the young person in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare? Did the agency understand the implications of substance misuse and mental health needs in their work? Should the practitioners not have worked in this way, comment should be made about the reasons for this.

2. When, and in what way, was the young person's wishes and feelings ascertained and taken into account of when making decisions about the provision of children's services? Was this information recorded? If this work was not undertaken, the reason for this not taking place should be noted.

3. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

4. Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?

5. What were the key relevant points or opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way, and if this was not the case, what was preventing this?

6. Were concerns about this young person shared between the relevant agencies in a timely manner, with appropriate communication and analysis? How did your agency work and liaise with services in other local authority areas when this was required? Were there any issues with the transition of services? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?

7. Did actions accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?

8. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out-of-hours services?

9. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

10. Were other organisations and professionals involved at points in the case where they should have been?

11. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards? If this was not the case, what was preventing this from happening?

12. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

13. Was there sufficient management accountability for decision-making, including the appropriate involvement of senior managers?

APPENDIX 2

SCR review team membership

Jeremy Leach, Wealden District Council	**Independent SCR Panel Chair**
East Sussex County Council Children's Services	Behaviour and Attendance Co-ordinator
	Service Manager
	Head of Children's Safeguards and Quality Assurance
East Sussex Local Safeguarding Children Board	LSCB Business Manager
East Sussex Clinical Commissioning Group	Designated Doctor Safeguarding Children, East Sussex
	Designated Nurse Safeguarding Children, East Sussex
Sussex Police	Child Protection and Safeguarding Manager, Sussex Police
Surrey and Borders Partnership NHS Foundation Trust	Consultant Nurse Safeguarding Children
Surrey County Council	Area Head of Children's Services
Surrey Safeguarding Children Board	LSCB Case Review Officer
Keith Ibbetson, Children's Services Consultant	Independent Overview Report Author

APPENDIX 3

List of documents and material considered by the SCR review team

		Chronology	Full individual management review	Other documentation or report
East Sussex	East Sussex Children's Social Care	X	X	
	East Sussex Education	X	X	
	East Sussex Health Trust - Acute	X	X	
	East Sussex Health Trust - Looked After Children Health Service	X	X	
	East Sussex Primary Care	X	X	
	Sussex Partnership NHS Foundation Trust	X	X	
	South East Coast Ambulance Trust	X		X
	Surrey and Sussex Probation Trust	X	X	
	Sussex Police	X	X	
	Crime Reduction Initiatives (CRI) - Targeted Connexions	X	X	
	CRI East Sussex Substance Misuse Service	X	X	
	Priory Hospitals Group	X	X	
Surrey	Surrey Children's Services	X	X	
	Catch-22	X	X	
	Surrey Youth Support Services	X	X	
	Surrey School Learning	X	X	
	Royal Surrey County Hospital NHS Trust	X	X	
	Frimley Park Hospital NHS Trust	X	X	
	Surrey and Borders Partnership NHS Foundation Trust	X	X	
	Surrey Primary Care	X	X	
	Surrey Police	X	X	
	Virgin Healthcare	X	X	
Thames Valley Area	Reading DIAS	X	X	
	Royal Berkshire NHS Foundation Trust	X	X	
	Thames Valley Police	X	X	
	Oasis Partnership	X	X	
	SMART CJS	X	X	
	Oxford Health NHS Foundation Trust			X
Hampshire	Hampshire Police	X	X	
West Sussex	West Sussex Children's Social Care	X	X	

APPENDIX 4

Principles from statutory guidance informing the SCR methodology

1. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
2. Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
3. Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition, Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

Working Together to Safeguard Children 2013 (Sections 4.9 and 4.10)

APPENDIX 5

References

Fortin, Jane (2009), *Children's Rights and the Developing Law*, 3rd edition, Cambridge University Press

HM Government (2013), *Working Together to Safeguard Children*

HM Government (2010), *Working Together to Safeguard Children*

LSCB Regulations 2006 (Regulation 5)

Ofsted (September 2011), *Annual unannounced inspection of contact, referral and assessment arrangements within Surrey County Council children's services*, letter summarising the findings of the recent unannounced inspection of contact, referral and assessment arrangements within local authority children's services in Surrey County Council conducted on 9 and 10 August 2011

Ofsted (October 2011) *Ages of concern: learning lessons from serious case reviews - a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to March 2011*

Vincent, Charles (2010), *Patient Safety*, 2nd edition, Wiley-Blackwell BMJ Books

http://foyer.net/about-us/#our-mission

www.talktofrank.com