Learning & Improvement Briefing 1

Disseminating and Embedding Learning from Serious Case Reviews

EW Serious Case Review May 2014

The Serious Case Review into the death of EW, aged 16 years, was published on 29 May 2014 by WSCB. EW lived in Worcestershire and had for a period of time been a Looked After Child (LAC). The full SCR Overview Report is available on the WSCB website www.worcestershiresafeguarding.org.uk

Summary:

EW's family originated from the West Midlands and were known to 16 agencies during the course of EW's life. As a young child EW was the subject of a child protection investigation when it was suspected that she had been sexually abused and she was referred to a Consultant Paediatrician after reportedly falling without apparent cause. No medical reason could be found and a psychiatric referral was made by the GP in respect of psychological problems. It was also noted that EW had expressed a wish to die from an early age. She was seen by a Consultant Psychologist, but treatment ceased due to lack of engagement.

The family moved to Worcestershire and EW started to undertake a caring role within the household providing physical and emotional support to her mother who had been injured in a car accident. EW's father developed depression after giving up work to care for EW's mother and he received support from Adult Mental Health Services. There were also problems with debt and domestic abuse within the family. Referrals were made to both Adult and Children's Services Social Care for support.

EW attended the Sexual Health Clinic at High School and stated that sexual activity had taken place between herself and an older male in a Position of Trust (Karate Instructor). However, she quickly retracted this, but it did result in a referral to Children's Social Care, a strategy meeting was held and an initial assessment undertaken. The referral was closed only to be opened again one month later when information was received that EW had been self harming and had expressed a wish to die.

EW received support from the Child & Adolescent Mental Health Service (CAHMS), but despite this took a serious drug overdose, which led to admission to a specialised adolescent psychiatric unit. Whilst there EW disclosed having been sexually abused by the same adult male, who was subsequently charged with criminal offences.

EW did not return to live with her family and was taken into voluntary care by the Local Authority. She was placed in foster care and continued to received support from CAHMS. During this time EW achieved very good results with school work and was actively involved with Worcestershire's Children in Care Council, Who Cares We Care. Tensions arose in the foster placement concerning the impending criminal proceedings. An unsettled period ensued with a disclosure by EW to a Consultant Psychiatrist that she had self harmed and had thoughts of committing suicide by hanging, which went as far as some preparation.

Relationships in the foster home became difficult, EW went to stay with friends and a decision was taken that she could not return to the foster placement. EW was very distressed by this and was seen by the Out of Hours GP Service. The following day she attempted contact with the fostering agency, but refused to speak with Social Workers from Children's Services or anyone else. She sent a message to her former foster carers which said "*please forgive me for what I am about to do*." Children's Services Emergency Duty Team was informed of the telephone calls and attempted to make contact with EW. The police were informed, but shortly afterwards a 999 call received which resulted in the discovery of EW's body. The criminal proceedings concluded following EW's death with a conviction and custodial sentence.

Lessons Learnt:

- Need for professionals not to restrict thinking to what they know, or are responsible for, but to consider the whole picture which includes both adults and children. Need to take personal responsibility for questioning, and where necessary challenging, the safeguarding of the child(ren) and any vulnerable adults.
- Information sharing and communication between agencies was inconsistent resulting in professionals being unaware of historical information, of events as they occurred and of the involvement of other agencies.
- Recording practices were not up to standard in the case records of Police Force 2, Children's Social Care and education.
- Blurring of professional boundaries & lack of understanding of respective roles and responsibilities
- Care planning process was not sufficiently robust, with a failure to keep plans updated.
- Instances where management oversight was lacking.
- Lack of a robust multi agency risk management plan despite indications of a strong possibility of recurrence of serious self harm.

Key Actions Taken:

- WSCB's Suicide Prevention Guidance - http://westmerciaconsortium.proceduresonline.com/
- Multi-agency risk assessment and risk management processes
- Re-commissioning of Child and Adolescent Mental Health Services in Worcestershire
- Service Redesign in Children's Social Care
- Improved co-ordination and support when LAC change schools.

Agencies and practitioners should respond to the publication of this SCR as outlined in the Learning and Improvement Framework which can be located at http://www.worcestershire.gov.uk/cms/safeguarding-children.aspx