Learning From a Serious Case Review (Hetty)

Hetty was 17 years and 5 months old at the time of her death and was a Looked After Child having been accommodated at a secure children's home for the last eight months of her life. Due to her risk-taking behaviour and previous instances of self harm staff checked Hetty every five minutes. On the last visit staff entered the room as she was not responding to staff and found that she had a ligature around her neck. Attempts were made to resuscitate Hetty but she was not responsive and despite best endeavours she died.

When not troubled Hetty was ambitious for the future and at various times talked about joining the army or more latterly before her death stated an intention to join the caring profession. "*Hetty was a bright and capable young woman who had the potential to achieve great things*."

Due to the very serious nature of Hetty's death and the regulatory bodies involved a number of inspections and investigations have been initiated.

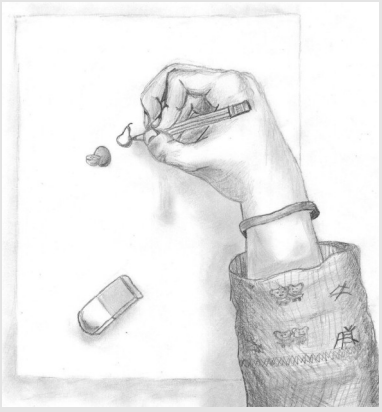
A Serious Case Review (SCR) was carried out by the Worcestershire Safeguarding Children Board (WSCB). The aim of a SCR was to identify learning for individual agencies, as well as for agencies working together to safeguard children. This enables, where appropriate, changes to be made to improve services and how agencies work individually and together to better safeguard and promote the welfare of children.

The Review highlighted a number of recommendations for agencies all of which have been implemented. In addition to single agency recommendations there were some multi-agency recommendations at a local and national level.

An overview of the learning can be found at: https://www.safeguardingworcestershire.org.uk/serious-case-reviews-library/

Learning from this review included:

Professionals need to consider how young people are best able to communicate and recognise that this may not be through talking. Professionals should recognise that young people may prefer to communicate in both formal and informal communication settings and may prefer to express their feelings through activities such as writing and drawing.



Further learning is detailed overleaf ….

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- **Effective information sharing** needs to be more consistent. Particularly in complex cases, it would be useful to have a chronology which follows a Young Person through different placements to assist in the effective sharing of information.

- Professionals at various stages need to demonstrate **professional curiosity.**

- Professionals should recognise and remember that **young people will not readily disclose abuse to them** (see No One Noticed No One Heard: a study of disclosure of childhood abuse. NSPCC 2013).

- When the expectation of the young person cannot be met it is **imperative that professionals feedback why this is the case** – without this they could be left with the feeling that nothing has changed.

- Professionals need better understanding and appreciation of **what constitutes a mental illness.** Severe risk-taking behaviour alone may not, on its own, constitute a mental illness. Professionals need to know what options are available to them if there is no mental health diagnosis.

- Professionals on making referrals or expressing concerns need to have the confidence to **appropriately challenge and escalate matters** when they feel the correct course of action is not being taken.

- It is important to acknowledge and give **appropriate weighting and emphasis to all sources of information**, including third party information. In this case more significance should have been given to the foster carers information.

- Consideration should be given to ensuring that **all aspects of parental responsibility are met.**