Serious Case Review

Summary of learning
in respect of the death of Hetty

Report by: Jon Chapman

Published 11th July, 2019

TABLE OF CONTENTS

1. Introduction

1.1 Hetty was 17 years and 5 months old at the time of her death and was a Looked after Child having been accommodated on 24th March 2015. Hetty spent time with foster carers before spending time at a number of placements. During the period of her placements Hetty started to present risk taking and self-harm behaviours of varying severity.

1.2 Due to the risk that Hetty presented to herself, she was made the subject of a secure order on 6th July 2016, on welfare grounds and accommodated at a Secure Children's Home in the North of England.

1.3 On 18th February 2017 at around 1.00 pm Hetty went to her room at the centre, complaining of feeling unwell. Due to her risk-taking behaviour and previous instances of self-harm staff checked Hetty every 5 minutes. At around 4.30 pm staff entered Hetty's room as she was not responding to staff and found that she had a ligature around her neck.

1.4 Attempts were made to resuscitate Hetty but she was not responsive and despite best endeavours she died.

1.5 The Worcestershire Safeguarding Children Board reviewed the case on 29th March 2017 and with reference to section 5 (2) b of the Local Safeguarding Children Board Regulations 2006, agreed that the circumstances of Hetty's death warranted a Serious Case Review.

2. Hetty

2.1 Hetty had two elder brothers, one younger step brother and two younger half-brothers and one half-sister. It is an enduring feature of this review that Hetty cared deeply for her half siblings and it was her continued concern for their welfare which caused Hetty much anxiety.

2.2 It is clear from speaking to those who knew Hetty well that she very much took on a caring role for her younger siblings whilst she was still resident with them and once she was separated from them not only missed them but worried for their welfare.

2.3 Everyone who knew Hetty would describe her as a very bright and articulate young person and mature beyond her years. At school she was in all the subjects top sets and was a 'straight A student' when she was progressing well without the burden of her anxieties which later disrupted her behaviour and schooling. She was said to be able to relate well to other students and had a good group of friends.

2.4 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.

2.5 The author of the review for the Secure Children's Home stated in the review that 'there is a genuine human tragedy at the heart of this Serious Case Review' and quoted from the eulogy read out by Hetty's Case Manager at a memorial service held for Hetty at the centre.

"*Hetty was a bright and capable young woman who had the potential to achieve great things ... as we saw when received student of the term and so so proud of this. Hetty aspired to be a mental health nurse and she had a kindness and compassion that would have suited this perfectly".*

3. Overview of events

3.1 Hetty was one of three children, the family moved to the Worcestershire area in 2009. The family had previous involvement with children services. Hetty's natural mother received a serious brain injury in 2009 in a car accident and requires support, despite this she retained parental responsibility.

3.2 Hetty's father re-married and from that relationship there was a step brother to Hetty. Her father went on to have three children, which were half brothers and sisters to Hetty and it is these children that Hetty cared deeply for, and her concerns for their welfare became the focus of Hetty's anxiety and concern.

3.3 Hetty and her siblings were the subject of two periods of Child Protection, the first for emotional abuse and the second for physical abuse. Hetty was accommodated with foster carers but after demonstrating severe risk-taking behaviour in the form of self-harm she had periods in a general paediatric hospital and a mental health hospital.

3.4 Hetty was placed at a Residential Home but whilst there made a serious attempt on her life by strangulation. She was returned to hospital where she was assessed as not showing any evidence of a psychotic episode, mood disorder or current mental illness and that she could return to the home with community CAMHS support.

3.5 In September 2014, Hetty moved to a longer-term residential placement. Between this time and June 2016, her self-harming behaviour continued with 70 recorded instances involving the use of ligatures, cutting, scratching and the ingestion of corrosive substances.

3.6 In November 2015, Hetty made some disclosures regarding serious sexual assault that required police investigation. Whilst Hetty wanted to progress the investigation there is no doubt that the investigative process caused her significant anxiety. This was exacerbated by her continued anxiety over the welfare of her siblings.

3.7 Hetty seemed more comfortable making disclosure in writing and poetry and on a number of occasions left items for staff to read.

3.8 On 6th June 2016, Hetty took a substantial paracetamol overdose, having been conveyed to hospital she continued to try to self-harm.

3.9 Hetty was moved to a higher staff ratio childrens home in Scotland, where she continued to try to self-harm. She absconded from the home and attempted to place herself on train lines.

3.10 In July 2016, a secure order to accommodate Hetty was obtained and she was moved to a secure childrens home in the North of England. There was significant difficulty in locating the appropriate setting for Hetty to be accommodated. During her time at the secure home Hetty was on a regime of 5-minute checks.

3.11 There was a lack of effective communication between the Local Authority Children Services and the secure home. There was a wealth of information held at the previous residential home, where Hetty had been located for nearly 22 months, and the new setting.

3.12 Hetty's main concern continued to be for the welfare of her siblings and despite numerous requests her contact with them was minimal.

3.13 There were episodes where Hetty continued to try to self-harm with one of the most severe being over the Christmas period 2016. Between July 2016 and January 2017 there were 39 recorded attempts at asphyxiation, 24 self-cutting episodes and 10 head punching episodes. On one night, staff recorded entering Hetty's room on 14 occasions to remove ligatures.

3.14 On the afternoon of 18th February 2017, Hetty went to her bed stating she felt unwell, staff undertook 5 minute checks. When staff attempted to rouse her for tea she was found with a tight ligature round her neck and was unresponsive. The ligature was removed, and CPR administered. Hetty was airlifted to hospital where she was pronounced dead.

4. Learning points from the case.

4.1 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. This escalation may be on a formal or more informal basis, but the main consideration is achieving the best safeguarding outcome. On two occasions professionals did not agree with the decision to step down Child Protection Plans and whilst these concerns were appropriately voiced there was no use of the LSCB formal escalation procedures. This may be due to a culture of reticence, or a lack of knowledge of what courses of action are open when a dispute arises. This could also be addressed at the start of conference meetings, reminding practitioners of their ability to appropriately challenge.

4.2 Effective information sharing needed to be more consistent, there were some good examples, but this did not happen in all cases. Individuals and agencies possessed information that would have assisted to keep Hetty safer and aided professionals as she moved between settings. Full records were made at various settings but as a matter of routine these did not follow Hetty when she transferred. It may have

assisted if a chronology and genogram was maintained and made available as a matter of routine when transfers of placements took place. This would have been a consistent and readily understandable form of information sharing.

4.3 Professionals at various stages needed to demonstrate more professional curiosity. This aspect crosses over several areas, such as not contacting the previous authority when undertaking assessments, and in the deeper questioning when indications were given by Hetty that there were issues she needed to disclose.

4.4 It is recognised that young people will not readily disclose abuse to professionals but there are often signs. The NSPCC report *No one noticed no one heard- a study of disclosures of childhood abuse disclosures*[1] concluded that children do disclose but we do not listen to these disclosures and there needed to be greater awareness on recognising these signs.

4.5 Although in some cases signs that caused professionals concern were recognised and referred to other responsible agencies, there was a pattern of concerns not being followed up. Not only does this lead to the potential of further abuse and the matter not being addressed it also leaves the young person with an understandable impression that they have not been heard. Where the expectation of the young person is not met, often for valid reasons, the rationale needs to be effectively communicated to the young person. Without this they are left with a feeling that nothing has been done and their concerns were not heard.

4.6 It is important to acknowledge and give appropriate weighting and emphasis to all sources of information, including third party information. This should be based on the actual source, and connection to other information and intelligence already received. More significance should have been given to information given by the experienced foster carers, who were passing on disclosures they were being given by Hetty in relation to her treatment and the concerns that she expressed about her siblings.

4.7 There was a lack of understanding by professionals and lay persons involved in this case regarding their appreciation of what constitutes a mental illness, and that severe risk-taking behaviour alone may not on its own constitute a mental illness. A better awareness of these issues would assist professionals to manage cases and expectation. Professionals also need to know what options are available to them if there is no mental health diagnosis.

4.8 Whilst there are some good individual examples of Hetty's voice being heard and professionals acting upon what she said, the message that she wanted heard most was her concern over the welfare of her siblings. This message was heard, frequently recorded and discussed, but not effectively acted upon. It therefore appeared to Hetty that she was not being listened to and this undoubtedly increased her anxiety.

[1] Allnock and Miller - No one noticed no one heard: a study of disclosures of childhood abuse disclosures - NSPCC 2013

4.9 More emphasis could have been placed on Hetty's desire to express her feelings in writing; consideration could have been given to this in both formal and non-formal communication settings. Letters and poems which were recovered from Hetty's room after her death give both a powerful and clear indication of her feelings and concerns, and how these translated into her sense of low self-esteem and a desire to harm herself.

4.10 During the formal recorded interviews, known as ABEs (Achieving Best Evidence), consideration could have been given to allowing and encouraging more written disclosure, the guidelines in this type of interviewing acknowledges that alternative methods of interview can be considered as long as the witness's well-being is safeguarded.[2]

4.11 It may have been possible to proceed at an earlier stage with care proceedings for Hetty's siblings. It appeared that matters stalled awaiting the outcome of the criminal investigation into the disclosures Hetty made. This undoubtedly put pressure on Hetty and increased her anxiety. Earlier consideration could have been given to using all the information already accumulated to progress the care proceedings without the reliance of a potential criminal court case.

4.12 Consideration should be given to ensuring that all aspects of parental responsibility are met. It was clear at times that Hetty did not wish her father to be involved in her care or decisions made on her behalf, yet he was. Her birth mother retained PR but was not routinely informed on all decisions that were taken.

4.13 General Practitioners are the 'hub' for medical information pertaining to a child or young person and they should be able to signpost practitioners to where more information can be accessed if they do not actually hold it.

5. Recommendations

1. The Worcestershire Safeguarding Children Board should ensure that the single agency recommendations identified by agencies participating in this review are completed and reported upon.

2. The Worcestershire Safeguarding Children Board should ensure that their escalation procedure is reviewed to promote healthy discussion and encourage resolution between agencies.

3. The Worcestershire Safeguarding Children Board should raise the circumstances of this review with the Department for Education to inform the ongoing debate on the future of Secure Children Homes and apparent gap in provision for young persons presenting with complex and challenging issues.

[2] Achieving Best Evidence in Criminal Proceedings guidance on interviewing victims and witnesses, and guidance on using special measures. Page 94 para 3.128

4. The Worcestershire Safeguarding Children Board should ensure that desired development of a shared multi-agency chronology for complex cases is passed to the Worcestershire Office of Data Analytics (WODA) for incorporation into the ongoing work.

5. The Worcestershire Safeguarding Children Board should liaise with Commissioners to address the apparent gap in services for those children and young persons who do not have a mental health diagnosis and are therefore not able to access Tier 4 Services but who have complex emotional needs requiring specialist services.

6. The Worcestershire Safeguarding Children Board should ensure that the learning from this review, in listening to the voice of the child in all its facets, is incorporated into the 'Voice of the Child briefings' and this to include the recognition of the potential signs of sexual abuse.