CALDERDALE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

Undertaken using SILP methodology

OVERVIEW REPORT

CHILD J

Born 14TH JUNE 2000

Died 7TH SEPTEMBER 2013

Mark Dalton

December 2014

CONTENTS

1. INTRODUCTION

Introduction to the Serious Case Review

1.1 Child J was 13 years old at the time of his death. On 7th September 2013 his body was found in woodland close to his home and his school; he had been missing since lunchtime the previous day, it would seem that he had taken his own life at some point on the 7th September. He had last been seen alive at approximately 1:30pm on 6th September as he left school. Although he faced numerous difficulties in his life he was not considered to be someone who would harm himself. No notes or letters suggesting premeditation have ever been found and the coroner recorded a narrative verdict.

The Statutory Basis for Conducting a Serious Case Review

1.2 The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90. Regulation 5 requires the LSCB to undertake a review in accordance with guidance set out in Section 4 of Working Together to Safeguard Children (2013). The mandatory criteria for carrying out a Serious Case Review include where:

a. abuse or neglect of a child is known or suspected; and

b. either:

    i. the child has died; or

    ii. a child is seriously harmed and there are concerns about how organisations and professionals worked together to safeguard the child.

Introduction to the Process

1.3 Chapter 4 of Working Together to Safeguard Children (2013) has established the principles that should be applied by Local Safeguarding Children Boards to the conduct of all reviews, including Serious Case Reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;

- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- 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;

- 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;

- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

- final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB Annual Reports and will inform inspections; and

- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

1.4 In particular, Serious Case Reviews (and other case reviews) should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;

- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform findings.

1.5 Local Safeguarding Children Boards may use any learning model which is consistent with the principles in this guidance.

The Decision-Making

1.6 The Independent Chair of Calderdale Safeguarding Children Board made the decision that a Serious Case Review should be conducted 8th October 2013 and the Department for Education were duly notified in accordance with statutory guidance. It was also approved that Significant Incident Learning Process (SILP) methodology should be used; and that Mark Dalton should be appointed as Lead Reviewer/Overview Report Author.

Introduction to the key principles of the Significant Incident Learning Process

1.7 SILP developed through the practice of conducting Serious Case Reviews in accordance with Working Together guidance, the limitations of these reviews, acknowledged in the Biennial Studies of Serious Case Reviews, were often that the voice of practice and experience was lost and reflected only through written records and third-party analysis. SILP developed as an approach to engage frontline staff and first line managers in conjunction with members of LSCB Serious Case Review Panels or Subcommittees, Designated and Specialist Safeguarding staff in the review process.

1.8 The involvement of frontline staff and first line managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

1.9 The process focuses on understanding why someone acted in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. This process is an open and transparent learning from practice, in order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

1.10 This engagement comprises:

- all agency reports being shared with Learning Event participants a week ahead
- a Learning Event comprising a large number of practitioners, managers and Safeguarding Leads coming together for a day
- a Recall Event at which the first draft of this Overview Report is debated.

In this Serious Case Review the individual analysis of actions was collated using a composite chronology rather than the usual approach of including these in individual agency reports. The individual agency management reports were consequently less detailed and did not contain the summary of agency actions and specific recommendations that such reports usually provide. The use of SILP methodology was new for Calderdale Safeguarding Children Board but as part of a plan following publication of Working Together 2013 to move into different methodologies and to help to develop the Serious Case Review Framework for Calderdale.

1.11 Analysis was undertaken by:

- Critical review of Agency reports
- Practitioner learning events as described above
- Review of combined Chronology
- Participation in panel discussions

The observations made in this report by the author were drawn from this analysis.

Parallel Processes

1.12 Two other investigations into aspects of the management of this case have been undertaken; West Yorkshire Police referred the 6th September 2013 missing report for Child J to the IPCC (as is standard procedure when there is police contact in the 48 hours prior to the death). The IPCC returned the case to West Yorkshire Police for the Force to deal with. The police responses in relation to the missing report and when the death of Child J was discovered were reviewed. There were no issues identified in respect of the police response to the missing report or the discovery of the death of Child J. The actions taken by his school in excluding Child J were subject of an independent review commissioned by the schools governing body.

The Lead Reviewer/Overview Report Author

1.13 Mark Dalton is an independent social worker with a 30 year background in Child Care. He has experience in local authority social services and the NSPCC. He chairs an LSCB Serious Case Review subcommittee and has been involved with multiagency safeguarding arrangements since 1998.

1.14 In addition to acting as lead reviewer for Serious Case Reviews, he provides clinical supervision for a specialist sexual abuse project, works as a freelance consultant, producing procedures and policies for local authority children's services and safeguarding boards and also works as a trainer.

An Introduction to the Subject: Child J

1.15 Child J is described by his school as usually a bright and smiling young person, but subject to significant mood swings - great highs and equally deep lows - a person who was affected by the difficulties and challenges faced by people he cared about. He was capable of deep and caring attachments and these were relationships that tended to develop over time with people who were stable and he could trust.

1.16 He was also described as cheeky, had a sense of humour and was a very sensitive boy. He enjoyed one to one attention and possibly related better in these settings than as part of a group.

1.17 He was a person with some behavioural and emotional difficulties and his behaviour was at a stage of becoming more challenging as he entered adolescence.

1.18 He attended mainstream schools throughout his life although he received some additional support.

1.19 He was the youngest of six siblings, and for most of his life he was brought up, along with four of his siblings in the care of his grandmother and her partner. As older siblings left home, they remained in touch and played a significant part in J's life. His mother also lived close by for much of the time, and a strong bond existed between them, although the relationship was unpredictable and sometimes difficult for him.

2. THE PROCESS

Purpose

2.1 The purpose of a review is to establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

2.2 Secondly, to identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on. Finally, what is expected to change as a result to improve the intra and inter-agency working and better safeguard and promote the welfare of children?

2.3 All reviews provide the opportunity for agencies to gain feedback from practice about their effectiveness to better understand their relative roles and how they can best work together.

2.4 At the time of Child J's death, those agencies who were actively involved included:

1. Children's Social Care – Calderdale Council
2. The Fostering Team - Calderdale Council
3. Safeguarding and Quality Assurance Team (IRO service) – Calderdale Council
4. West Yorkshire Police
5. Calderdale Clinical Commissioning Group (on behalf of NHS England)
6. Calderdale and Huddersfield Foundation Trust
7. Secondary School
8. Looked After and Adopted Children's Health Team (LAACH) – Calderdale Council[1]
9. Virtual School – Calderdale Council
10. Educational Psychological Service, Calderdale Council

[1] The LAACH Team no longer exists and is now known as Calderdale Therapeutic Services.

2.5 It was agreed that the review would also consider any other relevant reports, records or information deemed relevant to the review.

2.6 Terms of Reference - Scope of the Review

- The multi-agency review should consider the period from 01.09.2011 (when J commenced secondary school) to the date of death on 06.09.2013.

- Determine whether the policies, procedures and practice expectations of the agencies were followed during this period.

- Within the review dates, Key Practice Episodes (KPE's) and the personal impact on J should be considered for deeper analysis under the following broad headings (which comprise the specific Terms of Reference):

2.7 Connected Care Placement and meeting J's Needs

- The quality and longevity of relationships between the child, his family and the agencies involved with him.

- The quality of decision making relating to who he should live with.

- Connected care[2], and the extent to which issues such as contact arrangements (planned and unplanned), placement breakdowns and their impact on children compared with other types of placement.

- Changes of placement - what were the antecedents, behaviours and consequences for J?

[2] Connected care, also called Kinship care. Kinship care means that relatives or friends look after children who cannot live with their parents.
Kinship care may include people who are not related to the child but who are still in the child's social network.

2.8 Therapeutic needs and support

- The impact of the child's learning difficulties on his day to day life, quality of relationships, assimilation of information and rationalisation of events and levels of resilience.
- The quality and effectiveness of services provided including information sharing and planning.
- The quality of therapeutic input provided to the child and his carers.
- The role of school in recognising, understanding and managing J's behaviour and language in school.
- Was the support and intervention proportionate to J's needs?
- Impact of his exclusion from school on J and his behaviour.

2.9 Assessment, Investigation and outcome of allegations relating to sexually harmful behaviour

- Appropriateness of Police investigation into the allegations of sexually harmful behaviour, the outcome of the investigation and impact for J
- Whether multi-agency procedures were followed in relation to multi-agency assessment of Sexually Harmful Behaviour.
- Whether decision making by all agencies in the case was reasonable, given what was known at the time.

2.10 The role of Social Media and impact for J

- Analysis of social media activity in the week leading to J's death.
- The impact of social media in this case, how it affected those involved and implications for current and future practice.

2.11 Detail of Panel:

Head of Quality Calderdale Clinical Commissioning Group (CCG) – Chair

Calderdale Safeguarding Children Board (CSCB) Manager

Multi Agency Trainer, CSCB (who for part of this SCR Process was Interim CSCB Board Manager)

Designated Nurse CCG

Named Nurse - South West Yorkshire Partnership Foundation Trust

Serious Case Review Officer – West Yorkshire Police

Head of Service Early Intervention and Safeguarding, Calderdale Metropolitan Borough Council (CMBC)

Service Manager, Safeguarding and Quality Assurance Service, CMBC

Designated Nurse, Calderdale and Huddersfield NHS Foundation Trust

Engagement with the Family

2.12 Following initial approaches by letter from the Interim Board Manager and the Lead Reviewer, the step grandfather, biological mother and older sibling of child J agreed to be interviewed. These separate interviews were conducted by the Interim Board Manager and Lead Reviewer and took place the day after the learning event. These meetings provided the opportunity to explain the review process and gain an understanding of their perception of the events leading up to J's death. Other family members were approached and have chosen not to participate in the review process. Key points which were raised in these interviews have been woven into the relevant parts of the text.

3. INTRODUCTION TO THE FAMILY

Background

3.1 The information presented in this part of the report is to identify specific areas of J's life, which were relevant because they influenced how he behaved and how the professionals trying to support him engaged with him and his family.

3.2 J was the youngest of six siblings, there is a 10 year age span between the youngest and oldest, and therefore, at the time of this review, three of his siblings were young adults. From the age of two years he lived with his maternal grandmother and maternal step grandfather. (They are referred to as "grandparents" throughout this report. Although the distinction that he was J's step-grandfather was an important one to the family).

3.3 Four of the children had been removed from the care of their mother on an emergency basis when J was aged two and were placed with the grandparents; the second oldest child was placed with her paternal grandparents. The placement was not originally expected to be long term or permanent, however, when rehabilitation back to the care of their mother was ruled out, the desirability of keeping the siblings together within their family and with access to their mother was obvious and a legislative requirement in accordance with the Children Act 1989.

3.4 Family members remained physically close, mainly living in the same district and in the case of J's mother and his oldest sister, on the same estate and within a few hundred yards of the grandparents' home.

3.5 In July 2012 J's great-grandmother also moved into the home to be cared for as part of the family. This was an important development for J he had a strong attachment to her but caring for her increasingly limited the time his grandmother had available for J

3.6 Relationships within the family appear complex; the children in placement had different needs and abilities, and correspondingly required different parenting techniques and levels of professional support. At the beginning of the period under

review, J lived with his grandparents, great grandmother and three other siblings - the two older children having left home. This was a period of stability for child J. It is reported that his siblings were more able, and integrated well into mainstream educational and social activities. There is a three year age gap between J and the next youngest sibling – the professionals from the learning event perceived that developmentally the difference between Child J and his 16-year-old sister was significant, and this was exacerbated by his behavioural and emotional difficulties which accentuated his immaturity. Contact with J's mother remained an important factor throughout his life; this relationship was inconsistent and varied between being a source of great comfort and a source of great distress for J At its most positive, J appeared to enjoy being the "baby of the family" and liked one to one attention from his mother. At its worst, this relationship could be competitive with those of his other siblings and could result in hurtful and distressing things being said on both sides. Although an important attachment this was clearly a much damaged one that perpetuated some of the problems with J's behaviour.

3.7 A further important factor in determining the quality of J's relationship with his mother was the pre-existing relationship between his mother and grandmother (i.e. her mother); this relationship could be volatile and when they were not getting on it made contact more difficult for J

3.8 The key stable relationship throughout J's life was with his grandparents, although it is apparent there could be a distinction between grandmother and step grandfather; who would analyse J's behaviour differently. With regard to the relationship with his grandmother J was her "baby"; the bond was strong and she seems to have been very protective of him and anxious about him getting into trouble; being conscious that he was vulnerable because of his level of learning needs and emotional immaturity.

3.9 The grandparents engaged with the various agencies working with the children to differing degrees, and in markedly different ways that became more pronounced as time went on; step grandfather would attend most of the external appointments and participate in therapeutic sessions with J with the LAACH (Looked

After and Adopted Children's Health), while the grandmother seemed to set the rules in the house and made her views known through the LAC reviews.

3.10 The LAACH team (now known as Calderdale Therapeutic Services) is a dedicated, specialist mental health team for Calderdale Looked After and Adopted children and care leavers. It provides support, consultancy and direct intervention and assessments, in particular, to help ensure placement stability and permanence and prevent breakdown where possible.

Placement and Legal Status

3.11 J along with his siblings was on a full Care Order to Calderdale Council. Although he was placed with grandparents, this arrangement was not a straightforward connected care arrangement[3]. The children and grandparents continued to require significant input in order to maintain the placement. The grandparents were at times, resistant to input from the local authority and due to their status as connected carers Children's Services seemed to find it difficult to exercise their authority and insist on actions which would have been in the best interest of the children. (Inability to control contact with the mother, and to know who was actually living in the household are two such examples of this). At one time the grandparents had considered applying for a special guardianship order, but decided against this.

3.12 There is evidence from the reports provided that the Fostering Team and Children's Social Care recognised the difficult job the grandparents had taken on and attempted to provide appropriate support when these needs were identified.

3.13 As carers the grandparent's both had backgrounds of working with children in educational settings and some experience of children with special needs, and contributed to planning for all their grandchildren during formal reviews. Their

3 https://www.education.gov.uk/consultations/downloadableDocs/care%20planning%20placements%20and%20case%20review%20regulations%20england%202010.pdf

energies were pulled in different directions; including the care of the great-grandmother, four children in placement, managing contact arrangements, supporting the older siblings who had left home and their own health needs. Inevitably it proved difficult to always prioritise J's needs when there were so many other demands on their time and energy.

Education

3.14 For many young people, the transition to secondary school could be a difficult time representing a first step into a more complex adult world. This is particularly so for a young person in the care system with additional needs. J's primary school had developed a good working relationship with his family, understood his needs and was able to successfully employ a number of different strategies to manage his behaviour.

3.15 At the time of transition to secondary school J's behavioural traits were well known and ways of managing his behaviour were identified which would be used regularly throughout his school life. It was known, for example, that J could be easily goaded and teased; his grandparents were concerned that his peers would soon recognise this and possibly provoke him for a reaction. His primary school had identified a positive way of managing J's behaviour when he lost his temper; he did not respond to confrontation or direct challenge, but given time and space and treated with a degree of calmness he would usually come around and was keen to rebuild relationships. Key to this was a relationship with a consistent support worker who made themselves available when J felt anxious or threatened.

3.16 The potential for the transition to secondary school to be difficult for J was recognised in the liaison process between the respective schools, and in the event, the transition was positive and successful. This was the result of a comprehensive liaison process between the two schools which involved staff from the secondary school, attending regularly over a period of months to meet children and several visits at different times of day to the secondary school. This approach enabled J to continue his education in the school which served his community and where most of his friends would have attended.

3.17 J had first received therapeutic input from the LAACH Team in 2008 at primary school in the form of play therapy, this work ended in January 2010 as it was concluded that J was not ready to undertake further therapeutic work until he was more able to understand more complex ideas. At this time the opening and closure of cases was not a rigorous process; on 1st April 2011 the LAACH team wrote to the grandparents advising them that as there had been no intervention for 12 months a REFLECT[4] Meeting had been agreed to review J's therapeutic needs. The meeting took place on 22nd June 2011; LAACH once again became involved with J just before his transition to secondary school. Different ways of supporting the family were discussed and one intervention which proved to be significant and consistent over the next two years was joint therapy between J and his step-grandfather. Additional support had been offered to other family members which was well received and helpful; J's grandparents believed that he needed additional therapeutic support to understand relationships within the family and to support him in a larger school[5].

3.18 At the time of transition the grandparents were concerned that J did not have a Statement of Educational Need (SEN), although this had been considered at primary school he was supported through School Action Plus. His grandparents believed J needed additional therapeutic support to understand relationships within the family and to succeed in a larger school. The decision about a Statement of Special Educational need was discussed regularly at reviews, such an assessment was advocated by the grandparents when J was in secondary school, however, he did not meet the threshold for formal assessment.

3.19 The secondary school tried to maintain a consistent approach to J; the concerns were usually about aggressive behaviour towards other pupils. Schools records referred regularly to J displaying "angry outbursts"; while these may have been impulsive and related to the specific circumstance at any given time, a more significant source of anxiety existed for J concerning his relationship with his natural mother. This relationship was inconsistent and anxiety provoking for J; it seems likely

[4] REFLECT Meetings are multi-agency planning meeting held with families

[5] Discussed at: LAC review 09/05/11, REFLECT Meeting 22/06/11, Fostering Review 18/10/11 (raised by IRO), Virtual School Personal Education Plan 18.11.12

that at least some of his angry outbursts were expressions of his feelings about his mother or attempts to defend her.

4. Key Practice Episodes and Contexts

4.1 Key Practice Episodes are significant events in the child's timeline which were drawn from discussions with family, professionals and evidence from chronologies.

Context A

4.1.1 Despite the initial transition to secondary school being successful, from the beginning of 2013, it would seem that J was displaying the behavioural traits that were identified when he first moved to secondary school, and while much of his behaviour could be contained, using the methods and techniques described previously they were not always successful. There was a succession of fixed term exclusions for verbally aggressive behaviour. The School staff felt that these were possibly a reaction to stresses at home.

4.1.2 J was effectively grounded by not being allowed out of the garden for fear of the trouble he may get into. This had first been noted as a sanction in May 2012 and was used periodically as a way of trying to control J's behaviour. An unintended consequence of this was that he missed out on opportunities to socialise and develop normal friendships; a view he expressed to his LAACH worker in a therapy session on 18 February 2013.

4.1.3 The impact of great-grandmother moving into the home should not be underestimated. As well, as an extra body in an already overcrowded home, this elderly lady required a significant amount of care which meant that J's grandmother had less time to spend with him.

Key Practice Episode 1

4.1.4 For J the situation at home appeared to reach a turning point in March 2013, when an argument with one of his siblings resulted in a minor injury to J. This was appropriately reported to Children's Social Care (on 20.3.13) and a strategy discussion took place between Police and Social Care, with the decision that Social Care would deal with the matter. The Police again became involved with J following an alleged theft from a neighbour.

4.1.5 Police attended at the neighbour's address, the neighbour had already realised that she had made a mistake and no theft had occurred. The Police Officer attended at maternal grandmother's house to check that J was well.

4.1.6 The Police Officer was informed by J's grandmother that Child J was in trouble at school and wanted to live with his sister. The Officer reports Grandmother as telling J "if you keep doing this, they'll take you away". The Officer gained the impression that this was something that had been brought up in the family before. The grandparents felt that the Officer did not appreciate that for J's grandmother him being "taken away" wasn't a threat but a longstanding fear she had that the authorities would intervene and remove the children from her care. J told the Police Officer that he did not want to live with his grandmother, and he ran to his eldest sister's house whilst the Police Officer was there.

4.1.7 The Police response was described to the LAACH worker by the grandparents as being to tell J that if he couldn't live at home they would have to take him to a children's home without any of his possessions. There is clearly a difference between the Police version and what the family believed had been said and it is unfortunate that this did not come to light at the time to enable it to be resolved.

4.1.8 It is quite likely that involvement of the Police and the fear of having to live in a children's home had been used before in arguments between J. and his grandparents. It is apparent that there was considerable frustration directed towards J as a result of his behaviour and tension between grandparents and his mother and older sister. This incident occurred against a backdrop of increasing tension and anxiety and arguments at home. There was a lesson here for professionals about not taking at face value everything that was reported.

4.1.9 Following this incident on 25th March J ran to the home of his eldest sister who agreed he could stay there in the short term. She was aged 23 and lived with her partner and young child a few hundred yards from the grandparents' home.

Key Practice Episode 2

4.2.1 Initially, the placement with his sister seemed a positive experience; it was one that allowed the emotional temperature at home to cool down, it kept J within his family and provided respite for his carers. It was clear from the outset that this could only ever be a short-term arrangement because the sister and her partner lived in a two bedroomed house with one small child and another baby expected within six months. Children's Social Care agreed to the placement on a temporary basis for up to 28 days and undertook the necessary checks on his sister and her partner; the initial viability assessment was completed on 10th April, and Police checks were completed on 12th April. The intention throughout was that this placement would provide J breathing space and would enable bridges to be rebuilt back with his grandparents. For their part the grandparents have stated that they were not aware that the placement with the older sister was a short term plan.

4.2.2 Unfortunately, due to a deterioration in relationships between family members, the placement with J's older sister made reconciliation with his grandparents more difficult, rather than less. In the face of what seemed to him a rejection J expressed a desire to stay with his eldest sister and her partner for the long-term.

Context B

4.2.3 By this time – the end of April 2013 - the recurrent theme of J's distress being acted out by a corresponding deterioration in his behaviour at school was once again apparent, the virtual school liaised with Children's Social Care; correctly identifying the uncertainty over his placement with his sister, as the likely cause of this stress.

4.2.4 It is evident from the agency reports that there was professional concern about the long-term viability of this placement for several reasons; the abrupt end of his long term placement with his grandparents, which as recently as the LAC Review on 1st March was believed to be meeting his needs. This concern focused on whether his sister could meet J's needs in the long-term, the ability of this young couple to meet those needs alongside their own expanding young family and the possibility that the viability assessment would prove negative.

4.2.5 The concerns are also supported by information from the wider family and community, which raised serious questions about the sister's ability to supervise J; it is reported, for example, that he had been seen out at 1:30am and had been staying at his mother's house without supervision. It is quite likely that these incidents occurred but it is equally likely that the information was passed on to Children's Social Care, with a view to undermining the placement in the eyes of the local authority.

4.2.6 The dilemma was that in the absence of an acceptable alternative, the placement with J's sister still seemed to be the best option and one which he clearly favoured. The local authority has a clear duty to involve children in plans about their future and must respect their wishes and feelings wherever possible. There are only two other options; residential care or foster care - in both cases, J had made it very clear that he would abscond and thereby place himself at further risk. A LAC review should have been held at the point J's placement with his grandparents had disrupted. However a Care Planning meeting was held on the 9th May to discuss the current Care Plan; fundamentally that it did not meet J's emotional needs. This was partly because of the disruption caused by the break down in the relationship with J's mother, uncertainty about whether he would be allowed to remain living with his sister and problems at school. The meeting resolved to continue offering the current level of support and to reconvene a fortnight later.

4.2.7 Calderdale Children's Services procedures for Looked After Children state:

> *Disruption Meetings should be convened in relation to children whose planned long term placement in a children's home or foster care has ended abruptly or on an unplanned basis. Strenuous efforts must be made to seek to resolve the unplanned endings of placements for children. The child's Social Worker will lead in this process and should consult with and keep the Independent Reviewing Officer (IRO) informed.*[6]

4.2.8 It is apparent from the information presented in the chronology that workers from the Fostering Team, the IRO and Social Worker were aware of this requirement

[6] 4.3.1 Placement and Disruption Meetings s2.
http://calderdalechildcare.proceduresonline.com/chapters/p_place_disrup_meet.htm#disrup_meeting

and it was first discussed as early as 25th March. The view was expressed that it was not in J's best interest to hold a Disruption Meeting, given the existing family feud and the fact that J moved from one connected carer to another. The suggestion is also made that attending such meeting could be quite challenging and difficult for him as it would inevitably involve face-to-face contact with members of the family who were still quite negative about him and his behaviour. As time went on the practical value of such a meeting was questioned; given that J returned to his grandparents care 28th June.

4.2.9 While it is a requirement to keep the IRO updated with changes of placement, there was a recurrent practical difficulty in this case; as arrangements changed frequently and without warning.

Key Practice Episode 3

4.3.1 The Connected Persons Assessment was completed on 10th June, it catalogued six reasons why the placement would not be viable - all of which were known previously to Children's Social Care - in essence, there were concerns about the overcrowded and poor home conditions and the ability of the carers to meet J's needs. The conclusion of the assessment recommended that the eldest sister and partner could play a role in future respite for J. It also recommended a process for a planned move whereby J was given a high degree of involvement in selecting the placement as well as reassurance that his sister would remain integral to his future care. The plan was for J to remain in the care of his eldest sister, whilst the plans were taken forward.

4.3.2 In June 2013 the prospect of a move away from the area was discussed; J's sister's partner came from the North East and three options were mooted; a move to his home town, to move within the area or to go abroad. The discussions of the Care planning meeting[7] of 18th June are reported in a contradictory way; by LAACH – who record that "the family are moving to the North East or abroad, and Social Care who minute the meeting that the family are not moving out of the area.

[7] Attended by: Social Worker; Virtual School; LAACH; School; Child J's carers

4.3.3 J stated that he would like to move out of the area because it would solve a lot of his problems. Any of these changes would have represented a significant new start for J and given his commitment to his family and the area he had always lived in, the fact that he would countenance moving away indicates the level of disaffection he was feeling. At this time he was not seeing his mother, siblings or grandparents despite living in close proximity to them.

Key Practice Episode 4

4.4.1 The volatility of the placement is illustrated by the events over three days in the middle of June. On the 18th June J is described as "excellent at home" in a Care Planning Meeting, the following day he broke a window in the front door in an argument with a friend resulting in the breakdown of the placement because of "grief" from neighbours and an admission by his sister that they could no longer look after J On the 21st June the situation became untenable after J alleged that he had been assaulted by his sister's partner. The outcome of the investigation of the incident is significant in the light of subsequent events. J did not sustain any injury, the context of the incident was that following the decision to end the placement, J blamed his sister and boyfriend and interpreted this as a rejection. Consequently he told his sister's partner that if he could not stay there he would ensure that their 2 year old daughter would also be removed. The assault comprised J being pushed into a hedge and the partner's fist being pushed against the side of his head. The decision was taken that there would be no further action and there was no on-going risk as his sister and family were moving to the North East. This was the correct assessment at the time, and one which was revisited on 7th August when his social worker visited him in the North East and discussed the incident leading to the assault with him.

Key Practice Episode 5

4.5.1 Following this incident J went missing on 21st June, aware that there was no option other than foster care. A Foster placement in a neighbouring town had been identified and was still available but this option was rejected by J because of its distance from home (approximately 12 miles). He took himself off to his second eldest sister and stayed with her for the weekend. This was not an approved placement, and the Local Authority kept the Foster placement open, however those involved knew that J had said that he would not stay there.

4.5.2 Eventually after a week of sofa surfing with his second eldest sister and refusing to stay at alternative Foster Carers, the relationship with his grandparents was patched up and J returned to their care on 28th June. There seems to have been anxiety all round about whether the return would work; there continued to be regular problems at school with aggressive behaviour and assaults on other pupils resulting in regular sanctions including exclusions.

Context C

4.5.3 Children's Social Care, the LAACH team and School attempted to address the intractable family situation and following a professionals meeting on 18th July devised a therapeutic approach to address some of J's needs and to reduce his isolation from his grandparents and siblings. The approach they agreed upon was a combination of individual support from J and awareness that there should be a systemic response to avoid J being scapegoated for all the family's problems and also to re-build the relationship between the family and Children's Social Care. An initial family meeting was planned involving 6 members of the household along with workers from LAACH, Children's Social Care and Fostering Team. A considerable amount of preparation went into this meeting; involving individual sessions with J and his grandparents and there is a clear sense of the family relationships still being tenuous at this time. Unfortunately these good intentions were once again overtaken by events and the meeting did not take place.

Key Practice Episode 6

4.6.1 Any sense of progress was short-lived, on 2nd August the grandparents reported J missing along with £340 belonging to his great grandmother. His grandparents reported to Social Care Emergency Duty Team at 9:00pm that he had not returned at the expected time of 4:30pm and they had discovered the money had gone missing. At quarter past midnight J's oldest sister called from her partner's home town (a distance of approximately 80 miles) to say that he had turned up apparently out of the blue at their address and they would keep him overnight given the lateness of the hour.

4.6.2 The discovery that J had run away to the North East was a complete surprise to family and professionals alike. Following the initial contact from the oldest sister that he was safe she offered for J to stay with them for the summer holidays; with the upset of the previous month put to one side. Cleveland Police undertook a safe and well check on 2nd August and J stated that he had left home because he was being bullied by family members. Professionals were compliant with policies and procedures regarding Child J's absence. The local Children's Services were not informed that J was living in their area, and whilst a notification was not required (i.e. this was not a placement move, but a missing child where agencies knew his whereabouts) it would have been good practice for the local authority to inform partners and local agencies that he was living in their area.

4.6.3 J rang his social worker on 5th August to ask whether he could remain with his eldest sister for the school holidays. Children's Social Care recognised that this could not be regarded as a "placement" but they would allow (but not financially support) him to stay with his sister for a few extra days. Part of the rationale was to allow things to cool down back at the grandparents' home. Whilst they would allow him to return at some point in the future, they wanted reassurance that issues would be addressed particularly the theft of the money.

Context D

4.6.4 J was visited by his social worker on 7th August who explained to J and his sister that he should return to Calderdale where alternative plans could be made,

they were warned that if he did not return the local authority would consider issuing a Harbouring Notice. He was seen at the home of his sister's partner's mother and told the social worker that he wanted to remain there. He explained that he did not want to return to his previous home because he felt scapegoated in the family and blamed for everything. The one positive change seems to have been that J now understood that his sister and partner had not rejected him, but the negative viability assessment had meant he could not stay with them.

4.6.5 The case once again posed a dilemma for Children's Social Care as they were faced with a number of unworkable and unrealistic options; J was refusing to return to Calderdale, and there was no acceptable placement available (the previously identified placement was still available but J refused to consider this). He wanted to stay with his sister and yet it was not possible for him to legally remain there. His placement with grandparents was no longer an option, because his grandparents made it clear that they did not want J to return to their care under these circumstances.

4.6.6 The situation was untenable and explained to all parties, J could not stay in North East as this constituted an unauthorised placement, he would have to return home and proper plans would have to be made. In addition, the investigation of the theft of the £340 was continuing and West Yorkshire Police were in the process of arranging a voluntary attendance interview with J accompanied by his Social worker. There was a pressing need for a Care Planning meeting, which took place on 14th August. Whilst this meeting summarised the concerns in relation to J it did not resolve the central issues; that J was still refusing to return to Calderdale and did not agree to the plan for his care.

4.6.7 The Fostering Team worked hard to identify a potentially suitable alternative Foster placement, and one was identified on 21st of August with carers in J's home district.

<u>Key Practice Episode 7</u>

4.7.1 Attempts to engage his sister in persuading him to return in time for the new school year were successful. He was persuaded to return on 22nd August, he was

collected by his social worker and brought back to Calderdale by car. The placement arrangements were for an emergency placement to be available while an alternative long term placement was sought. Leaving his sister proved to be a difficult and emotional episode for both of them, it is reported that he was tearful and angry on the journey home – saying that the only place he wanted to live was with his sister, and this continued even as he entered the foster home.

4.7.2 In fact J only stayed one night in foster care before moving once again to his second eldest sister's home in a neighbouring district on 23rd August. This placement had not been identified as a possible option prior to J moving to her home; it had not been raised at the Care Planning meeting on 14th August or discussed with J and his sister in the North East. Children's Social Care reacted quickly and undertook an initial viability assessment the next day, and the placement was sanctioned by the Head of Service.

Context E

4.7.3 J's second eldest sister lived with her partner in a two bedroomed flat, and like his eldest sister she had a small child and was expecting her second baby. Again the balance for Children's Social Care was between listening to the voice of the child and exercising the control and judgement they were required to do as corporate parent. This sister and her partner claimed to be fully aware of J's behaviour problems and the placement was approved by the Head of Service on a short-term basis.

4.7.4 Initially a very positive and settled period of care seemed to be in evidence; J was very happy to be with his sister and they reported there had been no problems as he settled in. This was confirmed by his new social worker who undertook a home visit on 23rd August and confirmed by his sister a few days later on 27th August in a telephone conversation with the social worker. The impression that J seemed to be "choosing" his own placement again was raised by his grandparents and caused them some disquiet. It adversely affected an already difficult relationship and cooperation between grandparents (who were still J's permanent carers) and Children's Social Care was extremely strained. These views were made very forcefully to the Fostering Team social worker during a visit on 29th August and in

subsequent phone conversations. It took repeated requests to get J.'s belongings from the grandparent's and eventually they were made available on 3rd September.

4.7.5 The relationship with the second eldest sister remained positive, she showed an understanding of J's needs, although they could be difficult to meet; he craved attention and competed for her affection when he saw this being given to her young son. Overall he felt positive about the placement and told his social worker on 5th September that he enjoyed living there. He was anxious about the outcome of the assessment of his sister and partner as carers (in the light of the experience of assessment of his eldest sister this was understandable). He discussed contact with his grandmother initially away from the family home. His sister noted that following this meeting with his social worker he came home quiet and reflective, it was assumed he may have been worrying about his eldest sister who was due to give birth imminently.

Key Practice Episode 8

4.8.1 J's behaviour resulted in Police involvement on three occasions in a relatively short period of time; on the 31st August a complaint had been received that J had threatened younger children with a screwdriver – an allegation that proved to be false. Secondly on 1st September when J was interviewed at a Police Station in the presence of his second eldest sister in relation to the theft of the money from his great grandmother, an offence he continued to deny. The Police concluded that there was insufficient evidence for J to be charged with theft of the money and he was told this prior to leaving the Police Station.

4.8.2 The final contact with the Police occurred on 3rd September an apparently more significant incident of inappropriate sexual behaviour where it was alleged he had exposed himself to girls. This incident was investigated and again the initial report proved to be inaccurate and no offence had been committed, J's behaviour may have been offensive, but it was not abusive. Essentially it entailed rude and silly behaviour on his part, which was observed by children playing in the neighbouring garden.

4.8.3 J was not spoken to by the Police in relation to the allegations of sexual assault and may not have been aware that the matters were formally dropped; the Police attempted to inform J of this on 6th September by which time he had gone missing.

4.8.4 The alleged sexual assault became the topic of gossip on Facebook and J received a message from his girlfriend on 4th September that she had been told he had touched a 7 year old girl and therefore she was ending their friendship.

Context F

4.8.5 With regard to education, it was made clear to J that he would be expected to improve his behaviour and participate in the full school curriculum and begin working towards GCSE qualifications. He had told his social worker that he found the classes with older boys difficult and preferred working on his own. At this time he continued to have individual support and had his own keyworker within school.

Key Practice Episode 9

4.9.1 The events of 6th September take on a different significance in the light of what happened later that day, however at the time they did not appear to be particularly different from incidents which had arisen many times before. J had started back at school for the new term 2 days earlier.

4.9.2 J's school noted a change in his behaviour and personality at the beginning of the autumn term; he had grown physically but had also become more aggressive and less amenable to persuasion, their speculation was that his experiences in the North East had affected him in a negative way.

4.9.3 J had been involved in bullying a more vulnerable pupil in conjunction with another boy, the incident was discovered by staff at lunchtime. When challenged by staff both boys were rude and walked off. The other boy was taken to wait outside the Head Teacher's office, the Head then went in search of J who had walked off. When the Head found J he requested that he return to his office (This was a tried

and tested technique which had always worked in the past – school recognised that J could not cope with direct challenge but given the opportunity to reflect would usually be able to discuss his behaviour.) On this occasion J did not respond as expected and punched the Head Teacher twice and was verbally abusive to him. J was escorted off the premises still displaying signs of anger – he would probably have been aware that the consequences of his actions would lead to a period of exclusion, although as he was escorted off the premises he was repeatedly reassured that no one was angry with him and the situation could be sorted out on Monday. J left the school premises at approximately 1:40pm.

4.9.4 The school contacted Children's Social Care and left a message for J's social worker, they did not have a contact number for the sister who was caring for him. The social worker responded and undertook to inform the carer about the incident at school; to forewarn her that J may be upset when he arrived home.

Key Practice Episode 10

4.10.1 Coincidentally the Police visited the sister's home that evening to speak to J in relation to the allegation of inappropriate sexual behaviour and the Officer was informed that he had not returned home from school following the incident with the Head Teacher. The interpretation was that J would know he was in trouble for the incident at school and would disappear for a time. The sister wanted to contact friends and family to see if he was there before reporting him missing. It was only a month since J had run away to the North East so this was not an unreasonable suggestion. The officer agreed with this plan and they agreed to report J missing if he had not returned within the hour.

4.10.2 J was reported missing at 9:22 by his sister, he was assessed as medium risk; meaning that the risk posed was likely to place J in danger or threat to himself or others. This was the correct assessment given Child J's level of vulnerability and known patterns of behaviour under the joint Local Authority and Police procedure in place in September 2013. The known addresses in the North East were also checked as part of the Police enquiries.

4.10.3 J's body was not discovered until the following day, the 7th September; he was found in woodland and had been there all night. Either through tragic accident or design he had taken his own life.

Context G

4.10.4 The arrival of the Police at 8:10pm on the evening of the 6th was coincidental; the Detective Constable visited to inform J and his sister that the allegation of sexually inappropriate behaviour had been dealt with and would not be taken any further. The police officer was informed about the incident at school and that J had been permanently excluded at lunchtime, and had not been seen since. The sister was in the process of contacting J's friends and other family members prior to reporting him missing to the Police. The Officer was persuaded to allow J's sister a further hour to complete her own checks before a formal missing person's report was made at 9:22pm.

4.10.5 At the time, and given the context of J's previous episodes of going missing when he was in trouble the decision to delay reporting him missing to the Police was understandable. Pragmatically, the sister was undertaking the first obvious checks which would form part of a missing person enquiry, and without the coincidence of the Police visiting to discuss another matter, the sister would not have informed them until after she had undertaken her own checks. Given the circumstances in which J was subsequently found there is no evidence to suggest that the one hour delay made any material difference to the eventual outcome.

5. ANALYSIS

5.1 The transition from primary to secondary school was well-managed as a result of close liaison between the two schools and the family. This meant the secondary school were able to put additional support in place from the beginning.

5.2 The decision regarding the Statement of Educational Need was the correct one, because the threshold is based on learning need rather than behavioural or emotional factors. The review has noted that the new code of practice for SEN, for which Calderdale is a pathfinder (from September 2014) will put forward a different approach involving Education, Health and Care (EHC[8]) assessments identifying areas for intervention. For those young people who fail to meet the threshold, the process would still enable the identification of problems and appropriate interventions. The implications for children such as J is that it is likely that the local authority would have undertaken an Education, Health and Care Assessment which would lead to collate greater collaborative work between agencies.

5.3 The first breakdown in the placement with grandparents illustrates and brings into focus the challenges of working with J and his extended family. This was an unusual placement; whilst as carers they had the legal status of Foster Carers, they engaged with various agencies as (at various times) co-therapists with the professionals trying to support 4 children in placement with distinct needs. In addition to caring for the children and an elderly and frail lady, they also had their own needs.

5.4 Contact with J's natural mother was a significant variable in his life, and proved to be a damaging factor due to its inconsistency. However due to his mother's circumstances it was not reliable; in the period under review it ranged from her plans for J to live with her, to a situation of no contact and allegations from her

[8] The Government is replacing the current Statutory Assessment Process and Statements for children with special educational needs. It is being replaced with an EHC Assessment and EHC Plan for children/young people aged 0-25 years. This is part of Children and Families Bill SEND Legislation and will become law from September 2014. An EHC Assessment brings together professionals from education, health and care to work in partnership with families to listen, understand and plan support to enable their child/young person to achieve all they want from life. The EHC Plan describes what outcomes we all want for the child/young person and the support that is needed to achieve these outcomes. The new EHC Assessments and EHC Plans hold all of the statutory protections for the child/young person as within the current statementing process.

that J had rejected her. He also stayed with her overnight which was not sanctioned by the local authority or his grandparents.

5.5 The potential for contact with his mother to be distressing for J was recognised by both his social worker and grandparents. However, in practical terms, it was almost impossible to put boundaries and restrictions on this because they lived in close proximity, contact took place with J's other siblings, they could communicate freely and privately over the phone and they were able to engineer an ad hoc meeting whenever they wanted. While contact arrangements were discussed in reviews and the normal social work contacts with the family, it may have been helpful to acknowledge that the unregulated contact was having a negative impact on J and for Children's Social Care to discuss this directly with his mother.

5.6 Wider family dynamics were also significant, alliances within the family shifted frequently; fallings out were relatively common and difficult to resolve as they usually manifested themselves through family members refusing to speak to each other.

5.7 The other point of stability, apart from home, for most young people is their school. In J's case school seems to have been a barometer of his emotional and mental health. In many cases the emotion behind aggressive behaviour is fear. In J's case it would seem that the aggressive outbursts reported in the School Management Report increased in inverse proportion to his sense of stability and belonging; therefore during May there was an escalation of aggressive incidents which had diminished by mid-June in response to an alternative education package and also as he became more settled with his oldest sister.

5.8 The placement with J's oldest sister was not a realistic proposition. However, the local authority was compelled to undertake a Viability Assessment as they had put themselves forward as carers for J. As the Viability Assessment concluded in listing the reasons why it was not suitable as a long term placement, all of the factors were known from the day J moved in. Past experience would also show that at some point, a contingency plan would be needed; recognition of this may have speeded up the search for an alternative placement.

5.9 Effectively J chose his own “placement” when he moved to his sister in the North East (although this was never recognised as a legal placement. There was some confusion about the status of the care he received whilst in the North East, it is best described as an un-authorised absence), as a young person subject of a full care order, the local authority has the key role in determining where a young person lives and ideally should have exercised this more proactively. However, they faced an ethical and practical dilemma; J had clearly expressed the wish to live with his sister and also stated that he would not stay at any other foster home. Short of physical restraint (and his behaviour would not have met the threshold for this), the only “power” the local authority Social Workers have is the power of persuasion. Children’s Social Care had to make a decision as to whether they could persuade J to return to his home town or consider alternative legal remedies open to them and/or alternative care arrangements.

5.10 There was no mechanism for reviewing the breakdown of the placement other than a Disruption Meeting. The procedures do not imply discretion about whether a Disruption Meeting should be held - and it would have enabled some of the issues between family members to be addressed directly. One of the main reasons cited in the case records for not convening a Disruption Meeting was concern about the impact of such a meeting on J The potential benefit for the practitioners of sharing their information and concerns by holding a meeting without J was not considered at this time. Although Care Planning Meetings were held on 9th and 20th May they did not address the issues of the placement breakdown with the grandparents.

5.11 A further lesson for those attempting to work with J arose over his reaction to the news he could not stay with his sister and her partner as a result of the Viability Assessment. It would seem that he did not properly understand that the decision had been taken out of their hands by the negative Viability Assessment - he interpreted this as a rejection – as he explained to his social worker on 7th August during a home visit. Rejection and fear of rejection were important factors in understanding how J viewed the world. Therefore those issues which may be taken by him as examples of being rejected needed to be handled particularly sensitively. Consideration should always be given to how young people are told, who communicates the message and how the young person is supported subsequently.

In this case it may have been helpful if the independent Social Worker who had completed the Viability Assessment had been involved in explaining to J the reasons for her negative assessment.

5.12 J remained in the North East longer than was appropriate, although this was permitted by Children's Social Care they were again working with an extremely difficult situation; J was refusing to return and he would have known that the family in the North East were offering a place for him to live. Meanwhile the Fostering Team were working to identify any potential placement that might be suitable back in his home town. Suitable placements for teenagers with additional needs are hard to find at the best of times, yet experienced carers in J's home neighbourhood were identified.

5.13 J's experiences in the North East are thought to have changed him in terms of both his behaviour and attitudes; when he returned to school he presented as both more aggressive and harder to reason with. The school did not have the opportunity to analyse further as it was only the second day of term. He had chosen his sister's partner's mother as the person who would care for him. J's behaviour in the North East suggests that he was desperate to avoid a return to his home town and fearful of being placed in Foster Care outside of the family.

5.14 From previous contact with the family it was known that there was a strong family myth that any care outside of the family was seen as dangerous and unsafe with the potential of breaking family ties. J had bought into this fiction and was extremely anxious about living with anyone outside the family.

5.15 In the history of the working relationship between professionals and the family, there had been strong disagreements and differences at times which had affected their ability to work effectively together for the benefit of the children; certain workers had not been allowed to call at the house for example. The episode of J moving to his second eldest sister was a case in point; his grandparents did not support him living there and predicted that the situation would break down. The mechanisms for escalating these concerns and seeking additional support to help resolution were not utilised; for example, a Professionals Meeting could have been

considered, independent advocacy for J may have supported him or further help and support from the LAACH team.

5.16 J had again effectively negotiated his own placement when he ran away to his second eldest sister. There is no way of knowing whether this placement would have been any more successful than previous attempts to place J with his family. The view shared by most professionals involved with J was that while a placement within the wider family was problematic a placement outside of the family was a worse option with a higher risk of running away and given J's vulnerability at greater risk of harm or criminality.

5.17 J's grandparents continued to have rights and responsibilities as his family and permanent carers. This meant they were entitled to be informed of decisions about his education and placement arrangements. However, they did not agree with the placement and this made constructive dialogue difficult. Decisions about contact arrangements should have been more of a priority and were allowed to drift.

5.18 School did not have up-to-date contact information for J although they had requested this on three occasions and also attended meetings with the sister caring for J and had requested this information from her directly on 4th September. They were dependent on Children's Social Care to contact his sister to inform them of the exclusion. The school was not aware on 6th September when J was excluded that they did not have this information until they tried to contact his carer.

5.19 Dealing with the exclusion of a vulnerable Looked After Child is a sensitive issue. The outcome of an outright assault on a teacher would usually be exclusion. The process of escorting a young person off the school site clearly implies they have been excluded, even though J was reassured that the situation could be sorted out the following Monday. It is apparent from some of the recording from the school and virtual school that they thought that J had been permanently excluded. It would have been best practice to keep J on the school site until definite arrangements could be made for either his social worker or his sister to collect him.

5.20 The decisions the Head Teacher had to balance were the need to safeguard J, other pupils and staff in the light of uncharacteristically aggressive behaviour.

Removing J from the premises addressed some of these issues, but placed the school in breach of DfE guidance on exclusions from schools.[9]

[9] Exclusion from maintained schools, academies and pupil referral units in England. DfE 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/269681/Exclusion_from_maintained_schools__academies_and_pupil_referral_units.pdf

6. KEY FINDINGS INCORPORATING THE TERMS OF REFERENCE

Connected Care Placement and meeting J's Needs

The quality and longevity of relationships between the child, his family and the agencies involved with him.

6.1 It is important to remember the context of the placement with the grandparents; J, along with his siblings was removed on an emergency basis from an environment where he had been neglected, emotionally abused and possibly subject to domestic violence. The unplanned nature of the removal would have made placement with grandparents potentially the best option because it would keep open the possibility of rehabilitation (legally an option that had to be actively considered), offered continuity and stability to all the children, and made contact arrangements relatively straightforward.

6.2 J had additional needs which would have been impossible to assess when he was placed. His development was also affected by environmental factors and other external influences which were also not predictable. As a younger child the family had contained and responded to his needs, it is not unusual for a crisis to occur in early adolescence.

6.3 The long term effects of emotional abuse in early years are now more widely recognised[10] and that it can have long term consequences. In J's case behaviours such as stealing, bullying and running away may all have been manifestations of this.

6.4 With regard to the response to his needs the LAACH team provided therapeutic support over a number of years – the offer of long term work rather than a package of support from a statutory agency is relatively unusual and is a positive aspect of the support offered to maintain J at home. The Management Reviews from the Fostering Team and Children's Social Care comment on the problems of staff turnover in the workforce, yet J and his grandparents were able to develop a relationship with the same LAACH worker over a number of years.

[10] Childhood Emotional Abuse and the Attachment System Across the Life Cycle: What Theory and Research Tell Us. Shelley A. Riggs. Journal of Aggression, Maltreatment & Trauma, 19:5–51, 2010

The quality of decision making relating to where J should live.

6.5 The local authority was aware of the potential problems of J living with his older sisters. Unfortunately alternative foster placements were not considered acceptable by J who had a misplaced fear of Foster Care and residential homes.

6.6 J was never "placed" with his older siblings; he ran to their care when relationships at home became too difficult for him. The local authority followed the appropriate procedures and Viability Assessments were completed under Regulation 24 of the Care Planning and Placement Regulations which is an emergency temporary approval of a connected carer. The Regulations specify that the Regulation 24 assessment should be completed and authorised prior to a child being placed,[11] however the assessment was completed 25 days later due to the placement up to that stage being classified as overnight contact.

6.7 The Local Authority had to balance the potential risks of him remaining with his older sister against the definite risks of what would happen if he was placed with Foster Carers i.e. he would abscond and place himself at risk. For a while the option of returning to his grandparents care was also closed to him, and therefore trying to maintain him at his sister's home was reasonable, although this was not considered as a long-term option.

6.8 There were tried and tested techniques for working with J on difficult areas, but these needed time and a calm environment. He lacked the capacity to make informed choices all the time, but at the time when he was running away from his problems he did, and he needed a different level of therapeutic support. (Ideally he also needed an independent advocate - although it should be noted that he rejected advocacy on four occasions because he felt too many people were already involved in his life).

6.9 The reality of caring for J was that he presented regular challenges to his carers which increased as he entered puberty and were exacerbated by the complex

[11] Children's Social Care Procedures Manual – Placement with Connected Persons.
http://calderdalechildcare.proceduresonline.com/chapters/p_fos_11_reg_38_place.htm

emotional family relationships which surrounded him. Responding to these needs in isolation would be challenging enough without the additional pressures his grandparents faced. They were offered all the available support which is provided for Foster Carers; courses designed to help them parent teenagers; manage hostility and aggression and; training events on relevant topics such as adolescent mental health. Their working background meant that the content of many of these courses seemed familiar to them, and therefore, in their view, unlikely to improve their parenting. As Connected Carers, they were not subject to annual appraisal as Foster Carers (although an annual review took place). The local procedures state that there should be 4 visits per year from a Fostering Team social worker and they should be regular and made by a qualified worker and it seems that the minimum number of visits were not made during the period under review.

6.10 The relationship between J's grandparents and Children's Social Care is difficult to fully appreciate; there were very frank discussions and disagreements about J's behaviour, care needs and placement. There are several references to the grandparent's anger with Children's Social Care, but little evidence of any meaningful dialogue or constructive challenge of the role they played.

6.11 The significant impact on all members of the family of the arrival of his great grandmother was not objectively assessed as an important change to the family structure. Although the impact was acknowledged in meetings, this event should have led to a reappraisal of the grandparent's ability to cope and highlight the need for additional support.

Connected care, and the extent to which issues such as contact arrangements (planned and unplanned), placement breakdowns and their impact on children compared with other types of placement.

6.12 Connected Care placements have different dynamics and need a different level of support to other Foster placements. The needs of carers also need to be addressed, although the main focus must remain their ability to provide a home for the children in their care. The standards are imposed through the National Minimum

Standards for Foster Care and form the basis for judging the suitability of a placement. The records indicate that at times. J's grandparents struggled to meet the standards, and were sometimes reluctant to work with the Fostering Team to improve them.

6.13 Connected Care can cover a range of formal and informal living arrangements, the care provided to J and his siblings by his birth grandmother and her partner would be defined as formal connected care, as the placement was supported by a full Care Order, and as such the children would be subject to the same review processes as other looked after children placed with foster carers.

6.14 The assessment of Connected Carers, has historically tended to focus on the absence of negative rather than the existence of positive factors in making a placement; in other words, unless there are strong contraindications a connected care placement would be favoured over a normal Foster placement. The belief that Connected Care is intrinsically better is enshrined in the Children Act 1989 (Sec 23 (2) ii) and reinforced by the amendments to the Act in 2011 (Sec 22c), the Adoption and Children Act 2002 and the Children and Young Persons Act 2008.

6.15 However, the evidence concerning the benefits of Connected Care is equivocal[12] and Connected Care placements are not in themselves of better quality simply because of a pre-existing relationship. They bring their own tensions and pressures, as evidenced in this case with regard to the issues of controlling damaging contact, engaging the carers in on-going therapeutic support and influencing the use of controls and sanctions on a young person.

6.16 In the case of J's grandparents the challenges they faced as carers were discussed in reviews throughout the period covered in this Review. These included the statutory LAC reviews, Team around the Child (TAC) meetings, REFLECT Meetings and Personal Education Plan (PEP) meetings, although the focus of all these reviews is, appropriately J, they make reference to some of the problems of the "standards" within the placement and attempts to engage the grandparents in addressing these.

[12] Research and Practice briefings: Children and families. 16 Family and Friends Care. https://www.rip.org.uk/resources/publications/frontline-resources/family-and-friends-care-/

6.17 In recognition of this, Calderdale Council has established a dedicated Connected Care team as part of its overall fostering service provision. The team became operational in April 2014, with the aim of offering support, which recognises the dual needs of the child and the connected carers.

Changes of placement - what were the Antecedents, Behaviours and Consequences for J?

6.18 There are three significant "changes of placement" in the period under review; common themes have emerged which suggest that the behaviour was prompted by flight from a difficult situation, rather than a positive choice to move to a more suitable placement i.e. he ran away from rather than ran to. The most powerful antecedent would seem to be fear of rejection, when the situation with his grandparents was on the point of breaking down for whatever reason; J chose to seek refuge with his older siblings.

6.19 It would have seemed to J that he literally had nowhere else to turn; he had a fear of being placed in a Foster home, far away from his family and no longer being part of it. At the time of his death he was estranged from his grandparents and some of his siblings, he had been told that it would not be possible for him to live with his oldest sister's partner's family in the North East, he had rejected the two foster placements identified by Calderdale, and it is likely that he had some anxiety about the prospect of the placement with his second eldest sister being sanctioned by the local authority.

6.20 These difficulties coincided with additional pressures within the home for the family, and the parenting techniques which had worked successfully with J's siblings did not seem to be so effective with him.

6.21 On each of the three occasions when J lived with his older siblings, his behaviour was initially reported as noticeably better; he was calm, integrated into the family unit and obviously happy. These reports do not tell the whole story; they are against a background of ongoing family disputes and shifting alliances, and it is not

clear whether the reported improvements in behaviour were in response to good parenting or the absence of boundaries, although it is more likely to be the latter; given the increase in freedom when placed with his sister's, which contrasted with the more restrictive regime imposed by his grandparents.

6.22 Unfortunately, the first episode of living with an older sibling ended with fractious recriminations and an allegation of a physical assault against J. Subsequent terminations of the temporary living arrangements were explained to J as sensitively as possible to allow him to retain a sense of choice and control although there were not particularly successful in achieving this goal.

Therapeutic needs and support

The impact of the child's learning difficulties on his day to day life, quality of relationships, assimilation of information, and rationalisation of events and levels of resilience

6.23 J's level of learning difficulty was not as significant as his emotional problems in determining how he coped on a day-to-day level. The reports from school strongly suggest that his normal mode of behaviour could be managed successfully within the specialist provision of the school, techniques for managing his behaviour had been passed from primary to secondary school and were effective in the majority of incidents in that his behavioural outbursts did not result in external exclusions and were for the most part managed within school.

6.24 School had recognised that J's ability to control his impulsive aggressive behaviour depended very largely on his emotional state; this in turn was hugely affected by the quality of his relationships with members of his family, particularly his mother. The inconsistencies and rejection in this contact reached a level where it could be described as emotionally abusive; whilst J could be protected to a certain extent from physical contact, telephone contact, text messages and social media contact proved impossible to control.

The quality and effectiveness of services provided including information sharing and planning

6.25 Children's Social Care fulfilled their statutory responsibilities to J in accordance with local and national guidance; during the period under review LAC (Looked After Child) reviews took place on time and took place in a child centred way following the appropriate consultation with the young person and family, the records indicate that actions were followed up between reviews. LAC reviews were interspersed with formal Care Planning meetings which attempted to draw together the work to support J and the work to support his grandparents as carers. The records of meetings show they were well attended by appropriate representatives from the School, Children's Social Care, the LAACH team and grandparents.

6.26 The workers were consistent and resourceful in their endeavours to meet the needs of the family, and one of the real challenges was the fluid and changing nature of their needs, and on occasion their reluctance to take up the offers of help.

The quality of therapeutic input provided to the child and his carers

6.27 J was never formally diagnosed as having an attachment disorder although this possibility was raised at Primary School and during LAC reviews, but from what is known about his background and his behaviour this could have been a helpful diagnosis to discuss with the family and agencies working with him. Attachment disorders are the result of neglectful and abusive early life experiences, and this was true for the first two years of J's life and the reason that he, along with his siblings was unable to remain in his mother's care. An earlier Educational Psychologist's assessment in 2007 had concluded that he was a complex child with aspects of autistic behaviours, functioning below expectation and had issues in relation to his behaviour and relationship with peers.

6.28 J received support from the LAACH team whilst at Primary School, and throughout his secondary school career. The interventions during the period under review comprised of dyadic therapeutic sessions involving J and his grandfather.

This is an approach where the active involvement of a primary caregiver is seen as a positive feature and is seen as an appropriate approach for attachment disorders in foster children. A positive relationship was established between the therapist and the family, the feedback given to the review from the family indicates that they thought highly of the worker and appreciated her efforts to help J. J had the same allocated worker for a number of years; this was also a significant relationship that he appears to have trusted.

6.29 These sessions were beneficial; the main drawback was that they did not involve the most significant relationship in J's life, which was recognised to be the one with his grandmother. The need to involve her was recognised; to the extent that a plan for undertaking cognitive behavioural therapy (CBT) was devised with the aim of this leading to joint work with J.

6.30 A further significant intervention was planned in July 2013, following J's return to his grandparents care - a family group meeting was planned in considerable detail, which showed initial promise in tackling some of the issues which arose within the family home. Dealing with these issues was a priority because of the significant problems which existed between J and his siblings at that time. This approach would also potentially address the miscommunication and rumours which existed in the family and fuelled some of the conflict. Unfortunately J went missing and was accused of stealing money from his great grandmother before the meeting could take place.

6.31 Overall, the LAACH team were resourceful and tenacious in trying to address the issues within the family. The worker was consistent and able to stay engaged for several years, in the overall service context of staffing problems and changes of worker in Children's Social Care and the Fostering Team, this consistency was helpful.

The role of school in recognising, understanding and managing J's behaviour and language in school

Was the support and intervention proportionate to J's needs?

Impact of his exclusion from school on J and his behaviour

6.32 J's school approached the challenge of managing his behaviour in a consistent and measured way, based on a belief that most of his disruptive behaviour was a reaction to emotional distress caused by events outside of school.

6.33 The school recognised that J had additional needs, although not the subject of a formal SEN statement, and responded to these by offering J a place in the Learning Resource Centre with an individual key worker and personalised timetable combining mainstream lessons with one to one or small group work focusing on anger management and self-esteem work. These sessions were used to help J face the consequences of his actions.

6.34 Despite these interventions J continued to exhibit difficult and challenging behaviour and serious consideration was given to whether this was the right school for him in May 2013. These difficult times coincided with upheaval at home with J moving between members of his family. School again accommodated these difficulties, and made positive plans for J to move to Key Stage 4 with a personalised timetable.

6.35 There were several occasions when the repetition of angry outbursts and assaults on fellow pupils could have led to a permanent exclusion. The school were understanding and flexible in their response; adjusting his timetable and the level of support available to him, for the last half of the summer term these arrangements were reviewed on a weekly basis. The school were involved in Care Planning Meetings and aware that permanent exclusion would represent a further rejection for J and with the rest of his life in turmoil school represented a refuge and a link to the community he knew best.

6.36 In addition to maintaining J in mainstream school, the Head Teacher and staff were able to maintain a good working relationship with the family and information was often shared with them, which was not given to Children's Social Care.

Assessment, Investigation and outcome of allegations relating to sexually harmful behaviour

Appropriateness of Police investigation into the allegations of sexually harmful behaviour, the outcome of the investigation and impact for J?

Whether multi-agency procedures were followed in relation to multi-agency assessment of Sexually Harmful Behaviour?

Whether decision making by all agencies in the case was reasonable, given what was known at the time?

6.37 This review has considered the allegations of sexually harmful behaviour, and whether they can be linked, and are indicative of a more serious problem.

6.38 Concerns about J's sexualised behaviour were first noticed in 2008 and again in 2009. In 2011 there were two reports of J using sexualised language at home and in the school, and a few other incidents of inappropriate touching.

6.39 Initially two or three possible examples of sexually harmful behaviour were identified:

- sending sexually explicit Facebook messages to a younger vulnerable female pupil in March 2012
- an allegation by two younger girls that he had sexually assaulted them in August 2013 (This was investigated by the Police and there was no credible evidence that any offences had been committed by J)
- he is alleged to have kissed a 10-year-old girl in a game of dare in September 2013.

6.40 The response to these incidents was proportionate and complied with the West Yorkshire SCB procedures; a Strategy Discussion was held with Social Care in the Calderdale MAST to discuss child protection concerns. The outcome of the Strategy Discussion was that the Police needed to ascertain further details of the allegations by undertaking enquiries with alleged victims of the sexual assault prior

to proceeding with a joint Police/Social Care Section 47 investigation. It was subsequently established that no criminal offences had been committed.

6.41 This review has identified that the procedures are offence focused and do not provide an adequate framework for multiagency discussion of sexualised behaviour which may not constitute an offence, but causes problems for the young person and their peer group. An extra dimension to this is the use of social media; both for spreading inappropriate content and labelling/bullying of young people. J may have been both an instigator and victim of this kind of behaviour.

6.42 The behaviours do not indicate that J had an underlying problem with his sexual behaviour and they would not meet the threshold for a formal Strategy Discussion. Developmentally this is a time when physical development and emotional development go out of sync. Social pressures driven by social media activity and access to sexualised content online are a source of misinformation about the nature of sexual relationships, causing great deal of confusion.

6.43 J's level of sexual knowledge and experience is not known, it would be typical to find that his true level of understanding about sex and relationships was quite limited. It would be important to try and discuss these incidents further with J because they illustrate the potential for his impulsive behaviour getting him into serious trouble. With his intellectual limitations, he would find it difficult to see things from the perspective of the other person in these interactions. His lack of insight into the impact of his behaviour on more vulnerable peers is demonstrated by his tendency to bully and apparent difficulty in understanding how his behaviour would cause offence. It is known that one of these incidents led to rumours and gossip on Facebook that he had assaulted two little girls, which led to his girlfriend ending their relationship.

6.44 A key area in any work with young people who display problems with their sexual behaviour and sexual knowledge, is to look at issues of self-esteem and

connectedness to family and carers. These are important issues for all young people and would be particularly relevant for J[13]

The role of Social Media and its impact for J

The impact of social media in this case, how it affected those involved and implications for current and future practice

6.45 The first indication of the problems J would have with social media emerged in March 2012. He had engaged in inappropriate sexual discussions with a vulnerable female pupil. J's behaviour can be seen on a continuum of inappropriate sexual behaviour, the incident in itself is not serious, but alongside other comments he had made, as well as concerns about some of his non-sexual behaviour it needed to be taken seriously and seen in the context of the effect on the victim.

6.46 Recent research[14] suggests that around half 11 and 12-year-olds in the UK have an underage profile although most of the popular sites have a minimum age of 13. J was not unusual therefore in using Facebook and making posts of his favourite bands and TV shows. It is not known whether J could access the Internet via a smart phone or was dependent on the use of a home computer - which would have allowed the possibility of oversight by his carers.

6.47 J was very familiar with this technology; there are reports from his Primary School of him accessing Facebook and viewing inappropriate sexual images, his Facebook page contains content which is adult orientated, although this is typical of many boys of his age. The nature of social networking sites is self-evidently that they are a network and therefore a few clicks away from content which is completely unsuitable.

6.48 As with all online activity, use of social media has the capacity to be both positive and negative; the advantages for social media contact is that it allowed J to

[13] Children and Young people with harmful sexual behaviours. Hackett. S. Research Review Executive Summary Research in Practice. Dartington 2014

[14] Younger children and social networking sites: a blind spot. NSPCC, November 2013

remain in contact with his extended family, to see photographs of his nieces and nephews and otherwise feel involved in family. It is known that these factors were all important for J and over time they would have helped counter the negative associations of identifying with his paternal birth family.

6.49 The negative aspect was that it equally allowed unregulated contact and access to messages which were distressing to J. He did not have the maturity to deal with these and they would have played on his vulnerability, particularly his fear of rejection. There has been no hard evidence of online bullying, although the suggestion has been made that following the alleged sexual assault there was at least some Facebook content purporting to identify him as a paedophile (the message from his girlfriend stating that she had been told he had touched a 7 year old girl). Recent research[15] would suggest that this kind of online bullying is unfortunately a relatively common experience over with one in four (28%) experiencing something upsetting in a 12 month period.

6.50 This case provides further evidence of the need for social media providers to recognise and accept that many of their users are below the minimum age of 13 and provide online help and guidance about bullying and inappropriate content on their website.

[15] The Experiences of 11 – 16 year olds on social networking sites. NSPCC February 2014. http://www.nspcc.org.uk/Inform/resourcesforprofessionals/onlinesafety/11-16-social-networking-report_wdf101574.pdf

7. LEARNING (see Appendix 1 for Children's Social Care Action Plan and Appendix 2 for individual agency learning and reflection)

NB. The numbers in brackets cross reference to Section 5 – Analysis.

7.1 The management of the transition from primary to secondary was good practice. The primary school undertook a comprehensive transition with J In year 6; this involved staff from his secondary school visiting on several occasions in the last half of the summer term. J and his peers also visited the secondary school at different times of day. His personal education plan detailed the behaviour management strategies that worked in Primary School, and these were forwarded to his new school.

7.2 This preparation was important in helping Secondary School, manage his behaviour and contain him within the school, as far as possible.

7.3 What was clear was that the Fostering Team in Calderdale needed to develop its specialist skills for supporting Connected Persons. The assumption was made by most within the team that Connected Persons should be treated in exactly the same way as mainstream carers, in accordance with the statutory guidance. For those with a greater specialist knowledge in this area, there is acceptance that though they should be treated the same, they are not and often lack training due to unplanned placements; they live within the community from which the child was taken into care; their socio-economic status is generally significantly less than mainstream carers and they often disengage with services deepening their isolation.

7.4 Social Workers and LAC Reviews must recognise and deal with the implications of unregulated contact between a subject child and members of his family having a negative effect and raise this explicitly and honestly with the family (nos. 5 and 17).

7.5 The fundamental difficulty facing workers was the pre-existing damaged relationships between members of the family. Alliances between and across the three generations of family members shifted and changed regularly. At times they would be united - and at times united against the local authority. One of the

consequences of this was that it proved difficult to address concerns about negative impact concerning one family member without this being used elsewhere in the family as part of a completely separate argument.

7.6 The recording made available through the composite chronology demonstrates that the working relationship with J's carers and other family members was at times difficult and acrimonious. There were some professionals the family simply refused to work with or would place restrictions on their working with the children such as not allowing them in the house. The relationships were not uniformly bad; but extremely variable, and at worst, very damaging.

7.7 It may have been in the context of attempts to preserve the relationship as far as possible, but there is little recorded evidence of challenge of the family about their attitude and its impact on the level of support to the children. It may be that in similar cases workers delivering difficult messages need to be supported by senior or more experienced colleagues. There were times during the period under review where it was necessary to confront the family with the consequences of their actions on the welfare of the children.

7.8 A specific difficulty was the problem of controlling damaging contact between J and his mother. Contact restrictions were breached which lead to clear safeguarding concerns from the allegations of lack of supervision (J being seen out at 1:30am) through to the emotional harm of family rows and broken promises. Expectations on the family's ability to control these situations were low and the records do not show that they were formally addressed.

7.9 The need for a contingency plan is a recognised aspect of the Care Planning, Placement and Case Review regulations. The possibility that living with his oldest sister in March 2013 might provide a long-term placement did not develop until he had been there for several weeks. The issues raised by the viability assessment were all previously known and therefore, a contingency plan should have formed part of the care planning.

7.10 The failure to invoke a Disruption Meeting was a missed opportunity; overcoming the concern that it would be a difficult meeting for J; facing up robustly could have helped repair the broken relationships within the family.

7.11 A Disruption Meeting is not a discretionary process; a meeting should have been held within 12 weeks of the break down in the placement at grandparents. The failure to hold a Disruption Meeting did not protect J from negative comments made about him by family members, and would have been an opportunity for workers to confront some family members with the impact of their comments.

7.11 Professionals meetings without family, can be a valuable opportunity to realise the totality of the situation

7.12 A discussion between the IRO and LAACH Team and Social Care continued for some months, the final decision not to hold a Disruption Meeting was taken on 26th June; because of the length of time since the placement had broken down, the fact that J was still not settled, and also because the possibility of J returning to the care of his grandparents was mooted.

7.13 At times, Children's Social Care struggle to identify the appropriate venue to discuss concerns about the impact that the parenting style and wider family relationships were having on J. The formality of the structure of a Disruption Meeting could have been used to aid this discussion.

7.14 Children's Social Care needs to ensure that its workers have the training and support to develop the skills of working directly with the young person in explaining processes, e.g. the outcomes of viability assessments not coinciding with the wishes of the young person.

7.15 The child's ability to understand is affected by two main factors; their developmental ability and previous experiences. In J's case it is not clear that the workers with the most experience and the best relationship with him were used to communicate difficult information to him. At times, the strength of emotional feeling will block cognitive reasoning, it is particularly important, therefore, to prepare for an angry reaction by forewarning and preparing other professionals. Due to his

difficulties it would have been appropriate to consider enlisting the help of those professionals and certain family members he trusted who were available to support his understanding and could give a consistent message.

7.16 There was a need for direct work with J to understand his world and to scotch the myths regarding fostering.

7.17 This case has raised the issue about how professionals work with families in crisis when things change very quickly. It is apparent that the LAACH worker, IRO, School and Children's Social Care all provided forums for J to express his wishes. The difficulty arose in the extent to which professionally they felt compelled to go along with decisions, which they suspected would fail and potentially cause distress to J. It must also be recognised that at times J was not to be reasoned with; he was adamant that he would run away from a placement he didn't like.

7.18 The need for professionals to step back in this case and reflect on the chaos in the family instead of mimicking the chaos was needed to become 'unstuck'.

7.19 There was also a need to undertake direct work with J around this issue. Whilst many aspects of his life were volatile, one aspect which was, paradoxically consistent, was the regular breakdown in his living arrangements. J was offered advocacy and refused it, but this may have been beneficial source of support for him.

7.20 All schools should have up-to-date contact information for the parents and carers of their pupils. The secondary school had systems in place to collect this information initially, but the process of keeping it updated was more hit and miss. School staff were in a face-to-face meeting with J's sister, on 4th September and neglected to ask for her phone number.

7.21 Following the assault on the Head Teacher, J faced permanent exclusion from secondary school. He had previously been subject to internal exclusions, and fixed term exclusions and it is noted in the management review from his school that he could have faced permanent exclusion on two or three occasions by the end of year 8. The Head Teacher was aware of his responsibility to avoid as far as possible excluding any pupil who was a looked after child.

7.22 The assault on the headteacher, therefore, crossed a boundary into unacceptable behaviour. The physical assault against the Head Teacher was serious enough to warrant a decision to permanently exclude, however there were a range of a contributory factors which had exacerbated J's stress level and these should have been taken into account. It is accepted that all decisions to permanently exclude have to be ratified by the governing body of the school.

7.23 Having made the decision to escort J off the school site the Head Teacher has a duty to inform parents or carers as soon as possible, and preferably before J left the premises. It was at this point the school became aware that they did not have contact details for J's sister, and were therefore dependent on Children's Social Care to pass the message on, which they were able to do. Unfortunately by this time, J had gone missing and was not seen alive again.

7.24 The actions taken by the school did not comply with the procedures for exclusion. Whilst it is accepted that the actions taken were designed to calm the situation and to safeguard J and other pupils, escorting him off the school premises with no prior arrangements in place to ensure his safety was a risky strategy and outside of the school's safeguarding policies.

7.25 A simple and effective change of policy would be to keep the excluded young person on the school premises until arrangements have been made with his parent or carer to collect them from the school.

8. CONCLUSION

8.1 Working Together to Safeguard Children (2013) requires that any SCR considers whether the death of a child or young person could have been predicted or prevented. This SCR concludes that J's death was not a predicable event, as an impulsive rather than a pre-planned act it could have potentially have been prevented if a number of circumstances had been slightly different, but these would not have been the conscious acts of individuals intervening to prevent suicide and no blame should be apportioned to professionals or family for behaving as they did.

8.2 With the benefit of hindsight, it is possible to identify that there were a number of stress factors which J was poorly equipped to deal with; these included the allegations of alleged sexual assault, the theft of money from his family and the final incident at school, which led to his removal from the premises. These were serious events, but not unique or dissimilar from previous difficulties he had faced. In attempting to understand the narrative of his last months, the participants in the review process have noted the unwitting process of options becoming closed off for J (options about where he would live and to a certain extent, contact with his family) and fewer alternatives available.

8.3 Even after he had been missing for several hours, his family still expected him to arrive of his own volition.

8.4 There are significant gaps in the information concerning J's last few weeks; the impact of his time in the North East is not known. There were a number of unresolved issues such as re-establishing contact with his grandmother and mother which he had started to discuss with his social worker, which may also have played on his mind.

8.5 There remains the possibility that this impulsive boy may have accidentally killed himself. The final event in J's life occurred following a period of great upheaval and change in a relatively short space of time. School and other agencies did not have time to take stock and adjust to the impact of some of these changes and the stress that J may have felt.

8.6 The suicide of a young person provokes considerable reflection and re-examination amongst family and professionals who naturally re-evaluate their inter-actions to see if there were signs and indications that were missed or give any clues to the state of mind that would lead to such an event.

8.7 J's physical development was outstripping his emotional and intellectual maturity; he did not have the resources to deal with all the change going on around him or to articulate his problems. In the records available there are many occasions when a change in his mood is noted although it is often impossible to know what prompted that change

8.8 It is known that self-harm is often prompted by a combination of less serious incidents which appear overwhelming when seen together, rather than a single traumatic event.[16] At the time of his death J would have believed the Police were still investigating the allegations of inappropriate sexual behaviour (there was a failed attempt to speak to him on the 6th September when he was already missing). The long term placement with his sister had not yet been agreed by Children's Social Care (the fact they were being assessed may have been a further source of anxiety given the previous experience of Viability Assessments). The relationship with his grandparents and some of his siblings was still fractious and unsettled; he knew that they still believed that he had stolen from his great grandmother. He was not having contact with his mother at the time. He was worried about his sister in the North East and the impending birth of her baby. School was posing new challenges as he entered Year 9. These are the known variables; there were also changes to his behaviour that have been attributed to events over the summer without any real understanding of what may have occurred.

[16] Thematic Review of deaths of children and young people through probable suicide, 2006 -2012. Public Health Wales NHS Trust p19

9. RECOMMENDATIONS

9.1 Calderdale LSCB

a) The LSCB to review the West Yorkshire Procedures and Local Guidance where children are missing or are absent, with specific reference to information sharing and the notification of partner agencies. This must include children who are not missing but placed elsewhere.

b) The LSCB should satisfy itself that all schools within the borough have clear polices and recording systems to safely exclude children where necessary and that children are not allowed off school premises without adequate safeguards and the involvement of parents or carers.

c) The LSCB should review the provision of training regarding young people and their use of social media. This training should also be made available to Foster Carers and others who may have substantial contact with young people. Practitioners working with all young people should be sensitive to the likelihood that they are engaged in using social media. There should be a professional curiosity about their online usage and clear advice given about the potential risks, particularly for vulnerable children.

d) The LSCB website should include access to a wider range of material for children and young people and professionals on the subject of e-safety.

e) The LSCB uses Multi Agency Reflective Practice Sessions to encourage professionals to step back and reflect in families in crisis where there are lots of changes.

f) The LSCB reinforces guidance around professionals meeting without families, whilst ensuring good practice is followed and families are kept informed throughout processes.

9.2 Children's Social Care

Connected Care

a) The connected care team should review all connected care placements where children are subject to statutory orders to assess whether the placements continue to provide an appropriate placement and can adapt to meet the changing needs of the individual child as well as meeting the minimum National Standards for Foster care 2011 and the Fostering Regulations 2012.

b) Connected carers who are unable to meet basic requirements for bedrooms, privacy and other fundamental needs should be offered help to address these needs, as far as possible.

c) Young people living in connected care arrangements may face particular difficulties in expressing dissatisfaction with the placement. Therefore consideration should be given to the provision of independent advocacy to assist them in raising these issues. Advocacy services and other groups such as the 'right to voice group' and the local authority should review how they are introduced to young people to re-examine how they engage reluctant young people who would benefit from their intervention.

d) Professionals working with Foster Carers (including Connected Carers) and Residential Homes should ensure they make children aware of the potential dangers of social media. Professionals must regularly discuss this as an important issue around caring for the child/young person.

9.3 Independent Reviewing Service

Looked After Children Reviews

a) Discussions about contact arrangements should routinely address the potential risk of unregulated contact (i.e. by phone or social media)

b) The child or young person's use of social media should be discussed as part of the review. Carers should be reminded that the minimum age for use of social media is 13 years.

c) The IRO should maintain a specific focus on the Care Plan and ensure that other agencies and individuals understand the requirement to keep them fully informed when Care Plans change.

d) Where there are specific concerns relating to the quality of a connected care placement. There should be clear consultation with the IRO as part of the planning process.

e) The Independent Reviewing Service should develop a mechanism for reviewing LAC placements in circumstances where plans change frequently and unexpectedly.

f) The Independent Reviewing Service to review dispute resolution processes

NB Independent Reviewing Service recommendations a) and b) are also relevant to Children's Social Care because the issues of safe practice (a) and day to day management of the case (b) are the Social Workers responsibility.

9.4 LAC physical & emotional health and well-being

a) Strengths and Difficulties Questionnaire (SDQ)[17] screening for eligible LAC will be integrated into the statutory LAC health assessment process, ensuring a holistic approach to assessing and monitoring physical and emotional health and well-being. SDQ scores will be assessed by the LAACH service and appropriate interventions and services will be offered to individual LAC.

[17] The Strengths and Difficulties Questionnaire (SDQ) is a brief questionnaire that can be administered to the parents and teachers of 4- to 16-year-olds and to 11- to 16-year-olds themselves. Besides covering common areas of emotional and behavioural difficulties, it also enquires whether the informant thinks that the child has a problem in these areas and, if so, asks about resultant distress and social impairment. (see also http://www.sdqinfo.com/)

9.5 Education

a) Assurance that Schools adhere to their exclusion policies to ensure that children and young people are not excluded without clear arrangements being in place for children to be met or collected from the school premises.

b) Schools ensure there is accurate, up-to-date contact information for the current parent/carer of all children on roll.

c) The virtual school head should always be consulted when exclusion of a looked after child is being considered.

d) Personal Education Plans (PEP's), when appropriate, should include reference to behaviour strategies and contingency plans for managing challenging behaviour.