



BOURNEMOUTH & POOLE LOCAL SAFEGUARDING CHILDREN BOARD

CASE REVIEW W

OVERVIEW REPORT

EXECUTIVE SUMMARY

18 March 2011

1 INTRODUCTION

- 1.1 Three young people from the Poole area were arrested in the spring of 2009 and subsequently appeared in court charged with the murder of an adult male who was sleeping rough in the Bournemouth area. The assault was captured on CCTV - the man was well known in the area and liked by the community.
- 1.2 All three young people were known to a number of welfare agencies and there had been varying levels of concern at different times regarding their needs, vulnerabilities and risks that they posed both to themselves and others. Their families were also well known to agencies.
- 1.3 All of the young men were remanded to a Young Offender Institute (YOI). The trial at Winchester Crown Court concluded a year after the offence, when all three accused were found guilty of manslaughter. They are all due for release in 2011.
- 1.4 The circumstances of the case did not meet the criteria for a Serious Case Review by Bournemouth & Poole Local Safeguarding Children's Board, (LSCB), as set out in Working Together Chapter 8. However, given the very serious nature of the alleged offence by three young people on an adult, and a high level of concern given their previous profile and extent of multi-agency involvement in their lives, it was agreed by the Director of Children's Services (Borough of Poole), in consultation with the Independent Chair of the Bournemouth & Poole LSCB, that a case review should be carried out.
- 1.5 Soon after the manslaughter incident, an initial management review was carried out by Poole Children's Trust. However, at the conclusion of the criminal trial, it was considered that more information was available regarding the circumstances of the offence and of the three young men, which would support a further more detailed review of services provided and offered to these young men.
- 1.6 It was therefore decided that an Independent Case Review needed to be undertaken within the auspices of the LSCB to supplement the work already completed by Poole Children's Trust audit. A new set of Terms of Reference were devised for this review.
- 1.7 A Review Panel of senior managers from local agencies was established under the chairmanship of the Independent Chair of the LSCB, and an Independent Person, with considerable experience of involvement in Serious Case Reviews in other parts of the South of England, was commissioned to be the author of the Overview Report. It was from the Overview Report that this Executive Summary has been produced.

2 TERMS OF REFERENCE/SCOPE

- 2.1 The purpose of this Review was to consider what lessons could be learned about the way that agencies worked together locally to address the needs of young people who presented with persistent or escalating anti-social behaviours. The outcome of this Review will be to identify if improvements are found to be necessary in the light of the lessons learned, then to implement relevant changes to individual and organisational practice via recommendations and action plans.
- 2.2 The following agencies were tasked with providing agency reports including chronologies of their involvement with the young persons and their families, which were merged for each of the three young people and contributed to further through consultation with the Overview author:
 - Dorset Police
 - Bournemouth & Poole Youth Offending Team (YOT)
 - Education Services (Schools, Youth Services and other education support services – Borough of Poole CYPIS)

- Borough of Poole Children's & Social Care (CYPSC)
- NHS Bournemouth & Poole - Commissioning & Community Health Services (GPs and School Health nurses – B & PCHS)
- Dorset Healthcare University Foundation Trust (Child Adolescent Mental Health Service (CAMHS) & Adults Service - DHFT)
- Connexions
- Borough of Poole Adult Services
- Borough of Poole Housing & Community Services (Housing Advice & Options and Anti-Social Behaviour Team - ASBT)
- Poole Hospital NHS Foundation Trust

2.3 The aim of this review was to identify any gaps in information, analysis or recommendations that existed between the first audit process by the Children's Trust and this Review commissioned by the LSCB.

2.4 The families of the young men, and the three young men themselves, were informed about the process and later asked if they wanted to contribute - which they agreed to do.

2.5 Consideration was given by each contributing agency, and within the Overview Reports, whether or not issues of ethnicity, religion, diversity and equalities were effectively identified and addressed by the services that were provided to the families.

2.6 Key Issues for the Independent Review to consider

- What interventions were undertaken in addressing the anti-social behaviour of these three young men, as well as a possible local gang culture? Could these interventions have been harnessed more effectively in order to have achieved more positive outcomes for these young men, and the respective community?
- Were formal processes such as Child in Need, Common Assessment Framework and processes within Youth Offending used effectively in addressing safeguarding risks to these young men, or regarding risks that they may have posed to others?
- Was information sharing between agencies effective in managing the range of interventions which were undertaken with these young men and their families?

2.7 The time parameters for the original case review went from the birth of the young men and this information has been used to give a perspective of their early lives and their families. The specific focus of this Review was the period from when each young person attained the age of criminal responsibility (10 years).

3 DETAILS OF FAMILY/SUBJECTS

3.1 Throughout this report, the young people will be referred to as Young Person A (YPA) Young Person B (YPB) and Young Person C (YPC), who were aged between 14 years and 16 years at the time of the manslaughter incident taking place.

4 INTERVIEWS

4.1 It was important for the Overview report to be balanced so that it not only incorporated the records and views of the agencies who are responsible for protecting children and young people but also to hear how those families and young people experienced the services offered by those professionals. The Overview author therefore separately interviewed the three young people and also interviewed key members of their families. The salient points and views on their experience of their lives leading up to the incident, and the services offered by professionals, are detailed in the Overview Report.

5 KEY ISSUES

Engagement/Intervention of Agencies

A key finding from this review was that although opportunities presented themselves for agencies to intervene at early stages with each of the families of the three young persons, these were not consistently taken.

- 5.1 There appeared to have been difficulties for the majority of agencies to engage with these very challenging families who appeared to lack confidence and knowledge in accessing support from partner agencies. This highlighted the need for agencies to have grasped opportunities to work with the families and be more challenging in their assessments and collation of information to help identify risk factors.
- 5.2 It was clear that each agency, at different points, set out to offer support and assist the families to help cope with their sons' behavioural issues. However, there appeared to be a common theme where agencies were working in isolation and that there was insufficient information sharing to give a holistic picture of the concerns for these young people. However, YOT and Connexions in particular, took huge responsibility in their support of YPA and were highly commended by the family. In the Overview Author's view, an integrated planning process would overall have been the best approach.
- 5.3 Agencies at times accepted too easily responses from the family indicating that they were coping and did not need support. Professionals needed to be objective and question why the families did not want to engage with them. It is clear that they were not going to accept assistance easily and would have required empowerment and consistency from the agencies to encourage the families to ask for and accept support. These could therefore have been considered as missed opportunities.
- 5.4 When there were earlier concerns about the parenting capacity to manage the disruptive behaviour of one of the young people, the case did not reach the threshold for CYPSC intervention, but there was no apparent alternative or exit strategy from CYPSC, nor agreed plans/strategies for other agencies to support these families.
- 5.5 There was no evidence of agencies, and in particular CYPSC, utilising those professionals (specialists in the field) with clear links to the Traveller Community (which was the cultural background of one of the families), which could have been used to broker relationships.
- 5.6 There were delays in both YPA and YPB receiving "anger management" help once it was offered, and in fact in YPA's case having waited 18 months, he never actually received it. There appeared to be a lot of confusion about when they would receive this, who would carry it out, and how long it would last. This left the individuals and their parents anxious and frustrated.
- 5.7 There was evidence especially with one of the young men that one to one mentoring (anger management) had a big impact on him. He and his mother also agreed that this was of great help to him, but felt disappointed and let down when it stopped. There was no clarity around the whole process; it appeared confusing. This highlighted the difficulties for agencies in supporting children, young people and their families with sustainable services with limited budgets and resources
- 5.8 The one agency that each of the young people felt helped them in some way was the YOT and Youth Services such as the youth club. Even when there is only minimal contact, if trust and respect are present, it gives a far greater foundation to build relationships with young people and make a difference.
- 5.9 All three attended the Youth Advisory Service where they received appropriate health advice. This was a good example of where these three young people felt empowered to engage in the service.

Professional Judgement/Assessments

- 5.10 Some of the occasions when assessments were undertaken or when opportunities arose to do so, occurred from 2001 onwards, and so it needs to be acknowledged that inter agency practice and processes have gone through changes since that time. However during the history of involvement, agencies were aware of each family's background, and this history, if taken into consideration might have identified triggers/signs in the families which could have assisted in predicting escalating behavioural problems in each of the young people.
- 5.11 In the case of YPC there was a lack of assessment carried out when his home circumstances changed and his escalating behaviour problems were becoming difficult to manage.
- 5.12 There were six opportunities in the early periods of involvement, for CYPSC to carry out initial assessments (IAs) in respect of these young men and their families. On two occasions the families assured CYPSC that their assistance was not required, whilst on another the school agreed to work with the family. Some services were provided following Initial Assessments with one family. However there were missed opportunities, when being more proactive to engage with the families could potentially have created some change. There was also an occasion when child protection concerns could have been given consideration.
- 5.13 The Common Assessment Framework (CAF) is used nationally as an assessment tool for families and should be completed with the family. In this case the Overview Author could find evidence of five being completed which were used more as a request for resources or as a referral to another agency. There appeared to have been confusion as to when and how to complete them, which questioned how well agencies understood the CAF process. This issue was already recognised by key agencies, and is being addressed locally to improve the use of CAFs and their support for children and their families.
- 5.14 There was a further occasion when an assessment should have been undertaken, under the requirements of a local protocol, when one of the young person's circumstances significantly changed. There was a lack of involvement of key health agencies at the time. Whilst the potential for separate housing requirements were considered, his needs were considered as "too high and complex", although this did not prompt other alternatives to be explored. It needs to be noted that work has now been undertaken by local services to develop joint working arrangements to comply with recent national requirements¹ which has meant that young people's experience of assessment for housing has been tangibly different.

Multi-Agency Working

- 5.15 There was some evidence of agencies committed to working with the families; however, agencies generally had intermittent interventions in their provision of support for the families. It was undoubtedly very difficult to make and encourage change when dealing with limited information and complex, hard to reach families. It needs to be acknowledged that the families themselves did not always want to accept help. It would nevertheless appear that in this case agencies did not work sufficiently robustly and proactively in a multi-agency arena to gain the families engagement in order to help support them in their care of these young people.

¹ The Southwark Judgement, made by the Law Lords in May 2009, is a piece of case law that obliges children's services to provide accommodation and support to homeless 16- and 17-year-olds.

- 5.16 Risk assessments were intermittently carried out by individual agencies although there was little evidence to suggest that thorough multi-agency assessments were carried out. The multi-agency risk assessment process could have created the opportunity for better risk management in order to keep young people and their families safer.
- 5.17 There appeared to have been a number of processes in place for multi-agency meetings to share information and jointly assess risk for those 'high risk' young people which were not followed. This highlighted a lack of understanding and existence of clear pathways to initiating pro-active multi-agency meetings. However these meetings are more readily available now.
- 5.18 Agencies who worked with the families were amenable to allowing other agencies to take over responsibility. Although this was appropriate in most cases, it was hard to find much in the way of evidence where agencies confirmed that other agencies carried out their role/duty to protect these young people.
- 5.19 There were 24 meetings predominantly at the school held for YPA and a smaller number for YPB and YPC that were often well attended by agencies. However not all key agencies attended and there was confusion as to who was invited and whether they were the most appropriate. More consistent attendance by all appropriate agencies would have increased the chance of robust multi-agency risk assessments.

Peer Pressure/Anti-Social Behaviour

- 5.20 The anti-social behaviour of the young people escalated greatly the closer it got to the incident of manslaughter. A number of agencies including the School, Police, ASBT and YOT were involved with them and were aware of the escalation in destructive behaviour. Collectively none of the agencies seemed able to address their offending or reduce the level of this behaviour.
- 5.21 The agencies in this case appeared to have had little understanding of what young people acting as part of a group meant, and the impact that this could have on this community. There was some DCSF Guidance on working with young people affected by group anti social behaviour in the community, which was going through the consultation stage at the time of this incident. Had the risk assessment tool attached to this guidance been used, all three young men would potentially have been assessed as a 'high risk'.
- 5.22 The sheer power of peer pressure did not appear to have been picked up by agencies. All three young persons have later admitted to finding confidence from being part of a group, which they lacked as individuals. The natural progression for these young people was to find their voice through the group and then use it to make their stamp on society. There was evidence to suggest a 'group identity'; with some of the risks factors/criteria from the risk assessment tool referred to above, evident in the group. The management review however accepted from the professionals working with these young men, that they were not operating as a gang.
- 5.23 There was a lack of reference or understanding of the misuse by young people of alcohol and drugs - It was not clear why substance abuse was not considered as part of any assessment of risk.
- 5.24 The ASBT appeared to have received a number of notifications of anti-social behaviour involving these three young people, who were placed on Acceptable Behaviour contracts (ABCs). The ASBT had varying levels of involvement but there appeared to be no evidence that this involvement reduced incidents of anti-social behaviour. The young people themselves said that they ignored the contracts and the curfews, and as this had no negative impact, it appeared as though destructive behaviours could continue without sufficient challenge.

- 5.25 There was information recorded highlighting concerns of two of the young men's involvement in animal cruelty. Understanding the links that research has demonstrated regarding child abuse, animal abuse and domestic abuse showed that these were indicators/predictors of escalating reckless risky behaviour. The use of Restorative Justice Procedures at such times seemed to generate some success with the young person involved, and potentially could have been used more broadly with the young people in relation to other instances.

Family Issues

- 5.26 All three boys had difficult family upbringings and appeared to lack consistent positive male role models. When interviewed, all three felt that had they had a positive father figure around when they were younger, that they may have had a better chance of keeping out of trouble.
- 5.27 There were a number of examples of the mother of each of the young people struggling to manage their son's behaviour. There were also times when they asked for help from professionals, and in particular from the school and health services.
- 5.28 Cultural and literacy issues do not appear to have been assessed sufficiently to take into account the needs of the families and the impact on the families of them accepting and using support.

Health Related Issues

- 5.29 There appeared to be little to no therapeutic help offered to the families. YPA and his mother both stated in their interviews that external help and support would have been useful during one particular crisis in their lives. YPB had some success with the anger management facilitator as did YPA with the school nurse, both examples highlighting that they were in fact able to engage in receiving some form of help.
- 5.30 When one of the young men was diagnosed with ADHD he was very quickly prescribed medication to help manage the condition, which helped greatly. A diagnosis of Asperger's was explored but it is not clear that this process was pursued. Generally in respect of the work of different agencies, insufficient interventions were used to identify the root causes of such issues. Overall, a more holistic approach may have assisted in managing the causes of his subsequent negative behaviour.
- 5.31 As a result of non-attendance with the consultant community paediatrician, medication for ADHD ceased and the young person was offered no alternative. He also took himself off the medication because he claimed that he fell asleep at school. The non-attendance policy at that time lacked engagement with the parents and the original referrer, where a more determined and focussed 'follow up' process may well have re-engaged this young person.
- 5.32 All three young people attended Poole Hospital's A and E department on a number of occasions. They attended with varying injuries but only minimal details of how they had come by those injuries were recorded. These could have been signs of their escalating risky and often dangerous behaviour which if shared appropriately could have identified the need for a more robust assessment of needs and risk. A recent internal review has addressed this issue.
- 5.33 The Child and Adolescent Mental Health Service (CAMHS) had little involvement with these young people. There was mention of referrals made to them but only one appointment was taken up by one of the three young people. More could potentially have been done by agencies who were involved with the families to engage with them and to get them to accept some of the specialist help that was on offer.

School Related Issues

- 5.34 All three young people and their families highlighted school as the main agency that let them down. Undoubtedly the school found it very challenging to manage the difficult behaviours of these young men, but the use of exclusions was seen by the families and young people as a way to punish them, and the sheer volume only led to making them feel more marginalised as they didn't feel they had a voice. The result of this was rather than improving their behaviour, it tended to only escalate it by giving them more time to use anti-social behaviour in their own peer group.
- 5.35 Whilst two of the young persons were permanently excluded from school, the third was referred to the Personalised Learning Centre for support and respite following 15 exclusions. There was no evidence of a transition plan for these young people in offering them a mentor who could outreach and assertively engage with them, listening to what they had to say regarding their experience and advocating on their behalf.

Communications/Information Sharing

- 5.36 There was clear evidence of some good examples of agencies sharing information appropriately. However there were a number of occasions where it was intermittent and at times, completely missed. Examples of these were the A and E Department of Poole Hospital and Dorset Police who failed to appropriately share information with CYPSC following their regular contact with these young people especially after arrest. This has improved more recently and Dorset Police are carrying out a further review to ensure appropriate information sharing in respect of children and young people coming to their notice.
- 5.37 Adult Social Care worked with the mother of YPC to provide her with additional support. However there appears to have been no evidence of Adult Services linking in with Children's Services to work jointly to help with the management of her son's escalation of risky and anti-social behaviour. Practice in this respect has changed since that time in that Adult Services now routinely enquire whether any service user has children or lives with them. Where appropriate, it is now expected that links are made with Children's Services (CYPSC)

Record Keeping/Reviews

- 5.38 There were some good examples of record keeping from most agencies but there were also examples where it should have been better. Chronologies/summaries at the front of files did not always reflect the depth of history of the families and the number of contacts which led at times to a 'start again' (reference, Ofsted lessons from Serious Case Reviews 2009 – 2010) process rather than utilising prior information and assessments to inform the 'here and now'.
- 5.39 There was some confusion in the case of the possible diagnosis of Asperger's. The records show that he was diagnosed with ADHD and prescribed medication to assist with this condition and also medication to assist with his sleep problems. However communication with the family did not give them a clear explanation of this as a diagnosis and what proposed interventions may have been necessary.
- 5.40 The records for the period YPB spent at middle school cannot be located and therefore it was not possible to say when his poor behaviour started and whether it could have been assessed and managed earlier. He and his mother believe that he was doing well and had no real issues until he went to senior school but without records this cannot be confirmed. This does raise an issue in the retention and transition of records as they play an essential part in how future schools or agencies engage with and manage young people.

6. SUMMARY OF OVERVIEW REPORT RECOMMENDATIONS

In addition to the recommendations below, there are numerous individual agency recommendations, developed from their own analysis of their work with these young persons and their families.

Recommendation 1

The LSCB needs to work with partner agencies to develop a policy on how agencies can jointly and individually work with hard to reach families as effectively as possible. Such a policy will need to include robust management oversight processes.

Recommendation 2

Restorative Justice (RJ) has been successful especially within the youth justice system. YOT and the ASBT are part of the RJ process but the current policy needs to be promoted to ensure all agencies are fully aware of how to refer a case for a RJ conference and their roles within it.

Recommendation 3

Police and ASBT need to ensure early interventions are made proactively to address behavioural change more effectively. With the proposed governmental reduction in use of ASBO's, policy needs to be reviewed to identify the most appropriate processes to deal with escalating anti-social behaviour in partnership. Such a review should also identify the most effective response to breaches of orders and recommend changes to this practice if appropriate.

Recommendation 4

Poole CYPSC should ensure that their thresholds of intervention document and the remit of the Targeted Services Team are appropriately disseminated to relevant agencies.

Recommendation 5

The risk assessment tool within the recent DCSF Guidance should be used by relevant agencies at an early stage where the behaviour of young people starts to escalate to anti-social behaviour and criminality. The existing processes such as the Families at Risk panel will need to incorporate this in its work.

Recommendation 6

Training on 'the impact of a 'group identity' born out of peer pressure should be rolled out to professionals who work within Safer Neighbourhood Police Teams, YOT, ASBT, CAMHS and Schools. The relevant 2009 guidance should be utilised for this purpose.

Recommendation 7

Any assessments of risk with young people who are presenting challenging and anti social behaviours must include enquiries into the extent of any substance misuse, and the impact of this on their behaviours and relationships with their families.

Recommendation 8

Multi-agency meetings such as the Families at Risk panel, set up to share information and jointly assess risk for high risk young people in Poole should be reviewed to ensure that there is an embedded process and meeting structure that all agencies know how to access, are aware of the criteria for referral and expectations of what may be achieved.

Recommendation 9

All agencies working with challenging behaviours by young people, need to assure the LSCB that relevant and contemporaneous recording of significant events and contacts are developed and utilised as an integral part of their case record keeping processes and are used to inform holistic assessments.

Recommendation 10

Schools within the Bournemouth and Poole Local Authority area need to review their use of internal and external exclusions as to their effectiveness in improving disruptive and aggressive behaviour and to see if there is a better way of working with young people and their families to help keep them safe and at school. The 'Team around the school' meetings have proved a positive step in achieving success and this process needs to be embedded in multi-agency procedures.

Recommendation 11

When health professionals and relevant specialists, such as those within the Child and Adolescent Mental Health Service, carry out assessments on children and young people with complex conditions such as ADHD and Asperger's, records need to be clear and concise regarding the outcome of such assessments, so that parents and other professionals are appropriately informed and fully understand them.

Recommendation 12

Present the recently conducted Borough of Poole Review of CAF processes to the LSCB with consideration of whether the issues identified in the W case have been addressed in the CAF review and the identified changes have been made, with particular emphasis on the need for clarity in the role of 'lead professional'.

7. LESSONS LEARNED AND BEST PRACTICE GUIDANCE

This review and The Children's Trust review have identified a number of other areas that are generic in their link to lessons learnt from previous Serious Case Reviews and not just pertinent to this case. These will be listed below so that agencies are reminded of previous learning and what represents best practice.

- 7.1 When information is collected in respect of a family's culture and ethnicity at an early stage and forms an integral part of any assessment, then this will generate a much more informed understanding of the family's circumstances and thereby greatly enhance the likelihood of more relevant and successful interventions with them.
- 7.2 Assessments of risk to families can only be effective and informative if all records relating to both the children and the significant adults in the family are accessed, whether they be held by either Children's or Adult's Services. It is essential that these two services speak to each other and appropriately share information.
- 7.3 Management oversight and audits of record keeping practices are essential to ensuring that an agency is delivering effective safeguarding practice and that there is continuous improvement where necessary in case recording. Professionals need to be held to account where record keeping is below an acceptable level.
- 7.4 If agencies are able to utilise opportunities that present themselves for early engagement with families in order to carry out focussed risk assessments with them, followed by evidence based interventions, then there is greater likelihood of addressing and curtailing the development of challenging behaviours at this early stage
- 7.5 Practice with young people is more effective if professionals focus upon the causes of behavioural issues and deal with these through early intervention rather than treating the symptoms.
- 7.6 Professionals need to work more closely with families to improve and support their parenting skills especially as in this case where parents were at times desperate for help in dealing with their sons escalating behaviour.

- 7.7 Failures to assess male carers or significant males within the family will compromise the quality and value of any assessments undertaken. As will the impact of the absence of a positive male role model within the family.
- 7.8 Young people appear to respond well to positive role models, especially within the school environment, who can have a powerful impact on their lives. It is a positive step to have someone to provide a genuine mentor/advocate role in order to present young peoples views effectively.
- 7.9 The retention and transition of school files is essential to the assessment of a child as they move from school to school.
- 7.10 The reasons why young people are acting out and/or showing aggressive behaviour are varied; hence an assessment looking at the causes would be appropriate before referring on for support such as anger management. It is important that once referred, there is little delay of support being offered.
- 7.11 When young people are prescribed medication to help manage their illness and the resulting behaviour, especially those with conditions such as ADHD, if the young person's school is not made aware, their staff will be unable to monitor any changes or identify any risks in relation to the young person's behaviour.
- 7.12 Cruelty to animals is a safeguarding indicator for an assessment to be carried out on young people and is also an indicator/predictor in the escalation of violent behaviour. This information should be used in initial assessments and multi-agency risk assessments.
- 7.13 When predictors, indicators and triggers to growing anti-social behaviour are identified, shared and pro-actively worked on within a multi-agency arena through appropriate sharing of information and joint partnership meetings, then the likelihood of success in addressing these behaviours is significantly enhanced.
- 7.14 It is essential that professionals challenge parents who minimise issues within the family and if professionals take an objective stance about the work carried out by other professionals and also challenge them appropriately, this is much more likely to lead to effective multi agency practice.