# Tower Hamlets Safeguarding Children Board

## Serious Case Review Executive Summary

# Services provided for Child F

## June 2004 – January 2012

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**Interim Independent Chair - Tower Hamlets LSCB** Sarah Baker

**Serious Case Review Panel - Independent Chair** Kevin Harrington JP

**Serious Case Review Overview Report Author** Keith Ibbetson

## 1 Background to the Serious Case Review and the reasons for carrying it out

1.1 Between February 2012 and July 2013 Tower Hamlets Safeguarding Children Board (LSCB) conducted a Serious Case Review (SCR) in relation to the services provided to a young person who is referred to as Child F. At the time of his death in January 2012 Child F was aged 15 and in the care of Tower Hamlets Council. Between 2002 and 2011 Child F had lived continuously in a foster home in Medway. In October 2011 he was sentenced to a 10 month Detention and Training Order (DTO) and placed at Cookham Wood Young Offender Institution (YOI). In January 2012 Child F hung himself in his cell at Cookham Wood with a ligature made from his trainer laces.

1.2 For some three weeks prior his death, prison staff had concerns that Child F had withdrawn from participation in the regime at the YOI and that he had self-harmed by cutting himself. On a number of occasions he had threatened to 'string up' (hang himself). As a result prison staff were supporting and monitoring Child F under the Assessment, Care in Custody and Teamwork (ACCT) procedures which the Prison Service uses to assess and support prisoners who are self-harming or believed to be at risk of suicide.

1.3 The SCR was carried out in order to fulfil the requirements of Chapter 8 of the statutory guidance *Working Together to Safeguard Children* [1] and the London Safeguarding Children Board Child Protection Procedures.[2] The statutory guidance requires that there should be a SCR when a child or young person dies in custody, including in a YOI.[3] Tower Hamlets LSCB was responsible for conducting the SCR because Child F was in the care of Tower Hamlets Council. Medway LSCB has been fully involved.

1.4 The SCR covers the period between 2004 and Child F's death in 2012. Some earlier events are referred to because some decisions made prior to 2002 were of lasting significance. The main focus of the SCR is on events that occurred after March 2010.

1.5 The SCR Overview Report seeks to provide sufficient details of the case to enable transparent scrutiny of the actions and decisions of professionals and to support legitimate public discussion while at the same time protecting the privacy of those involved. No individuals are identified in the published SCR documents. The requirement to publish SCR reports in full means that it is impossible to guarantee that the young person at the centre of the review, other family members and professionals who worked with the family will not be identified, particularly when a young person's death is a matter of public record and he has been identified in the media.

[1] HM Government, *Working Together to Safeguard Children – 2010.*
[2] http://www.londonscb.gov.uk/procedures
[3] HM Government, *Working Together to Safeguard Children – 2010* (paragraph 8.9)

## 2 Arrangements for the SCR

2.1 The SCR reviewed the work of the following agencies who were involved with Child F and his family:

- An independent fostering agency contracted by Tower Hamlets to provide a foster home for Child F
- Barts NHS Health Trust - the Trust and its predecessors undertook a number of health assessments of Child F under the regulations governing the health care of looked after children
- HM Cookham Wood Youth Offenders Institute
- East London Foundation NHS Trust – which provided the Child and Adolescent Mental Health Service to looked after children in Tower Hamlets
- Kent and Medway NHS Partnership Trust - which provided the Child and Adolescent Mental Health Service in Medway during the period under review
- Kent Police - which dealt with offences and alleged offences committed by Child F in Medway
- Kent and Medway NHS - dealing with GP services in the Medway area
- Medway Council Education Services, schools and an education project attended by Child F
- Medway Youth Offending Team (YOT)
- Medway NHS Foundation Trust – which provided acute hospital services
- Metropolitan Police Service -which dealt with the alleged abuse of Child F in his birth family in 2002 and a number of other allegations relating to family members
- Tower Hamlets Council - which had the overall responsibility to promote Child F's health and wellbeing as a looked after child
- The Youth Justice Board

The roles of all these agencies and the extent of their involvement are detailed in the full SCR overview report.

2.2 The review was conducted by a SCR panel which included senior representatives of LSCB member agencies from Tower Hamlets, Kent and Medway. Panel members had expertise in safeguarding children and detailed working knowledge of the professional standards relevant to all of the services involved.

2.3 The SCR panel was chaired by Kevin Harrington JP. The SCR overview report was prepared on behalf of the LSCB by Keith Ibbetson. Both the SCR panel chair and the report author are independent of the agencies involved and have expertise in children's safeguarding and substantial experience in conducting SCRs. The other members of the SCR panel were:

| SCR Panel members | |
|---|---|
| **Agency** | **Designation** |
| Independent SCR Panel Chair | Kevin Harrington JP |
| London Borough of Tower Hamlets | Interim Corporate Director for Education, Social Care and Wellbeing |
| London Borough of Tower Hamlets | Interim Service Head for Children's Social Care |
| London Borough of Tower Hamlets | Service Manager, Child Protection and Reviewing, Children's Social Care |
| Tower Hamlets Clinical Commissioning Group | Nurse Consultant for Safeguarding Children and Designated Nurse |
| Barts Health NHS Trust | Designated Doctor for Safeguarding Children (Community Services) |
| East London Foundation NHS Trust | Associate Director for Safeguarding Children |
| Metropolitan Police Service | Review Officer, Crime Academy and Review Group |
| Medway Council / Medway Safeguarding Children Board | Service Manager, Children's Independent Safeguarding and Reviewing Services |
| Youth Justice Board | Local Performance Advisor (London) |
| HM Cookham Wood Youth Offender Institution | Head of Integrated Children Services |
| Kent Police | Detective Chief Inspector |
| NHS Medway Clinical Commissioning Group | Designated Nurse for Safeguarding Children |
| Medway Council | Service Manager, Integrated Youth Support |

2.4 A number of other panel members are employed by agencies which had no involvement with Child F or his family, bringing additional independence to the work of the SCR Panel. The work of the SCR panel was supported by the Tower Hamlets Safeguarding Children Board Business Manager. A health overview report was prepared by the Designated Nurse for Safeguarding on behalf of NHS Medway (now NHS Medway Clinical Commissioning Group) which commissioned the health services most involved with Child F.

2.5 The purpose of the SCR is set out in *Working Together 2010* as follows:

- to draw together a full picture of the services provided for Child F and his family

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

2.6 The SCR focused on the following specific areas:

- The impact of sexual abuse, emotional abuse and neglect on Child F and the therapy or other provision that agencies made to help him recover
- The provision made in relation to Child F's emotional health and any identified mental health concerns
- The steps taken by Tower Hamlets Council and other agencies to safeguard and promote the wellbeing of Child F as a looked after child, including:
    - Child F's health
    - Child F's education
    - Contact and relationships with his family
    - Contact and relationships with his foster family
- The steps taken by Tower Hamlets Council, Medway Youth Offending Team (YOT) and other agencies in relation to Child F as a person who had committed offences or was at risk of doing so
- The provision made at Cookham Wood YOI and the liaison between the YOI and other agencies during Child F's detention there
- Steps taken by agencies to work together and to involve members of Child F's family in the hours before his death.

The SCR overview report provides comprehensive information on all of these matters.

The Executive Summary sets out the most important findings of the SCR.

## 3 Family involvement in the SCR

3.1 The author of the SCR overview report had separate contacts with Child F's parents to seek their views about the services that had been provided. The SCR is grateful that family members were able to make a positive contribution in relation to a traumatic event that continues to have a severe impact on their lives. The views of family members are reflected at a number of points in the SCR overview report and have influenced its findings. Family members were made aware of the main findings of the SCR before they were published.

## 4 Summary of professional involvement with Child F and his family

Family background

4.1 Child F was born in 1996 and was the youngest of four siblings who lived with their mother in Tower Hamlets. The four children had different fathers. Child F was of mixed heritage. His mother and his siblings are white. Child F's father was never part of this household but used to visit him. Child F's father lived with his wife and their child. Before he came into care in 2002 Child F had no contact with other members of his father's family.

4.2 Between 2000 and 2002 Child F and his siblings were on the child protection register because of neglect and emotional abuse. Later accounts given by Child F indicate that the children lived in an unsafe, chaotic and physically deprived environment. When he started at school Child F was identified as having special educational needs due to his emotional and behavioural difficulties.

4.3 In mid-2002 when Child F was six, all four children came into local authority care as a result of allegations that Child F had been sexually abused by a family member. Medical examination of Child F confirmed that he had been subjected to repeated anal rape over a substantial time. There was no criminal prosecution because at that point Child F did not give an account of who had been responsible for abusing him and there was no forensic evidence that linked the offences to a specific perpetrator.

4.4 The four children were found separate family placements. After staying briefly with his father who was not in a position to offer to look after him in the long term, Child F moved to a short term foster care placement in Medway. He remained in this placement for the remainder of his time in care and lived with his foster carers until October 2011 when he was given a custodial sentence and went to Cookham Wood Young Offender Institution.

4.5 In June 2004 the Family Proceedings Court made a Care Order, placing Child F in the long term care of Tower Hamlets Council. This gave the local authority responsibility for promoting all aspects of his health, development and education. The care plan agreed by the court was that Child F would remain in the care of his foster carers until he was an adult. The care plan included arrangements for Child F's mother to see him once a year and for there to be contact with two of his siblings. The local authority had not pursued the option of seeking an adoptive family for Child F.

4.6 Contact between Child F and one of his brothers ceased when that brother was adopted. Child F saw his mother until 2008 when she moved to another part of the UK and she stopped trying to maintain contact. Annual contact between Child F, his maternal grandmother and his sister continued until 2009. In 2011 attempts were made by the local authority social worker to make contact with Child F's mother, but by then Child F did not want to see her.

4.7 After he came into local authority care Child F's father began to be more involved in his life. Between 2002 and 2010 he had regular contact with Child F who also made overnight stays and went away on holiday with his father on one occasion. Contact between Child F and his father broke down in 2010. After this Child F's father tried to keep in touch with him, but Child F did not want to see him. The father remained in contact with the foster carers. After the breakdown in contact the local authority did not keep Child F's father informed about important developments in his son's life.

The impact of Child F's early childhood experience and the help provided

4.8 Despite being well cared for by his foster carers and becoming a loved and cherished member of their family, the abuse and neglect that Child F suffered had a profound effect on his emotional health and behaviour throughout the rest of his childhood. He always found it hard to make friends and to accept help or trust adults.

4.9 The signs and symptoms of abuse that Child F showed varied at different points in his life. For some time after he moved to his foster placement Child F's behaviour at home was often very disturbed. At primary school he found it difficult to regulate his behaviour when he was not closely supervised. He was aggressive to other children on a small number of occasions. Overall Child F coped reasonably well at primary school because of the support that he was given and because allowances were made for the difficulties that he had experienced.

4.10 During his primary school years Child F attended the Medway Child and Adolescent Mental Health (CAMHS) service for nearly three years where he saw an art therapist. There was a delay in help being provided because of the length of the court proceedings and because there was a lengthy waiting list in the CAMHS service. The therapy was designed to help Child F deal with the effects of the abuse that he had suffered and to cope better with the problems he faced in his school and family life. This was the only therapeutic help provided to Child F in relation to his abuse. Later he refused offers to meet with CAMHS professionals.

4.11 In 2008 (when he was 12) Child F was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and he received (in sequence) three different types of medication for this over approximately 12 months. The treatment was discontinued both because it had only a short term positive impact and because Child F refused to take the medications prescribed.

Worsening difficulties as Child F became an adolescent

4.12 As Child F became a teenager he became more preoccupied with his history, his identity and why he was not living with members of his family. This led to increasing difficulties in his behaviour at home, at school and in the community which led in due course to involvement with the police and the courts.

4.13 Child F attended a mainstream secondary school between September 2007 and September 2010. He always found it difficult to manage there and experienced a large

number of exclusions – both short term periods when he was required to work in the school's internal exclusion area and fixed term exclusions from the school. These were almost always the result of persistent low level disruptive behaviour although there were a small number of more serious incidents including assaults on other pupils.

4.14 The school and Medway Council's education service took measures to support Child F and there were numerous meetings between professionals from the school, Child F's foster carers, Medway Council and Tower Hamlets children's social care to try to find ways of helping Child F to modify his behaviour. These proved unsuccessful in part because Child F increasingly rejected the support offered and because there were confusions and uncertainties about what sort of additional support should be provided, how it should be arranged and who should fund it. Two educational psychologists assessed his needs and made recommendations, in 2009 and in 2011.

4.15 From mid-2008 (when he was 12) Child F's behaviour became more difficult for his foster carers to control and he committed a number of criminal offences in the community, such as setting fires. Kent Police offered support to Child F and his foster family and contact with neighbourhood early intervention schemes. Child F was not prosecuted and he was not referred to Medway Youth Offending Team until September 2010.

4.16 In September 2010 Child F's school said that it intended to exclude him permanently and efforts were made to find alternative provision. Between October and December 2010 Child F received no effective education. Between January and October 2011 he attended a project run by NACRO, where he participated in a catering course and other activities, which he sometimes enjoyed. It was only ever intended that Child F would attend this project for one or two days per week. He was excluded on a number of occasions and he often missed sessions, despite attempts to improve his attendance.

4.17 Between December 2010 and February 2011 Child F committed a number of offences, including thefts and assaults. He had knives in his possession and on one occasion carried a knife in circumstances that could have led to serious risk to Child F and others.

4.18 These difficulties placed further strain on Child F's foster carers and in January 2011 they gave Tower Hamlets Council notice that Child F would need to leave the placement. They were concerned because of the potential risk that Child F posed to family members including other foster children. Tower Hamlets proposed that Child F should move to a children's residential unit in London but the foster carers believed that this would be damaging to Child F and decided instead that he should remain with them. No additional support or expertise was provided to support the placement.

Involvement with the youth justice system and Medway Youth Offending Team

4.19 Medway YOT worked with Child F under community orders imposed by the Youth Court between December 2010 and October 2011. Until June 2011 Child F made some progress and attended many productive supervision sessions with his keyworker. Between mid-February and mid-June 2011 he committed no serious offences. From June 2011 Child F committed more offences and persistently refused to comply with the orders made by the court, leading him to be 'breached' and returned to court on several occasions. Between August and October 2011 Child F was sentenced to the Intensive Supervision and Support Programme (ISSP). This community sentence included a requirement for 25 hours of supervised activity each week and a very restrictive curfew. During September and October 2011 Child F continued to commit offences and failed to comply with the requirements of the ISSP. The accumulation of offences and breaches of his community sentence led to Child F appearing at the Youth Court in mid-October 2011. The court decided to sentence Child F to a custodial sentence, a 10 month Detention and Training Order.

4.20 Under this sentence the Youth Justice Board had the option to place Child F either in a Young Offender Institution (YOI) or to a Secure Training Centre (STC). STCs are smaller and have a higher ratio of staff to young people. Placement in a STC would have offered Child F a higher level of personal support. Following the recommendation made by Medway YOT Child F was sent to serve his sentence at Cookham Wood YOI, where he had previously been on remand in August 2011.

4.21 The YOT had recognised Child F's vulnerability in its previous assessments but due to shortcomings in the assessments undertaken and in its organisational arrangements during the critical court appearances in August and October 2011 the YOT did not make its views about Child F's vulnerability known to the court or recommend that he be placed in a STC.

Child F's experience in custody at Cookham Wood Young Offender Institution

4.22 Child F spent a week on remand at the YOI in August 2011 and was sentenced there in mid-October 2011 to serve the 5 month custodial element of his 10 month Detention and Training Order. His scheduled release date was in March 2012 with possible early release in February 2012.

4.23 In November 2011 the YOI consultant psychiatrist undertook an assessment because of Child F's history of ADHD and prescribed him medication. A plan was developed for members of the YOI mental health service to offer Child F counselling and support in the form of cognitive behaviour therapies, designed to help him think more constructively about his future. However Child F stopped taking his medication in the days prior to his death and there is no evidence that he took advantage of the proposed therapy.

4.24 Shortly before Christmas 2011 Child F started to withdraw from association with other young people. Later he started to cut and tattoo himself. From mid-January 2012 he made threats to 'string up' (prison slang for hang himself) and he began to block the observation panel in his cell door, forcing prison officers to enter his cell on many occasions to ensure that he was not harming himself.

4.25 As a result of the concern that Child F would harm himself he was monitored under the YOI's suicide and self-harm prevention procedures, briefly in October 2011, over the Christmas and New Year period and then from 6 January 2012 until his death. A number of prison officers and senior officers made considerable efforts to support him and to engage him and encourage Child F to join in the YOI regime. At the same time the YOI imposed punishments on Child F under its rewards and sanctions scheme and he was also subject to a number of formal disciplinary charges for tattooing, being abusive to staff or covering the observation panel in his cell door. The YOI did not have a consistent stance as to whether Child F's actions in cutting and tattooing himself should be considered as self-harm or as a breach of the prison regulations.

4.26 From October 2011 until January 2012 Tower Hamlets children's social care provided no allocated social worker for Child F. This meant that almost no work was undertaken on his case by the local authority and only very limited steps were taken to respond to information about Child F's deteriorating condition at the YOI. There was also no response from children's social care for requests made by Child F to see his grandmother and other family members. A new social worker was allocated to Child F in January 2012. He made contact with other professionals but he did not manage to see or speak to Child F before his death.

4.27 On several occasions in the last few days of his life Child F made threats that he would hang himself and twice prison officers found Child F with nooses made of trainer laces. However when he was seen by the consultant psychiatrist four days before he hung himself Child F denied that he had any suicidal plans or thoughts. On 23 January 2012 the last review meeting held under suicide and self-harm prevention procedures noted some improvement.

4.28 On the night of his fatal act of self-harm Child F phoned his foster parents and repeated a statement made previously that he did not want to return to live with them after his release as he did not want to cause them further distress. That evening for the first time at the YOI he mentioned the sexual abuse he had suffered as a young child in a conversation with a prison officer. Another officer who had a good relationship with Child F came from another wing in the YOI to spend time with him and offer additional support.

4.29 Child F was evidently very upset and as a result the frequency of his suicide and self-harm monitoring was increased to five observations per hour. Although these observations were carried out, Child F succeeded in hanging himself in the interval between observations. Child F was found and treated by prison officers and paramedics but sadly died the following day at a local hospital.

## 5 Summary of Serious Case Review Findings

Introduction

5.1 This section summarises the evaluation of the effectiveness of the services provided to Child F. Section 4 of the SCR Overview Report sets out the detailed evaluation on which it is based.

5.2 The evaluation is based on the combined chronology of events, the findings of individual management reviews prepared by agencies directly involved with Child F, discussions in the SCR panel meetings and discussions with the authors of individual agency reviews. Additional documents and information were made available by participating agencies to the author of this report and the SCR panel. The overview report author interviewed Child F's father and spoke to his mother on the phone. He interviewed Child F's foster carers. Along with two SCR panel members the author also visited Cookham Wood YOI. The Prison and Probation Ombudsman provided the SCR with access to the transcripts of its interviews with members of the YOT and staff at Cookham Wood.

5.3 While the SCR was undertaken as a result of the death of Child F in Cookham Wood YOI, it has identified a number of shortcomings in services that were provided before he went to Cookham Wood. Most of the evaluation focuses on the period between January 2010 and January 2012 but it has also been necessary to review some of the decisions made when Child F first came into care because they had a significant and lasting impact on him.

The impact of child sexual abuse and the response of agencies

5.4 Section 4.2 of the SCR Overview Report considers in detail the effects of sexual abuse on Child F over the remainder of his life and the response of professionals to this aspect of his history.

5.5 Child F suffered very severe sexual abuse up to the age of six when he was removed from his mother's care. The alleged perpetrator was a family member. Child F gave no account of events at the time but later consistently identified the same perpetrator. The SCR has concluded that there is a strong possibility that Child F was also sexually abused by adult males who were associated with his family, two of whom are known to have committed sexual offences against children.

5.6 As would be expected this sexual abuse had a lasting impact on every aspect of Child F's life. It increasingly occupied his thoughts in his teenage years. Child F engaged a member of YOI staff in conversation about his abuse and about his attitude to the person that he identified as the perpetrator a few hours before he hung himself.

5.7 The severity of Child F's abuse in early childhood and the fact that it occurred in parallel with neglect and emotional abuse is likely to have had a lasting negative impact on all aspects of his emotional and behavioural development.

5.8 The impact of sexual abuse was also compounded by the reaction of some family members who did not believe the accounts of what had happened to Child F or said that they did not. Consequently they were rejecting of Child F and blamed him for the children in the family coming into care. This remained a continuing focus of negative thoughts and feelings for Child F.

5.9 Child F initially showed very severe emotional and behavioural difficulties as a result of being abused and then being separated from his family, but as he grew to feel more comfortable and secure in his foster home the worst of these symptoms subsided. This enabled him to manage life at primary school, with considerable support from everyone involved and substantial allowances being made for his difficulties.

5.10 Child F received only very limited therapeutic support in relation to his sexual abuse. There were a number of reasons for this including the length of the family court proceedings, the fact that he was placed some distance from Tower Hamlets, the lack of capacity and skills in the CAMHS service in Medway and – when treatment was offered – the lack of a specific focus on his experience of sexual abuse. The circumstances in which therapy was offered and the reasons for the approach taken are set out in detail in Section 4.2 of the SCR Overview Report. When help was offered again in 2010 – 2011 Child F refused to attend CAMHS.

5.11 Later Child F was diagnosed with ADHD. It is not certain whether this diagnosis was reliable and the treatment with medication that followed from it had only a very limited and short term positive impact. This aspect of service provision is evaluated in detail in Section 4.3 of the SCR Overview Report.

5.12 Later again Child F was diagnosed as 'mildly' suffering from Autistic Spectrum Disorder. This diagnosis was not informed by the usual multi-disciplinary assessment or detailed knowledge of Child F's early development and was in the view of the SCR very questionable. It did not lead to any specific intervention or service provision.

5.13 Child F's difficulties re-emerged with considerable force in adolescence when it is a normal part of biological and social development for young people to become more focused on their identity and on sexual matters. Child F also became more preoccupied with what had happened to him and – whereas he had previously hardly spoken about his abuse – from 2010 onwards he mentioned it to a number of professionals.

5.14 Increasingly Child F's behaviour began to reflect the very severe impact on him of the abuse that he had suffered, leading to more and more difficulties in controlling his emotions and his behaviour. This gradually had a serious impact on his behaviour at school and in the community, so that from September 2010 onwards Child F committed a large number of (mainly minor) offences. Child F's increased offending and his inability to regulate his behaviour placed more and more strain on this school and his foster family, to the point where his foster placement nearly broke down in January 2011.

5.15 Child F's history meant that – as he himself increasingly recognised and stated – he was not able to trust any adult to help him, no matter how consistent, reliable or supportive they had been. This meant that as his difficulties got worse he found it harder to accept the services offered by professionals or the kindness and guidance of his foster carers. Whenever a professional began to make progress Child F would withdraw or behave in a way that ended the relationship.

5.16 In general the professionals working with Child F knew that he had been sexually abused and that this was why he was living with foster parents. However gradually over the years detailed knowledge of the gravity of what had happened to Child F was lost. Although there was some continuity among the professionals who worked with him there were also significant changes. For example Child F had eight local authority social workers between 2002 and 2012. Other key professionals left their jobs. Many significant reports and records were archived by Tower Hamlets children's social care. Records in the authority were split between paper files and the electronic client record system. Local authority files lack chronologies and summaries.

5.17 Other agencies and a large number of new professionals became involved with Child F between 2010 and 2012. They knew Child F's history in only general terms and often only gradually found out about the severity of his sexual abuse and then tried to adjust their interventions to take account of it. This led to delays in him receiving help. For example it was one of the factors that contributed to delays in the decision to undertake a full statutory assessment of Child F's SEN.

5.18 From January 2011 there were a number of crises which presented opportunities for a fundamental reassessment of Child F's needs. This should have led to a radical change in the level of support that was being provided for his foster parents and perhaps changes in his care plan altogether. Such an assessment needed to take into account the full history of Child F's abuse and the likely continuing impact of sexual abuse on him. These opportunities were missed in part because the full significance of Child F's history was not understood but also because there were professional and organisational failings by Tower Hamlets Council and other agencies. These episodes are evaluated in detail in Section 4.4 of the SCR Overview Report.

5.19 The SCR has considered Child F's experience in the wider context of research and practice experience about services for sexually abused children. It is likely that the shortcomings in the service that Child F received would have been replicated in many CAMHS services because of the lack of capacity and skills that exist and the uneven local distribution of services for children who have been sexually abused. The SCR makes recommendations in relation to the commissioning and delivery of such services.

Provision for Child F as a looked after child

5.20 Section 4.4 of the SCR Overview Report evaluates in detail the provision made for Child F as a looked after child by Tower Hamlets Council and its role in coordinating the provision made by other agencies to support Child F.

5.21 Child F was fortunate in that he lived with one set of foster carers throughout his 9 years in care. All of the evidence is that Child F was cared for in a professional way by foster carers who dealt with extremes of negative behaviour by trying to understand and accept Child F and by responding to him thoughtfully and positively.

5.22 The permanency plan agreed for Child F when he was made the subject of a Care Order in 2004 was for long term fostering. The local authority and the court chose this option against the initial directions made by the court and the local authority 'permanency panel' which was responsible for advising on the needs of children in long term care. Given his age and the fact that no member of his birth family could provide a home it would now be much more usual for a local authority dealing with a similar child to seek an adoptive home.

5.23 To have been successful, the plan for long term fostering relied on members of Child F's family continuing to play an important role throughout his childhood. Members of his family gradually lost touch with him and the local authority failed in the commitment that it had made to promote this contact or, given the breakdown in contact, to help Child F to understand why and how that had happened.

5.24 During his primary school years Child F was seen as living in a 'stable' placement. He became more difficult from the time that he went to secondary school in 2007 and particularly from 2010.

5.25 From February 2010 Tower Hamlets failed to coordinate an effective response to Child F's educational problems and after March 2010 the authority failed to respond to the breakdown in contact between Child F and his father. The shortcomings reflected the inexperience of Child F's allocated social worker and the lack of guidance and monitoring by managers. Arrangements for transfer of the case between social workers in September 2010 were below the standard required as there was no handover, notes of key meetings, contacts and agreed actions. This left professional colleagues in other agencies confused by the inaction of the local authority at a critical time and left Child F vulnerable to permanent exclusion from school.

5.26 A new social worker was allocated to the case in October 2010. She was much more experienced and did recognise the potential seriousness of the decline in Child F's behaviour. From April 2011 onwards Child F's social worker had substantial periods of absence from work and made little further positive contribution before Child F was removed from her caseload. No proper cover arrangements were made at this point. The social worker had also made a number of ill-considered interventions which alienated Child F's foster carers. During the period between October 2010 and October

2011 the social worker failed to coordinate the work of the other professionals involved, leaving professionals in Medway YOT and the fostering agency with effective responsibility for coordinating the work on the case.

5.27 A potential breakdown in the foster placement in January 2011 provided a significant opportunity to reassess the care plan for Child F and either 1) provide a significant increase in the support to his foster family or 2) move Child F to a different kind of placement, possibly providing a better solution to his educational difficulties at the same time. This opportunity was missed and the dialogue between the social worker and the Tower Hamlets Access to Resources Team (which had the responsibility to identify an alternative placement) failed to provide a proper assessment of Child F's needs and a constructive way forward. Child F's foster carers decided that they wanted him to remain with them largely because they felt that the alternative offered by the local authority – which was to move Child F to a local authority residential unit in London - would be detrimental to him.

5.28 During April – October 2011 Child F repeatedly failed to comply with orders made by the Youth Court, leading to him being remanded and then sentenced to custody. The Tower Hamlets looked after service failed to seek advice from the borough's own YOT, despite Child F's offending and then the risk of a custodial sentence

5.29 The supervision of the social worker who was responsible for Child F from October 2011 was also inadequate and records contain only two supervision discussions about Child F in 11 months. The local authority independent reviewing arrangements should have provided an additional mechanism to enable weaknesses in provision to be identified and rectified. However by the end of 2011 Tower Hamlets had not fully implemented the 2010 statutory guidance that required independent reviewing officers (IROs) to offer oversight of children's needs and development and to monitor their welfare between their six-monthly statutory reviews. For reasons unconnected to Child F's case his IRO was absent from his post for three months in mid-2011. A key middle management post in the independent reviewing service was vacant and left unfilled for five months during 2011.

5.30 After October 2011 Child F's case remained unallocated for over three months because of an unresolved disagreement between managers in the Tower Hamlets looked after children's service about who should be responsible for the case. This meant that during a period when Child F was in the YOI no one from the local authority was monitoring his welfare or able to recognise and respond to the deterioration in his condition. This was entirely unacceptable. The IRO only challenged the failure to allocate a social worker at the end of this three month period, shortly before the next scheduled looked after review.

5.31 There were also changes in middle and senior management posts in the looked after children's service during 2011 and at this point the newly appointed service manager did not act with the necessary authority to ensure that the dispute about allocating Child F's case was resolved. The reorganisation of the looked after children's service in

Tower Hamlets that took place in 2011 contributed to the shortcomings in provision made to Child F.

5.32 From March 2010 the local authority failed to communicate properly with Child F's mother and father. Child F's father had some communication with the foster carers, but it should not have been their responsibility to inform a parent about important developments. Child F's mother and father were not fully informed about important developments such as his worsening behaviour, his exclusion from school, the potential breakdown in his placement or his remand into custody in August 2011. Child F's father says that he found out that Child F was in Cookham Wood YOI some weeks after he went there. Child F's parents had a right to be informed about these developments and about the decisions and actions of the local authority. To the extent that it was judged to be in Child F's best interest, they should have been involved and consulted.

5.33 The SCR has tried to understand whether the concerns identified reflect wider shortcomings in the services provided by Tower Hamlets children's social care. In order to do this it has considered the findings of independent inspection reports to compare the services provided to Child F with the judgements made about wider local authority provision. Tower Hamlets has been the subject of two independent overall inspections of its services for looked after children since 2008.[4] Both offer an extremely positive view of services.

5.34 The 2012 Ofsted / CQC Inspection was undertaken five months after the death of Child F. It found that services for looked after children were '*good*' and that '*the council has demonstrated sustained improvement in a number of areas including placement stability and the achievement of educational outcomes'*. The inspection reported that '*outcomes (for looked after children) in relation to staying safe and enjoying and achieving are judged to be outstanding and are good for being healthy, making a positive contribution and economic well-being'*.[5]

5.35 The standard of provision made for Child F is at odds with the general picture of good and outstanding provision found by Ofsted. The SCR is only able to draw conclusions in relation to Child F's case. However there is a risk that Child F's case is not the only one where important aspects of the provision made were of an unacceptable standard. The local authority and the LSCB need to investigate this possibility further in order to establish whether other children are also vulnerable because of the type of shortcomings that affected the work with Child F.

5.36 Two potential areas of possible vulnerability need to be considered:

- children linked to the specific personnel and services involved with Child F

[4] Ofsted and CQC (2012) Inspection of Safeguarding and Looked After Services- Tower Hamlets; Ofsted (July 2008) Joint Area Review of Services for Looked After Children.

[5] Paragraphs 84 and 86

- children who share features with Child F which may not have been the focus of detailed scrutiny by external inspectors.

5.37 For example, it may be that looked after children who are living some distance from Tower Hamlets are more vulnerable. Compared to other London local authorities relatively few of Tower Hamlets' looked after children live a significant distance from the borough, but it would be wrong not to recognise that providing good care for these children poses additional challenges. It is striking that Child F's experience shares many of the difficulties identified in a recent thematic inspection of looked after children who are placed away from their home authority and involved in the youth justice system.[6]

5.38 The most recent Tower Hamlets Ofsted inspection (2012) makes many positive references to local provision and arrangements, but gives little detailed information on arrangements that apply to children who are looked after outside of Tower Hamlets. It is necessarily more difficult for the local authority to influence services in other localities and less easy for inspectors to evaluate in depth the services that these children receive.

5.39 It has been widely recognised that in the past inspections focused on compliance with specific indicators of performance and were insufficiently sensitive to the experience of young people. For example in the section of the SCR Overview report that deals with his education it is noted that Child F was never permanently excluded from school (a key concern of the authority and external inspectors) but that from September 2010 onwards he had very little meaningful education (a concern about the quality of provision and the child's experience).

5.40 The SCR has therefore recommended that the local authority should review its current quality assurance and audit arrangements to ensure that they address areas of potential risk and vulnerability identified in the SCR.

5.41 As part of its responsibility to monitor the provision made to safeguard children the LSCB should have arrangements in place to ensure that any weaknesses in standard of provision made by member agencies to looked after children are identified and that steps are being taken to eliminate them. The SCR has therefore also recommended that (in keeping with the requirements of *Working Together to Safeguard Children* 2013) the LSCB reviews its current arrangements for holding the local authority and other agencies to account in relation to the quality of work undertaken to safeguard looked after children to ensure that they are sufficiently challenging.

[6] HMI Probation, Ofsted and Estyn (2012) Looked After Children: An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home

Child F's education

5.42 Section 4.5 of the SCR Overview Report evaluates in detail the provision made to meet Child F's educational needs. All of the points in the following summary are developed and explained there.

5.43 Child F experienced difficulties throughout his secondary education and particularly from 2010 onwards. His school, foster carers, social workers and education specialists from Medway Council and Tower Hamlets Council spent considerable energy in trying to meet his special educational needs (SEN). A large number of meetings were held, but the outcomes were frustrating. Comparison of the records of different agencies and the views of Child F's foster carers show that there was considerable tension generated by the failure to find practical steps on the scale needed to assist Child F.

5.44 No effective solution to Child F's difficulties could be found within his school's own resources. Attempts to access local Medway resources such as the Pupil Referral Unit were unsuccessful because there were no spaces or there was disagreement as to whether this was the right approach. Correspondence between the authorities presents a confusing picture as to why it was that the attempts to make provision for Child F had failed and which agency had refused to accept various proposed solutions.

5.45 Staff in the Tower Hamlets Virtual School (which provided advice and advocacy in relation to the education of looked after children) refused to accept and would not fund proposals made by the foster carers and their agency for tuition arrangements or an alternative education provider. A formal approach could have been made to a panel of senior managers in Tower Hamlets who could have allocated additional funds to make alternative provision for Child F's education - but this was not done. Despite the circular and unproductive nature of many of the discussions Child F's social workers deferred to education specialists and did not ask social care managers to address the difficulties.

5.46 Two educational psychologists prepared reports on Child F. The first was of limited value because it took insufficient account of his early childhood experience. The second was of much more value and helped professionals understand the links between Child F's current difficulties and his history of abuse and attachment difficulties. It recommended alternative provision that might have assisted Child F.

5.47 In 2010 Tower Hamlets correctly pushed Child F's school to apply to Medway Council for a formal statement of SEN. The first application was rejected. Medway subsequently agreed to a formal assessment of SEN when Child F had no school and he was refusing to attend the alternative provision that had been arranged. The formal SEN assessment was initiated after the intervention of a senior Medway Council manager. Once the statement of SEN was produced Tower Hamlets social care decided that it did not agree with the recommendation made for an alternative educational provision where Child F would receive a degree of therapeutic support, instead preferring for Child F to attend a local project run by NACRO.

The SEN statement was never formally discussed in looked after review meetings or multi-agency meetings about Child F's education.

5.48 From January 2011 Child F attended a vocational course at a project run by NACRO, a criminal justice charity. The project Child F attended is not inspected by Ofsted, though the inspectorate has some oversight of the range of provision made by NACRO nationally. Medway Council informed the SCR that the project was well regarded within the Medway area. The plan was never for Child F to attend there for the 25 hours that is required by statutory guidance relating to the education of looked after children.

5.49 Child F engaged with some activities at the NACRO project for a brief period in February and March 2011, but he was the excluded on several occasions and his overall attendance was extremely poor. In total he attended on only 20 days or part days in the two school terms between January and July 2011, a level which would be considered entirely unacceptable for a child living with his parents in the community. Once Child F was on the roll at NACRO Tower Hamlets took no action to increase his attendance and did not consider alternative provision that would have offered a wider education.

5.50 These arrangements to meet Child F's SEN were inadequate. This lack of effective education contributed to his difficulties because he received so little education he had therefore considerable amounts of free time, increasing the risk of offending and the pressure on his foster carers. Considerable efforts were made to prevent Child F from being permanently excluded because such a step is viewed as being hugely detrimental to a young person but once he was receiving some form of alternative provision Tower Hamlets paid insufficient attention to its quality, Child F's attendance and whether or not it met his assessed educational needs. The SCR has made recommendations in relation to these issues.

5.51 Medway Council provided the SCR with a comprehensive individual management review of the provision made by the local authority, Child F's schools and NACRO. The review identifies that there were shortcomings in some aspects of the local provision made. For example: Child F's school could have had a greater awareness of the range of alternative educational provision available and fuller information could have been provided when the school first sought a formal assessment of SEN. There was no proper process in place to check that NACRO could meet the recommendations of Child F's SEN statement. At times Child F's schools did not fully understand the arrangements for supporting looked after children from another local authority and funding provision for them. The review makes a series of recommendations in relation to these findings.

The provision made by the local authority and other agencies in relation to Child F's identity and his heritage

5.52 The decisions made by professionals and their response to the issue of Child F's racial identity and ethnicity are evaluated in detail in Section 4.6 of the SCR Overview Report.

5.53 In his early years in care Child F made a number of comments (usually noted after contact visits) which indicated that his understanding of why he was living away from home was confused by the fact that he was the only child of mixed parentage in his mother's household. His confusion was amplified over time by the perception that his half siblings had retained stronger links with his mother or (as he saw it) fared better than him.

5.54 From 2010 onwards there are numerous reports indicating that Child F suffered from considerable confusion about his racial identity. He told a number of professionals that he viewed himself as white. He found it very difficult to cope with being seen and treated as a young black man and it was recorded that he expressed very negative views about his father and the African component of his heritage.

5.55 These difficulties were directly relevant to Child F's poor self-esteem, his recklessness, his criminal behaviour and his risk of self-harm. His lack of security and confidence about his racial identity became more apparent as Child F had more contact with people from different ethnic backgrounds in the youth justice system. Confusion and insecurity about this are also likely to have made it more difficult for Child F to adjust to life in the YOI where race and ethnicity have been observed to be significant factors in how young people relate to one another.

5.56 The original decision (in 2002) to place Child F with a white family in a predominantly white area was not made deliberately by Tower Hamlets: it occurred because a fortuitous emergency placement turned into a very successful permanent fostering placement. By the time the Care Order had been made in 2004 there were considerable risks in moving Child F. The arrangements that were then made to promote Child F's confidence in his racial identity relied on exposing Child F to a range of cultures, rather than addressing the way in which race and ethnicity were central to his life story. In order to have the self-esteem necessary to live confidently in a society where he would be viewed and treated as a young black man, Child F needed to be helped to develop a much more positive sense of his identity and a degree of pride in the African component of his heritage.

5.57 Whilst Child F's foster carers did everything they could to help Child F be emotionally secure, the framework within which they were dealing with his identity underestimated how important this issue would prove to be for Child F. The original decision of the court and the local authority to place Child F with white carers but not to develop a coherent plan to ensure that he was secure in his racial identity added to his vulnerability.

5.58 There is little doubt that Child F would have grown up better equipped to cope with the challenges that he would face in his life if he had had extensive day to day involvement with people who shared aspects of his heritage, looked more like him, were viewed and treated like him by society and who had dealt successfully with some of the particular difficulties that Child F was likely to face. This is most likely to have been achieved if he had been placed in a family with at least one black parent, with a network of black friends and extended family and he had lived in a community more mixed than Medway.

5.59 Medway YOT was the first agency to address concerns about Child F's racial identity positively and Child F's first YOT key worker made some progress before he was reallocated to another worker. The records suggest that Child F's school avoided discussions about race because it was not something that he was prepared to talk about, although some members of staff sensed that this issue was important.

5.60 The SCR is aware that this experience touches on a topic of current public policy debate. The government has published the Children and Families Bill 2013 which will remove from statute the requirement on adoption agencies in England to give '*due consideration to the child's religious persuasion, racial origin and cultural and linguistic background'* when placing a child for adoption. The intention is to ensure that the '*search for a* ***perfect or partial ethnic match does not become a barrier*** *to finding a child a parent'.*[7] It is not clear how this legislative change in relation to adoption will in due course affect guidance and practice in relation to short term and permanent fostering.

5.61 Child F's experience confirms that there are a number of children and young people for whom questions of racial identity and ethnicity have a tremendous significance and that it may be dangerous to underestimate this when assessing and planning to meet their needs.

<u>Provision for Child F as a young person who committed offences</u>

5.62 Section 4.7 of the SCR Overview Report contains a full account of the provision made by Medway Youth Offending Team (YOT) and other agencies with responsibilities in relation to Child F as a young person who had committed offences.

5.63 Medway YOT made substantial efforts to identify the factors that underpinned Child F's offending and to assist and supervise him. Between March and May 2011 the work of the YOT achieved some success because Child F engaged well with his then keyworker and for a period he committed only a small number of minor offences. Child F responded well to the knife awareness programme that he attended and he

[7] Children and Families Bill 2013 explanatory press release:
http://media.education.gov.uk/assets/files/pdf/c/children%20and%20families%20bill%20factsheet.pdf.

stopped his dangerous habit of carrying knives. After May 2011 the interventions had little impact and from June 2011 Child F committed a substantial number of further offences. Though mostly not serious these caused considerable distress to his foster parents and disruption to members of his local community. Child F would not comply with bail conditions or sentence conditions and this led to him being returned to court (breached) on several occasions. It was largely this as well as his continued offending which led to him being remanded (in August 2011) and then sentenced to custody in October 2011.

5.64 There were many positive steps taken by the YOT and in particular his first YOT keyworker identified and understood the significance of Child F's history of abuse and his confused racial identity and poor self-esteem. The work of the YOT was hampered throughout 2011 by the failure of Child F's allocated local authority social worker to become engaged with and actively support the interventions being made. At times it appears that the YOT and the fostering agency were coordinating the service provision. This was a repeated and legitimate source of frustration for the YOT.

5.65 The review has identified a small number of times when the YOT did not follow the required procedures. However these were not significant in the overall case history and in general Medway YOT did comply with the framework for youth justice set out by the National Youth Justice Standards. However the SCR has identified a number of concerns about the services provided.

5.66 A number of the difficulties arose from the nature of Child F's offending, linked to his highly unregulated pattern of behaviour, which in turn had its origins in his history of early childhood abuse and trauma. Although much good face to face work was done many of the interventions available to the YOT proved to be unsuitable and unsuccessful. After initial progress Child F found it impossible to sustain a good working relationship with his keyworker. Later when he was subject to more restrictive orders he was indifferent to the 'tough' approach of the Intensive Supervision and Support Programme and the high level of activity and monitoring imposed. Child F's poor self-esteem and lack of internal controls meant that he began to view it as inevitable that he would go into custody. Once this happened, Child F's behaviour deteriorated further and faster to the point where he effectively ceased complying with court orders altogether.

5.67 In order to identify opportunities for learning and service improvement from the YOT's contact with Child F and his foster carers the SCR has focused on wider professional aspects of the work undertaken with Child F, the type of services commissioned by the YOT and the overall management of Child F's 'journey' from initial contacts with the YOT to the final recommendations about his placement in the secure estate. Child F had involvement with at least 17 workers in the YOT in a period of less than a year. This was confusing to his foster carers and in all probability to Child F as well given his age, his immaturity, his lack of self-confidence and his difficulty in forming trusting relationships.

5.68 This pattern of multi-professional, multi-disciplinary service provision has developed in YOTs nationally, but there are times when this approach will undermine the effectiveness of interventions. There is a considerable challenge in finding the right balance between making available interventions that draw on a range of skills from a number of specialisms and disciplines while at the same time avoiding the involvement of an unnecessarily large number of people in face to face work with a young person. There is as yet no model that is a proven alternative to the large multi-disciplinary teams that operate in most YOTs, however active consideration needs to be given to the development of alternative approaches.

5.69 Given his history the arrangements in the YOT for assessing and responding to Child F's emotional and mental health needs were too inflexible. Greater flexibility could have been adopted at a number of points when Child F was breached for failure to comply with orders and returned to court by the YOT. When this happened his behaviour usually deteriorated further though the Youth Court never took decisive action over the breaches.

5.70 The focus of management supervision within the YOT was on compliance with procedures and the YJB National Standards and there was a lack of reflective supervision to consider why it was that the approaches that were being adopted were not working.

5.71 The YOT Manager has told the SCR that many of the approaches criticised by the SCR are consistent with the expectations of the Youth Justice Board and are consistent with the wider culture that most YOTs follow. This is accepted. It follows therefore that some of these wider cultural norms may not best suit the needs of offenders such as Child F and consequently may not be the best way of preventing them from offending and causing risk to themselves and to others.

5.72 The YOT played a central role when Child F was remanded into custody at Cookham Wood YOI in August 2011 and then sentenced there again in October 2011. Child F's vulnerability had been apparent to the YOT. All of the risk assessments and placement alerts that preceded his remand to the YOI had identified his vulnerability and recommended placement in a Secure Training Centre (STC) where Child F would have benefited from a much more child centred environment and a far higher level of personal contact with staff. All the evidence was that Child F was vulnerable – both in common sense terms and within the meaning of the relevant legislation – and that he should not have been remanded or sentenced to a YOI. Of course it is impossible to know how Child F would have fared in a STC.

5.73 Critical errors in the assessment of vulnerability and placement recommendations occurred as a result of a combination of poor professional judgements by some members of Medway YOT and a number of circumstantial, managerial and organisational factors which made it more difficult for YOT members to reach the correct professional judgements. A key post – offering substantial practice experience in dealing with remand hearings – was unfilled when Child F was first remanded into

custody. On one occasion the court duty worker involved had no access to key pieces of information from Child F's case record. It was also not the established practice within the YOT to ask the court to delay proceedings while a full assessment of vulnerability was carried out. When Child F was remanded to the YOI the placements service of the Youth Justice Board recognised that this outcome was at odds with the previous risk assessments and alerts which had all recommended placement in a STC. However the legal framework that was in place at the time for dealing with remands meant that no discretion could be exercised as to where Child F was placed.

5.74 After this first remand hearing, the YOT made no review of how Child F had come to be remanded to the YOI when previous assessments had stressed his vulnerability. His subsequent court appearances were treated as one off events and on different occasions different recommendations about placement were made. However when the time came for Child F to be sentenced for further offences the YOT recommended that he should be placed at the YOI because it was assumed that he had coped well there before and that it could meet his needs.

5.75 The SCR has made a number of recommendations both to the Medway YOT Management Board and to the Youth Justice Board.

Provision for Child F at Cookham Wood YOI

5.76 The provision made for Child F at Cookham Wood is evaluated in detail in Section 4.8 of the SCR Overview Report.

5.77 Many prison officers and senior staff as well as members of the health teams at Cookham Wood knew Child F as an individual, had a high level of concern about him and did their utmost to respond to his needs and keep him safe. Independent inspections have found that the systems for keeping the most vulnerable young people at Cookham Wood safe usually work well. The information provided by the YOI to the SCR supports this finding. Staff who work at the YOI usually provide a good level of care for young people bearing in mind the limitations of what is possible to achieve in a YOI.

5.78 However Child F's death and the circumstances that led to it have exposed weaknesses in the YOI's systems and arrangements which need to be addressed. Child F was supported and monitored for much of the last month of his life under the Prison Service ACCT arrangements which are designed to monitor and support prisoners who self-harm or are at risk of suicide. Over a short period of time this approach proved effective for dealing with concerns about self-harm, but it needs to be strengthened in order to deal better with serious or intractable and unusual problems such as those presented by Child F.

5.79 At present large numbers of prison officers and managers share some responsibility for safeguarding a vulnerable young person under the ACCT arrangements. However those with the most experience and expertise are not necessarily able to exercise a

decisive influence over the care provided. In future when a young person such as Child F is identified as being particularly vulnerable a smaller group of staff need to take a better defined responsibility for his safety so that they can understand and own the risk, develop a care plan and bring to bear all of the expertise that exists in the YOI to assist him. The SCR has recommended that in future a small group of senior managers in the YOI should have oversight of the welfare of each young person who is subject to the ACCT arrangements.

5.80 The YOI's systems need to be strengthened so that information about vulnerable young people that is known to different members of staff and held in different records can be brought together much more readily. This will allow those with specific expertise such as psychologists and psychiatrists to take all of the relevant information into account when they are making assessments of risk. Their expertise can then inform prison officers who have day to day responsibility for assessing and managing risk.

5.81 The most significant weakness in Child F's case was in the working relationship between the health service, the mental health service and prison officers in the YOI. If mental health practitioners had been aware of and taken proper account of the behaviour described in the records of custody staff it is likely that they would have assessed Child F's risk of suicide and self-harm as being much higher. This in turn should have influenced the way in which prison officers managed Child F on his wing.

5.82 Child F was supposed to be receiving psychological interventions to help him focus more positively on his future, but there is no evidence that these were being provided, possibly because Child F would not engage. Prison officers were led to believe that some progress was being made with these interventions. This may also have led them to underestimate the risk to Child F.

5.83 To make the YOI safer there needs to be a closer, more collaborative and more trusting working relationship between health services, prison officers and other professionals. Sharing information freely between services should be the norm, especially when a young person has emotional or mental health problems that affect their behaviour or when the young person has been identified as being at risk. This should include information about the medications that a young person is taking, information about when a young person is refusing medication and information about the progress or lack of progress of other mental health interventions that are being undertaken. Where it is relevant to behaviour and safety information should be shared about the young person's diagnosis. At present too much emphasis is placed on the importance of medical confidentiality.

5.84 The SCR found that the systems for managing young people's behaviour and punishing breaches of prison regulations at the YOI were complex and sometimes came into conflict with the attempts that prison officers were making to help and support Child F.

5.85 Across the secure estate for young people arrangements need to be put in place so that there can be full psychosocial assessment when a young person self-harms in a serious or repeated way. These should match or exceed expectations of good practice in the community for the management of self-harm because the population of young people in the secure estate is at significantly higher risk of self-harm. When a young person who has self-harmed is in care the local authority that is responsible for the young person also needs to be made accountable for ensuring that this happens.

5.86 In the hours before Child F hung himself two prison officers made special efforts to spend time with Child F in order to try to understand his state of mind and to offer him additional support. As a result of their intervention and concern the senior officer on the wing increased Child F's level of observation, and these observations were properly carried out. No consideration was given to a number of steps that might have prevented Child F from seriously harming himself such as moving him to another cell, keeping him under constant observation or removing his trainer laces. The full findings of the SCR in relation to this are set out in Section 4.8 of the SCR Overview Report which considers in detail the dilemmas that prison officers face in managing potential suicide risk. The SCR has made recommendations in relation to all of these matters.

## 6 Improving outcomes for other children and young people

6.1 The findings of the SCR and the recommendations that flow from them have been adopted by Tower Hamlets LSCB, Medway LSCB and the agencies directly involved. The LSCBs have produced plans that set out the actions needed to implement the recommendations, identify who is to be responsible for taking them forward and the timescales for completion. Many of these recommendations have already been fully or partly implemented.

6.2 Tower Hamlets LSCB and Medway LSCBs will oversee implementation of their respective recommendations to ensure that practice and outcomes for other children and young people improve.

## APPENDIX 1 - Recommendations from the SCR Overview Report and SCR Panel discussions

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
|---|---|---|---|---|---|
| 1. | Standards of social work practice, supervision and management in the Tower Hamlets Looked After Children's Service | The SCR has highlighted potential areas of risk and vulnerability in Tower Hamlets Children's Services | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | The Director of Education, Social Care and Wellbeing should review the current arrangements for quality assurance and audit in the local authority so as to ensure that they address all of the areas of potential risk and vulnerability for looked after children identified in the SCR |
| 2. | Standards of social work practice, supervision and management in the Tower Hamlets Looked After Children's Service | There was minimal evidence of supervisory and management input in Child F's case records and managers failed to make the necessary contribution to the case | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | The Director of Education, Social Care and Wellbeing should ensure that supervision notes and management decisions relating to looked after children address relevant issues and are clearly documented on the electronic case record of every individual child. |
| 3. | Responsibility of the LSCB to hold member agencies to account in relation to the safeguarding of looked after children | The SCR has highlighted potential areas of risk and vulnerability in Tower Hamlets Children's Services. These had not previously been identified by the LSCB which has a responsibility to hold member agencies to account in relation to the quality of work undertaken to safeguard looked after | Independent Chair Tower Hamlets LSCB | Tower Hamlets | Tower Hamlets LSCB should reviews its current arrangements for monitoring the standard of provision made by member agencies to looked after children so as to ensure that they are sufficiently challenging |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
|---|---|---|---|---|---|
| | | Children | | | |
| 4. | Tower Hamlets social work staff understanding of youth justice systems and services | Social work staff in Tower Hamlets did not refer Child F to Tower Hamlets YOT or consult the YOT when he was at risk of custody. They also significantly underestimated the risks to Child F while in custody | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | The Director of Education, Social Care and Wellbeing should ensure that staff in looked after and children in need services and the youth offending services work together in the most effective way in order to minimise risk to and vulnerability of young people in the youth justice system, including those in custody |
| 5. | Placement breakdown and work of Access to Resources Team in Tower Hamlets | When an alternative placement was needed for Child F there was no proper assessment of his needs and no consultation with people who knew him well. The process for identifying an alternative placement was bureaucratic and not child focused | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | The Director of Education, Social Care and Wellbeing should ensure that the arrangements for finding alternative placements for children always include a proper assessment of need, vulnerability and risk and that there is proper consultation |
| 6. | Role of independent reviewing officers (IRO) in Tower Hamlets | At key points the IRO service did not fulfil its responsibilities to get to know Child F ahead of review meetings or to monitor and safeguard Child F's welfare between review meetings. The IRO service should maintain a good working knowledge of the history of | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | The Director of Education, Social Care and Wellbeing Tower Hamlets should ensure that the IRO service takes on the full responsibilities required by the 2010 statutory guidance and that it demonstrates a positive impact on the lives of looked after children. |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
|---|---|---|---|---|---|
| | | every child whose permanency plan is that he or she will be looked after by the local authority. This will enable the care plan and reviews to address the long term needs of the child as well as immediate practical problems | | | |
| 7. | Tower Hamlets Emergency Duty Team | At the time of Child F's death the authority had no reliable overview of the activity of the Emergency Duty Team or means of tracking reports provided by EDT members | Director of Education, Social Care and Wellbeing Tower Hamlets | Tower Hamlets | Tower Hamlets Council should ensure that its Emergency Duty Team has proper systems in place for recording activity, logging EDT reports and attaching reports, emails and other documents to the local authority's electronic case recording system. Arrangements should be periodically audited to ensure their effectiveness. |
| 8. | Heath of looked after children living outside Tower Hamlets | Child F's health assessments and reviews were not based on comprehensive information. There is currently no system in place for designated health professionals in Tower Hamlets to monitor the quality of health reviews for looked after children living outside the borough | Director of Education, Social Care and Wellbeing Tower Hamlets and Chief Executive of the Clinical Commissioning Group | Tower Hamlets | The Director of Education, Social Care and Wellbeing and the Chief Executive of the Clinical Commissioning Group should ensure that the designated health professionals monitor the quality of health assessments and reviews of looked after children living outside Tower Hamlets |
| 9. | Education of Looked After | Child F's alternative education was not the provision | Director of Education, Social | Tower Hamlets | Tower Hamlets Council should develop its arrangements to monitor the provision of education |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
|---|---|---|---|---|---|
| | Children | recommended by his statement of SEN and provided for only limited attendance (below the existing statutory requirement). The level of provision made was not challenged by anyone involved | Care and Wellbeing Tower Hamlets | | to looked after children paying particular attention to the following:<br>• The attendance at school or alternative provision of 25 hours per week required by statutory guidance<br>• Ensuring that educational opportunities and outcomes for looked after children living outside the borough are as positive as those for children living in Tower Hamlets<br>• Ensuring that all looked after children receive education that meets their assessed needs and encompasses appropriate academic as well as vocational objectives<br>• The role of the Virtual School in promoting the education of looked after children working in partnership and challenging where necessary education authorities and education providers<br>• Compliance with statutory guidance in relation to the education of looked after children who are in custody |
| 10. | Education of Looked After Children | Child F's social workers deferred to education colleagues and did not have the skills and knowledge to challenge them, even when it was clear that his educational | Director of Education, Social Care and Wellbeing | Tower Hamlets | The Director of Education, Social Care and Wellbeing should ensure that social workers and their managers in the looked after children's service are effectively promoting the education of looked after children and that they have the necessary knowledge and skills to identify and challenge shortcomings in the provision |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
|---|---|---|---|---|---|
| | | needs were not being met | | | being made by schools and others in education services |
| 11. | Alternative educational provision | The alternative educational provision made for Child F was unduly shaped by the requirements of the youth justice system and did not offer a balanced or full curriculum. | Director of Education, Social Care and Wellbeing Tower Hamlets<br>Chief Executive Medway Council | Tower Hamlets and Medway | Director of Education, Social Care and Wellbeing Tower Hamlets and Director of Children's Services Medway Council should ensure that alternative educational provision made by organisations linked to the youth justice system or commissioned by YOTs has genuine educational merit and fulfils statutory education requirements. |
| 12. | Alternative educational provision | Child F was excluded without proper consultation from the NACRO project | Director of Children's Services Medway Council | National | The Director of Children's Services should ensure that when in future services are commissioned from NACRO or similar agencies the contract includes provision for proper consultation before excluding young people so that consideration can be given to a range of alternative methods of securing their engagement and compliance |
| 13. | Early intervention in response to criminal and anti-social behaviour | Child F committed a number of acts of anti-social behaviour and potential criminal offences between 2008 and 2010 which were known to Kent Police and other agencies but not reported to Medway YOT | Head of Public Protection Kent Police | Kent and Medway | Kent Police should ensure that all its officers involved in neighbourhood policing 1) are familiar with their responsibility to record contacts with young people 2) are familiar with their responsibilities under current early intervention policies (including the responsibility to notify the YOT) and 3) are alert to the fact that they may need to respond differently when dealing with children who have additional vulnerability (such as those who are looked after or who already have involvement with other agencies such as CAMHS). |
| 14. | Early intervention in response to | Child F was not referred to the YOT when he received | Chief Executive Medway Council | Medway | Medway YOT Management Board should satisfy itself that all young people who are made the subject of |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | criminal and anti-social behaviour | warnings and final warnings by Kent Police and received no service under his first referral order | | | Final Warnings and Referral Orders are given a good level of service and are helped to stop offending. |
| 15. | Culture of practice in YOTs | The large number of YOT workers who were involved with Child F diminished the effectiveness of the service provided | Chief Executive Medway Council | Medway | Medway YOT should develop a greater sensitivity to the 'the child's journey' through the YOT and in particular to 1) the number of YOT team members who work with the child and 2) the impact of changes in keyworker. |
| 16. | Culture of practice in YOTs | The large number of YOT workers who were involved with Child F diminished the effectiveness of the service provided –this is a national issue | Chief Executive Youth Justice Board | National | The Youth Justice Board should actively encourage the development of alternative approaches to youth justice provision which place greater value on 1) a small number of professionals within the YOT working with young people 2) a greater sensitivity to 'the child's journey' through the YOT and partner services. |
| 17. | Culture of practice in YOTs | Mental health provision made to Child F through the YOT was inadequate, reflecting an inflexible approach to the issue | Chief Executive Medway Council | Medway | Medway YOT should develop a more flexible and creative approach to meeting mental health needs of young people |
| 18. | Culture of practice in YOTs | When Child F was breached by the YOT insufficient recognition was given to what Child F was achieving on his Youth Rehabilitation Order. Returning him to court was counterproductive and the court took no decisive action | Chief Executive Medway Council | Medway | In keeping with regulations and national guidance Medway YOT should adopt a more flexible approach to breaching young people, making a balanced appraisal of what is being achieved through the order as well as failures to comply with specific requirements. |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| 19. | Culture of practice in YOTs | National guidance documents do not reflect fully the regulations and guidance. Guidance documents offer contradictory advice to YOTs | Chief Executive Youth Justice Board | National | The YJB should revise the National Youth Justice Standards so that they fully reflect the wording and spirit of Schedule 2, part 2 of the Criminal Justice and Immigration Act 2008 (in line with the wording of the guidance already contained in guidance on the 'Scaled Approach'). The YJB should encourage YOTs to make a balanced appraisal of what is being achieved through a community order as well as failures to comply with specific requirements when deciding whether or not to breach a young person. |
| 20. | Culture of practice in YOTs | The ISSP attended by Child F did not offer appropriate activities or supervision | Chief Executive Medway Council | Medway | Medway YOT Management Board should ensure that the Kent and Medway ISS programme is now of a good standard, matching activities to the assessed needs of individual young people and drawing on the experience of other YOTs |
| 21. | Culture of practice in YOTs | There were serious shortcomings in the YOTs court work, especially when assessing vulnerability | Chief Executive Medway Council | Medway | Medway YOT Management Board should ensure that the weaknesses in the arrangements for assessing vulnerability and making recommendations at court hearings identified in the SCR have been remedied |
| 22. | Culture of practice in YOTs | The statutory framework for dealing with remands for young people has been altered by the implementation of the LASPO Act 2012 and now requires more input from the YOT | Chief Executive Medway Council | Medway | Medway YOT Management Board should ensure that the YOT is properly prepared and resourced to deal with the implementation of the LASPO Act 2012 in relation to remands into custody of young people. |
| 23. | Culture of practice in YOTs | Once Child F was subject to the ISSP regime some | Chief Executive Medway Council | Medway | Medway YOT management board should ensure that when working with persistent or serious offenders |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | members of the YOT's awareness of vulnerability and safeguarding responsibilities was diminished | | | there is no loss of focus on awareness of vulnerability and safeguarding responsibilities by YOT members |
| 24. | Culture of practice in YOTs | Concerns about the shortcomings in practice of Tower Hamlets Children's Services were not addressed by the Medway YOT management team with the local authority at a sufficiently senior level | Chief Executive Medway Council | Medway | Medway YOT Management Board should ensure that the YOT has arrangements to bring concerns about shortcomings in the work of other agencies to the attention of the management group and address them with the agency concerned promptly and at a sufficiently senior level |
| 25. | Cookham Wood YOI – risk assessment and management | Historical information gathered in the initial screening of Child F about an incident of self-harm did not inform later risk assessments | Governor of Cookham Wood YOI | Cookham Wood YOI | The Governor should ensure that historical information gathered in the reception screening and health screening of young people at the YOI is accessible to staff and taken into account in later risk assessments |
| 26. | Cookham Wood YOI | Large numbers of prison officers, senior officers, other staff and prison managers were involved in Child F's care, but no one person had overall oversight or responsibility. Management checks on the ACCT document were regular but often 'procedural' | Governor of Cookham Wood YOI | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI should review the YOI's ACCT policies and procedures so as to ensure that for each prisoner subject to an AACT episode:<br>1) a named senior manager has overall accountability for the care provided<br>2) a small group of staff and managers is identified who are responsible for undertaking and leading the work with the young person<br>3) the ACCT review meeting notes make explicit |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | | | | reference to all concerning events and conversations contained in the on-going ACCT record<br><br>4) management checks consider the quality of work undertaken as well as compliance with the observations arrangements specified<br><br>5) all measures to safeguard a vulnerable prisoner are considered<br><br>6) reasons for decisions made are recorded |
| 27. | Cookham Wood YOI | The safer regimes meeting had useful discussions about Child F, but the meeting did not always receive up to date information and its role in managing Child F's care was not properly defined. The meeting considers large numbers of young people with many different types of need at any one meeting | Governor of Cookham Wood YOI | Cookham Wood YOI<br><br>In addition there may be learning for other YOIs | As part of the review of the ACCT arrangements the Governor of Cookham Wood YOI should review the membership and role of the safer regimes meeting so as to improve the quality of oversight provided by the YOI for vulnerable young people |
| 28. | Cookham Wood YOI | The YOI's current behaviour management policy is complex. Its implementation varies between different members of staff | Governor of Cookham Wood YOI | Cookham Wood YOI<br><br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI should review the YOI's overall behaviour management policy in order to reduce its complexity. |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| 29. | Cookham Wood YOI | The punishments imposed by adjudication hearings on Child F were at odds with the efforts prison staff working on the wing to engage and support Child F and made his Behaviour Improvement Programme impossible to implement. National Prison Service guidance on adjudications does allow for such flexibility | Governor of Cookham Wood YOI | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI should review the current arrangements for adjudication hearings in order to ensure that they do not conflict with the work of staff who are trying to support and engage a vulnerable prisoner (including those subject to ACCT and BIP) |
| 30. | Cookham Wood YOI | Prison officers did not have important information about Child F's medical diagnosis or the elements of his treatment plan. They were therefore not in a position to encourage compliance or support his involvement. Mental health team members had an approach to information sharing which was not consistent with the needs of vulnerable young people | Governor of Cookham Wood YOI | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Prison Health Partnership Board should ensure that in future there is a more proactive, flexible and child-centred approach to information sharing that will enable health staff to share information much more readily, particularly in relation to young people who have open ACCT documents. |
| 31. | Cookham Wood YOI | The level of resourcing available to the mental health team has been questioned in the review. Arrangements for | Governor of Cookham Wood YOI and the Prison Health Partnership Board | Cookham Wood YOI<br>In addition there may be learning for other | The Governor of Cookham Wood YOI and the Prison Health Partnership Board should commission a detailed review of the mental health contract at the YOI so as to ensure that the service is adequately |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | clinical and management supervision in the mental health service did not identify important shortcomings in the provision made for Child F | | YOIs | resourced and that supervision arrangements are effective. |
| 32. | Cookham Wood YOI | It cannot be established that all relevant information was made available and considered during psychiatric reviews on Child F | Governor of Cookham Wood YOI and the Prison Health Partnership Board | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Prison Health Partnership Board should ensure that all relevant information is made available and considered at psychiatric assessments and reviews, including information from the ACCT on-going record and ACCT review meetings. |
| 33. | Cookham Wood YOI | Two members of the mental health team – one senior and one newly appointed – had not attended ACCT training. As well as explaining the ACCT regime this training enables professionals to understand the roles of others in the YOI. It is essential that everyone who uses the ACCT arrangements attends the training | Governor of Cookham Wood YOI and the Prison Health Partnership Board | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Prison Health Partnership Board should ensure that in future all staff in the YOI who are involved in ACCT arrangements attend relevant training regardless of their seniority or level of experience and knowledge. |
| 34. | Cookham Wood YOI | No action was taken for 10 weeks over the failure of Tower Hamlets to allocate Child F a social worker | Governor of Cookham Wood YOI and the Manager of Medway YOT | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Medway YOT Manager should ensure that there are systems in place to identify swiftly any prisoner who is also a looked after young person who does not have an allocated local authority social worker and to seek urgent steps from the relevant local authority to |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | | | | remedy the situation |
| 35. | Cookham Wood YOI | Although the allocated caseworker played an active role the responsibilities of the resettlement team in the ACCT process were not defined | Governor of Cookham Wood YOI and the Medway YOT Manage | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Medway YOT Manager should undertake a review of the role of the Resettlement team caseworkers in the ACCT process. This should include responsibilities in relation to ACCT assessments, attendance at ACCT review meetings, sharing of information within the prison, the safer regimes meeting and links to agencies outside the prison. |
| 36. | Cookham Wood YOI | The level of experience of the caseworker and the support she was provided did not reflect the growing complexity of Child F's case as it developed | Governor of Cookham Wood YOI and the Medway YOT Manager | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Medway YOT Manager should review arrangements for the allocation, training and support of Resettlement Team Caseworkers so as to ensure that the experience and skill of the allocated case worker match the complexity of the case |
| 37. | Cookham Wood YOI | The caseworker was required to chair large, complex meetings dealing with issues of risk and vulnerability | Governor of Cookham Wood YOI and the Medway YOT Manager | Cookham Wood YOI<br>In addition there may be learning for other YOIs | The Governor of Cookham Wood YOI and the Medway YOT Manager should ensure that the members of the Resettlement Team have the skills and knowledge necessary to chair complex meetings. |
| 38. | Cookham Wood YOI | Previous inspections of the YOI had not identified concerns about the approach taken to information sharing between health services and prison staff | Chief Inspector of Prisons and Probation | National | The Chief Inspector of Prisons and Probation should consider how future inspections could evaluate the arrangements for information sharing between different services and professionals in the prison, including the effectiveness of arrangements in the prison to mitigate the risks arising from the use by different professionals of different electronic |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | | | | information systems. |
| 39. | Cookham Wood YOI | Best practice in community services is that a full psychosocial assessment is carried out following an incident of self-harm. In YOIs the assessment is limited to the immediate management of harm required under ACCT arrangements. As the prison population is more vulnerable a full psychosocial assessment of the young person should be undertaken after all incidents of serious or repeated self-harm | Chief Executive Youth Justice Board | National | The Chief Executive of the Youth Justice Board should ensure that arrangements are put in place for a full psychosocial assessment to be undertaken after all incidents of serious or repeated self-harm by a young person in a secure establishment. The arrangements should involve the secure establishment, the young person's YOT and (when the young person is looked after) the local authority |
| 40. | Cookham Wood YOI | ACCT training for the youth justice secure estate should be reviewed in order to ensure that it takes into account lessons from the SCR on Child F | Chief Executive Officer NOMS and Chief Executive of the Youth Justice Board | National | ACCT training developed by NOMS for the youth justice secure estate should be reviewed in order to ensure that it takes into account the findings of the SCR on Child F and other recent investigations into the deaths of young people in custody |
| 41. | Cookham Wood YOI | The SCR has made a number of recommendations to the Governor of Cookham Wood. The Prison and Probation Ombudsman has also made a number of recommendations. In these circumstances it is | Governor of Cookham Wood YOI and the Prison Health Partnership Board | Cookham Wood YOI | The Governor of Cookham Wood YOI and the Prison Health Partnership Board should consolidate and cross reference the recommendations made by the Prisons and Probation Ombudsman, the Clinical Review and the SCR into a unified action plan for the YOI |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | | essential that the governor of the prison, senior managers in the prison and health commissioners and providers review all of the recommendations, determine which should have the greatest priority and determine how to implement them through a unified action plan, cross referencing recommendations if necessary | | | |
| 42. | Collaborative working between YOTs and YOIs when a young person is at risk of self-harm or suicide | Current guidance from NOMS and YJB on the responsibilities of YOTs in relation to young people being cared for under the ACCT arrangements in YOIs is not compatible | Chief Executive of the Youth Justice Board and the Ministry of Justice | National | The YJB and the Ministry of Justice should review current guidance on ACCT arrangements to ensure that the responsibilities of YOTs, YOIs and local authorities are set out in a clear and consistent way in all guidance. |
| 43. | Collaborative working between YOTs and other establishments in the secure estate when a young person is at risk of self-harm or | There is currently no guidance to YOTs on their role when a young person is at risk of self-harm or suicide in STC or Secure Children's Home | Chief Executive of Youth Justice Board | National | The YJB should ensure that guidance is produced on YOT responsibilities towards young people placed in Secure Training Centres and Secure Children's Homes who are at risk of self-harm or suicide. |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | suicide | | | | |
| 44. | CAMHS services in Medway | There were shortcomings in relation to the clinical provision made in relation to ADHD and the tentative diagnosis of autistic spectrum disorder. The CAMHS service is now provided by another NHS Trust | Chief Executive of Sussex Partnership NHS Trust | Medway | Sussex Partnership NHS Trust should ensure that adequate arrangements are in place in Medway CAMHS for 1) the identification of ADHD and Autistic Spectrum Disorder and 2) clinical supervision of junior doctors |
| 45. | Services for children who have been sexually abused | There were shortcomings in relation to the provision made for Child F in relation to his experience of sexual abuse by Medway CAMHS. A national charity is currently commissioned to provide therapeutic services for some children | Chief Executive Medway Council | Medway | Medway Children's Trust should satisfy itself that proper provision is being made for the therapeutic needs of children who have been sexually abused who live in Medway, including looked after children who are placed in Medway by other local authorities |
| 46. | Therapeutic provision for children and young people who have been sexually abused | The shortcomings in relation to the provision made for Child F in relation to his experience of sexual abuse by Medway CAMHS are likely to be replicated in many localities. | Chief Executive NHS Commissioning Board | National | The NHS Commissioning Board should ensure that as part of its responsibility to commission specialist health services sufficient good quality therapeutic provision is made for children and young people who have been sexually abused in all local Child and Adolescent Mental Health Services |
| 47. | Services for children who have been sexually | At present no specific provision or training is available in the youth justice | Chief Executive of the Youth Justice | National | The Youth Justice Board should commission a review of the current provision and training available in the youth justice system (including the secure estate) for |

| | Focus of the recommendation | Why is a recommendation required? | Recommendation to | Scope of intended impact | Recommendation |
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| | abused and are known to professional in the youth justice system | system (including the secure estate) for professionals working with young people who have been sexually abused | Board | | professionals working with young people who have been sexually abused. |

## APPENDIX 2 - Recommendations made in Individual Management Reviews

The recommendations from the SCR overview report stand in addition to the recommendations made in individual management reviews prepared by agencies that had direct involvement with Child F. The following paragraphs give an indication of the areas of concern of individual agency recommendations, relating to the responsibilities for that individual agency. The full wording of these recommendations is set out in the Action Plans. Progress in the implementation of these recommendations is set out in the LSCB SCR Action Plan which is published alongside the LSCB overview report.

**Independent Fostering Agency**

- Establishing and implementing best practice approaches to meeting the cultural needs of children
- Better advocacy for children placed with the agency
- Improved practice in challenging concerns about practice in other agencies

**Kent and Medway Partnership Trust**

- Swifter allocations of looked after children in the CAMHS service
- Improved liaison with commissioners of health services for looked after children
- Regular review of therapy outcomes

**Kent Police**

- Missing Person's policy and procedures
- Improved response to contact with looked after children from outside of the Kent / Medway area

**Kent and Medway NHS**

- Greater clarity over responsibility for prescribing medication between GPs and CAMHS services

**Medway Council Education Services**

- Improvements in the arrangements for assessment of Special Educational Needs
- Improvements in the implementation of arrangements for the education of looked after children who are the responsibility of other local authorities

**Medway Youth Offending Team**

- Improved response to Final Warnings
- Improved management oversight of risk and vulnerability assessments

- Improved management of recommendations for placement when young people enter custody
- Improved management oversight of post court reports and pre-sentence reports
- Improved understanding among YOT members of their safeguarding responsibilities
- Improved supervision arrangements
- Better information for other agencies about the role of the YOT
- Improved sharing of information between the YOT and members of the Resettlement team at Cookham Wood YOI

**Medway NHS Foundation Trust**

- Ensure that staff dealing with emergencies are conversant with the legal framework for parental responsibility
- Improving the take up of medical assessments for looked after children

**Tower Hamlets Council Children's Social Care**

- Ensuring that important historical documents are entered into the current electronic recording system
- Improved 'life-story' work with children who are looked after
- Ending the practice of counting looked after children's reviews as statutory visits
- Improving the arrangements for case transfer

**YOI Cookham Wood - Clinical Review of Health Provision**

- Improved use of the health record system (SystmOne)
- Improved health screening on admission
- Improved management of medication
- Improved take up of ACCT training

**YOI Cookham Wood - National Offender Management Services**

- Improved take up of ACCT training
- Improvements to the ACCT regime
- Improved practice in challenging concerns about lack of information being provided by other agencies
- Improved understanding of the role of the Phoenix Unit within Cookham Wood
- Improved take up of ACCT training
- Revisions to the use of adjudications at Cookham Wood

## APPENDIX 3 Glossary of Terms and Abbreviations

| | Term or abbreviation | Link or reference |
|---|---|---|
| **ACCT** | Assessment, Care in Custody and Teamwork | System for assessing prisoners who are believed to be at risk of self harm and suicide, Ministry of Justice PSI 64/2011 |
| **ADHD** | Attention Deficit Hyperactivity Disorder | |
| **ART** | | Tower Hamlets social care Access to Resources Team |
| **ASSET** | Youth Offending Team tool to assess factors contributing to offending and the likelihood or reoffending | http://www.justice.gov.uk/youth-justice/assessment |
| **BIP** | Behaviour Improvement Plan | Prison service approach designed to offer short term rewards and incentives to address specific problems in behaviour |
| **CAMHS** | Child and Adolescent Mental Health | |
| **DTO** | Detention and Training Order | http://www.justice.gov.uk/youth-justice/courts-and-orders/disposals/youth-rehabilitation-order |
| **DYO** | Deter Young Offenders | http://www.justice.gov.uk/downloads/youth-justice/scaled-approach/dyo-scheme-management-framework.pdf |
| ***e-ASSET*** | Youth Offending Team electronic recording system | *http://www.justice.gov.uk/youth-justice/information-sharing-and-technology/easset-sentence-management-system* |
| **EDT** | Emergency Duty Team | |
| **ICS** | | *Social care electronic recording system* |
| **IEP** | Incentive and Earned Privileges Scheme | PSI 11 /2011 |
| **IRO** | Independent Reviewing Officer | http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/iro |
| **ISSP** | Intensive Supervision and Support Programme | http://www.yjb.gov.uk/publications/Resources/Downloads/ISSP_summary.pdf |
| **LAC** | Looked after child(ren) | A child may be 'looked after' by the local authority either because he is 'in care' because of a Care Order made under Section 31 Children Act 1989 (in which case the local authority shares parental responsibility with others) or 'accommodated' under S20 (in which case the local authority does not have parental responsibility) |
| **LSCB** | Local Safeguarding Children Board | http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children |
| **NACRO** | | http://www.nacro.org.uk/ |
| **NOMS** | National Offender Management Service | http://www.justice.gov.uk/about/noms |

| | | |
|---|---|---|
| **PEP** | Personal Educational Plan | |
| ***PNOMIS*** | Prison National Offender Management Information System | PSI 73/2011 (amended) |
| **PPO** | Prisons and Probation Ombudsman | http://www.ppo.gov.uk/ |
| **PRU** | Pupil Referral Unit | |
| **PSI and PSO** | Prison Service Instruction or Order | Ministry of Justice / NOMS instructions to prisons and other establishments |
| **ROSH** | Risk of Serious Harm | http://www.justice.gov.uk/downloads/youth-justice/assessment/asset-young-offender-assessment-profile/RiskForm.pdf |
| **ROTL** | Release on temporary licence | PSO 6300 |
| **RVMP** | Risk and Vulnerability Management Plan | http://yjbpublications.justice.gov.uk/en-gb/Resources/Downloads/Asset.pdf |
| **SCH** | Secure Children's Home | http://www.justice.gov.uk/youth-justice/custody |
| **SEN** | Special Educational Needs | |
| **SENCO** | School special educational needs coordinator | |
| **SIFA** | YJB Mental Health Screening Interview for Adolescents | http://www.justice.gov.uk/youth-justice/health/mental-health |
| **STC** | Secure Training Centre | http://www.justice.gov.uk/youth-justice/custody |
| **SystmOne** | Electronic health recording system | http://www.tpp-uk.com/modules/ |
| **Virtual School** | | http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/education/a00208592/virtual-school-head |
| **YJB** | Youth Justice Board | http://www.justice.gov.uk/about/yjb |
| **YOI** | Young offender Institution | http://www.justice.gov.uk/youth-justice/custody |
| **YOT** | Youth Offending Team | http://www.justice.gov.uk/youth-justice |
| **YRO** | Youth Rehabilitation Order | http://www.justice.gov.uk/youth-justice/courts-and-orders/disposals/youth-rehabilitation-order |

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