VERSION FOR PUBLICATION

CONCLUSIONS AND RECOMMENDATIONS

Of a

Significant Case Review

Undertaken on behalf of

Glasgow CPC

On D

16 September 2013

CONTENT

PURPOSE, CONTEXT, TEAM MEMBERSHIP AND ACTIVITIES

On 24th June 2011 D, then aged 13, was detained by the police because he had stabbed his foster carer. By the following day, Mrs L had died and D was charged with her murder. D appeared in court in August 2012 when his plea of culpable homicide was accepted. He was sentenced to 7 years detention and is currently in secure care.

This Significant Case Review was commissioned by Glasgow Child Protection Committee in the context of the Glasgow Significant Case Review Protocol of February 2010. A Significant Case Review is usually intended to discover whether lessons can be learned about the way child care and protection systems work together, in the light of a situation where children who have been part of the child protection or other welfare systems, have experienced significant harm. In this case, however, the emphasis was more about learning whether the care and protection systems could have anticipated and avoided the tragic outcomes that resulted from D's actions.

Summary of findings of the initial case review:

There was a preliminary examination of Ds Social Work case file, which was made available to the Initial Case Review process.

The Initial Case Review identified a number of key issues including:

- ***Complexity of managing neglect***
- ***Comprehensive integrated assessment*** - there were potential issues around the robustness of multi agency assessment and care planning
- ***Permanence Planning*** - there were potential issues around the lack of clear, permanence planning for D's future
- ***Parental non-compliance*** - There were issues around the recognition of the level of non compliance and its impact on care planning and implementation.

Remit

Based on the Initial Case Review, the following Significant Case Review remit was agreed with Glasgow Child Protection Committee:

1. ***Examine systems and arrangements to manage the complexity [redacted] both in relation to interventions and the basis for key decisions while D remained at home. This to include the effectiveness of multi-agency risk/needs assessments and the robustness of care plans, including the effectiveness of support given to the family.***

2. ***Examine systems in place for dealing with the impact of [redacted] on care planning and implementation***

3. ***Examine systems and arrangements for assessment and treatment in respect of mental health and psychological services in relation to D's emotional difficulties***

4. ***Examine systems and arrangements leading to the decision that D should be accommodated with foster carers.***

5. ***Examine systems and arrangements for matching D's needs with the skills and experience of the identified foster carers and arrangements for providing effective post-placement support***

Agencies Requested to Provide Chronologies and Reports

Each agency that had some direct involvement with the family and child was requested to undertake a single agency review and submit a chronology of events, and where appropriate, an analytical report. Chronologies and reports were received from the following:

- Social Work Services
- NHS GG&C
- Strathclyde Police (now call Police Scotland)
- Scottish Children's Reporter Administration (SCRA)
- Education Services
- Foster Care Associates Scotland (now called Core Assets)

Membership of Review Team

Colin Anderson	Independent Chair	
Jim Doyle	Quality Improvement Officer	Education Services
Moira McKinnon	Principal Officer	Social Work Services
Anne Ritchie	Independent Consultant	
Kirstie Maclean	Independent Consultant	
Dougie McKinlay	Detective Inspector	Police Scotland
Carol Bews	Child Protection Advisor	NHSGGC
Paul Harkness	Locality Reporter Manager	SCRA
Morna Stewart	Depute Director	Foster Care Associates Scotland (FCAS)

NB. Although Foster Care Associates Scotland (FCAS) is not a member of Glasgow Child Protection Committee, they participated as a full member of the Significant Case Review (SCR) Team and will take direct responsibility for implementing any lessons learned..

Process and Scope of Work

Single agency chronologies and reports were completed by: Police, Social Work, Health, Education, SCRA and FCAS. The reports were shared, analysed and discussed by the Panel who then agreed recommendations and actions.

In preparing this document, I have drawn heavily from reports prepared by Anne Ritchie and Kirstie Maclean, Independent Consultants. As Independent Chair of the Significant Case Review process, I would like to thank them both for their highly professional, well evidenced and analytical reports and for allowing me to incorporate significant exerts from their work within the body of this report**.**

The SCR team adopted a systems based and organisational learning approach. By looking at the whole system and work environment, and by identifying factors which support good practice, or create unsafe conditions, we can go beyond a focus on what happened to explain why it did so and thereby promote organisational learning that is vital to improving the quality of our work with vulnerable children and families.

Notes on redaction of this Report

This document contains the conclusions and recommendations of the Significant Case Review relating to D. In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the Data Protection Act 1998 ("the DPA"). Although there has been a criminal trial and extensive media coverage of this case, and a significant amount of both personal data and sensitive personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with the DPA. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as the DPA contains certain conditions which must first be met. The process of redacting the SCR has involved careful consideration of:-

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned.
- The public interest in disclosure.
- Considering whether information is sensitive personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual life, or the commission or alleged commission of an offence) and whether its inclusion in the SCR complies with the Data Protection Act 1998.
- Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to D himself and other people whose history was closely linked to D can only be released if it is lawful, necessary and proportionate to do so.

Following this, and on taking specialist legal advice, the review panel concluded that in the unique circumstances of this case, it would not be appropriate to release the main body of the report. The narrative of the report could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties, and it was felt that removing all such information would lead to the report being at best meaningless and at worst misleading.

The conclusions and recommendations have been included but with certain text (generally containing biographical details) redacted for the reasons set out above. Any redactions are clearly marked with the word "[Redacted]". Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

SIGNIFICANT CASE REVIEW PANEL CONCLUSIONS

The focus of this Significant Case Review has been unique. As described earlier, reviews are normally conducted in respect of children, within the child protection and child welfare systems, who may have experienced significant harm. In this case however the emphasis was more about learning whether the care and protection systems could have anticipated and avoided the tragic outcome that resulted from D's actions on 24 June 2011.

The ultimate question for the care and protection systems must be could and should Mrs L's death have been foreseen and prevented.

The SCR Panel found no evidence to suggest that the tragic circumstances which led to the death of D's foster carer could have been anticipated or prevented.

However, the SCR Team looked further to consider whether D had a known propensity for serious violence and therefore presented a severe danger to carers or whether he had particular mental health difficulties which meant his behaviour might be unpredictable.

[Redacted]. There was no evidence whatsoever of aggression towards adults since he had been accommodated three years previously.

[Redacted]

It was clear from the NHS, SCIR findings that a great deal of work had gone into developing and delivering a joint plan of care.

There was no evidence to suggest that what happened could have been prevented by health practitioners taking any other course of action or risk assessing in any other way. All health services were agreed that Mrs L's death came 'out of the blue' with no indication whatsoever that D was struggling or that the foster carers had any concerns that would have alerted the authorities to the risk

[Redacted]
Consideration was given to opening a Coordinated Support Plan (CSP) and some information was requested, but a decision was made not to progress this.

A CSP is only usually considered if there is a significant barrier to learning which would be supported by a multi agency approach. Nothing in D's profile suggests that this was the case. It is the SCR team's assessment that although D was a Looked After and Accommodated pupil, that alone did not constitute a need for a CSP.

In terms of managing the complexity of [redacted] by D it perhaps could have been anticipated that he might have responded in a more negative way to the impact of [redacted] and the continuing complexities and insecurities in his life, but again there was nothing to suggest he was capable of such violence.

There is evidence of good work being undertaken by a number of committed and conscientious Social Work staff. Once D was accommodated there is evidence of regular direct contact with D himself and his carers, effective liaison with the fostering agency and good professional communication with specialist colleagues. However there is also evidence that the Glasgow City Social Worker did not visit D until he had been in his final placement for 2 months. This is out with statutory requirements.

Structured, reflective supervision is crucial to the good management of complex cases such as this. It is the natural response of Social Workers to be empathetic and change is effected in Social Work practice through building a relationship with the client. It is, therefore, vital that workers have the opportunity to stand back and reflect on what is happening and what is being achieved (or is not being achieved). Structured reflective supervision is noticeably lacking at key points in the history of this case as far as Glasgow Social Workers were concerned.

Inadequate staffing, inexperienced staff, shortage of resources and disruption to supervisory and management structures all had an impact, not only at the time but in the longer term. This is a strategic and political issue because providing Social Work Services adequate to meet the needs of vulnerable children requires sufficient resource to be allocated, which needs to be argued for even more strongly at times of budgetary constraint.

If a chronology had been used it could not have failed to improve the management of this case. Glasgow has also been encouraging the use of the Graded Care Profile to assess neglect and it seems likely that it would have been helpful in this case had it been available. We understand that there is an existing commitment to embedding both the use of chronologies and the Graded Care Profile in Social Work practice.

[Redacted] succeeded in disrupting the planning and management of the work in this case. [Redacted]. It is a professional responsibility to recognise the need for advice and assistance and to seek it when required and it should be clear where such additional help can be sought.

The guidance does not currently include suggestions about what to do when local options have failed to bring sufficient control into the management of a case. It would be helpful to review this guidance to make it clear what additional advice is available; where that assistance can be sought; and the circumstances in which this should be done.

Consideration also needs to be given to managing aggression and threats directed to foster carers. In such circumstances, specific attention needs to be given to effective non disclosure of addresses and how best to support carers. This was a key factor leading to the ending of placement one and an underlying concern in placement two.

Monitoring Violent Incident Reports is not just important in terms of de-briefing staff on an individual basis but is also an important management tool with which to identify patterns that indicate the need for intervention. There is a clear overlap with identifying where work with [redacted] needs to be reviewed. It is not uncommon for violent incidents to be under-reported but that gives managers less opportunity to offer advice and assistance. The importance of this reporting should be included in any review of [redacted].

The decision to pursue permanence was not progressed when it should have been. Other such decisions may “drift” for similar reasons or for entirely different ones. The issue is not to focus just on why this happened in this case but to have a system that looks at all these decisions; identifies what is required in order to progress them; and puts practical measures in place to support that happening. We understand that such a system is underway and are confident that, had this been available four years ago, the issues in this case would have been quickly identified.

This report highlights system and practice concerns prior to D being looked after and accommodated, including workers and children’s panel members over identifying with mother’s plight and losing a “child at the centre” focus. Following D being looked after and accommodated, care systems and care planning became engaged and distracted by [redacted] thereby losing clarity of focus on the needs of D [redacted]. There is evidence to

support that systems designed to protect and meet the needs of children lost sight of the paramountcy principle as defined by the Children (Scotland) Act 1995. This principle means that when making any decision about a child's upbringing, the child's welfare should be paramount.

In terms of conveying D's views, it is our judgement that this could not have been done any better. The dilemma was rather that part of what D said was that he wanted to go home and wanted contact with his parents. Coupled with the points detailed about perceptions of the parents, this made reducing contact far from being a clear cut decision. Listening to children and helping disentangle the complexities of their experience, particularly when there is love for and loyalty to their family, and then assisting a Children's Hearing to be able to see their way through all the surrounding issues, is a challenge for everyone working with children and young people.

[Redacted]. The fact that he (D) appeared relatively unscathed should probably have rung alarm bells although, given the huge workload pressures on Social Work and health services in Glasgow, it is understandable that it did not.

D was described by some Glasgow Social Work and FCAS staff as resilient, but resilience is only to a very limited degree an innate quality. As an eminent Child Psychiatrist and his colleagues have stated, "It is an ultimate irony that at the time when the human is most vulnerable to the effects of trauma – during infancy and childhood – adults generally presume the most resilience"[1]. Resilience needs a range of positive inputs to develop and can remain fragile in children who have had poor starts in life. [Redacted].

The fact D had been accommodated by FCAS for three years meant that he was seen as a "known quantity" who they had observed making positive progress in his placements. Whilst true, this almost certainly led FCAS staff and his City of Glasgow Social Workers to underestimate the known impacts of trauma. "Children exposed to sudden, unexpected man-made violence appear to be more vulnerable [to trauma] – making the millions of children growing up with domestic violence or community violence at great risk for profound emotional, behavioural, physiological, cognitive and social problems"[2] .

It is not known what, if anything, triggered D's attack on Mrs L. There were no obvious symptoms of post traumatic stress disorder (PTSD), psychosis or other mental health conditions in the months or even hours before the attack. If D was suffering from PTSD, it is possible that something that Mrs L said or even in her demeanour, re-sensitised D to [redacted] and led to his extraordinarily disproportionate response. Disproportionate responses can be elicited in children with PTSD by apparently minor stressors. Nevertheless, it is almost unheard of that this leads to a murderous attack by a child and, although each child's circumstances need to be individually assessed, it would be unhelpful if a background of trauma was perceived as a barrier to foster care. The most therapeutic environment for a child affected by trauma is a loving, predictable and warm family environment – exactly what was being provided by Mr and Mrs L.

The overwhelming view of staff and previous carers was of a young boy who was flourishing in his placement, had formed good relationships with his carers and was looking forward happily and hopefully to a positive future. We found nothing that counteracted this view.

1 Perry B, Pollard R, Blakley T, Baker W, Vigilante D "Childhood Trauma, the Neurobiology of Adaptation, and "Use-Dependent" Development of the Brain: How "States" become "Traits" *Infant Mental Health Journal* Volume 16, Number 4, 1995

2 Perry et al 1995 op cit

However, as described in this report, we considered that a somewhat more cautious interpretation of D's progress might have been helpful in sensitising them to the possible risks he presented, albeit that his extreme violence was unforeseeable.

The reasons that D was placed with Mr and Mrs L were understandable in the context of the lack of foster placement availability and the staffing difficulties in the local office. Some members of the SCR Review Team felt they were outweighed by reasons that indicated he should not have been placed there. However, other Review Team members were of the view the decision to place D with Mr and Mrs L was appropriate at that time.

RECOMMENDATIONS AND ACTIONS

A comprehensive review of any case will inevitably highlight both good practice and learning issues. This review has been no different. The agency specific chronologies and reports have developed learning points for individual organisations, practitioners and managers and they have been addressed with the agencies and individuals in question. Specific recommendations have been made to FCAS under separate cover.

The following actions have been identified by the SCR Team as having the potential for policy and practice learning across Glasgow's child protection systems and for other agencies commissioned to provide child care services.

Action 1
All other agencies, with the exception of Police Scotland, should review existing staff supervision, support policies and systems to ensure that structured reflective supervision is embedded, especially in the management of complex cases. Police Scotland has their own arrangements in place.

Action 2
All agencies should ensure that the use of inter agency and single agency chronologies and case histories is embedded in policy and practice and that sufficient importance is given to reflective consideration of chronologies and case histories in case planning and risk assessment. This should have specific emphasis at the point of transfer to another worker or system.

Action 3
During the period under review there were significant changes within both organisations, the local authority was subject to change in organisational and staffing structures and the independent foster care organisation was subject to change associated with rapid growth. In both organisations, there was also a relatively high turnover of front line staff and first line managers in the particular offices involved. This can impact on the continuity of services, supervision and case management. Glasgow City Council Social Work Services and Core Assets (FCAS) need to ensure that robust systems are in place to ensure there is continuity of high quality services for vulnerable children and that there are sound processes for the transfer of information between "old and new" systems and workers.

Action 4
The Inter-agency Guidance on working with Hostile and Uncooperative Families should be reviewed and refreshed, with particular reference to what should be done when local options have failed to bring sufficient control to the management of a case. The review should also include agency policies on reporting violent incidents. Specific consideration also needs to be given to managing aggression and threats directed to foster carers.

Action 5
Glasgow City Council Social Work Services should put in place a system to monitor all permanence recommendations and decisions and where necessary, put practical measures in place to ensure child centred and timely outcomes.

Action 6
Glasgow City Council Social Work Services should always agree and sign placement agreements with independent fostering agencies, where possible prior to placement. They should also always provide copies of LAAC reviews and other relevant documents to the fostering agency. When approving foster carers and matching children with them, greater

weight should be given to the foster carers' previous experiences, particularly with regard to the age range of children to be placed.

Action 7
All agencies should review practice to ensure that, where children's unusually good behaviour is not in keeping with their experiences, carers, foster agency, health and local authority staff are alert to potential risks and have opportunities to discuss them. The focus for these reflective discussions should be any underlying reasons and possible responses.

Action 8
All agencies directly involved in making and supporting foster placements should review how their systems, services and decisions can be more conducive to developing children's attachments and resilience and to mitigating trauma.

Action 9
Glasgow City Council Social Work Services and Children's Hearings Scotland should consider how supervised, restricted or terminated contact can be managed appropriately in the context of children having access to social networking sites.

WHAT NEXT

The findings contained within this report will be submitted to Glasgow Child Protection Committee. The Committee will ensure that all recommendations and action points will have a designated lead responsibility and clear timescales and will monitor progress 6 monthly.

Single agencies will be responsible for implementing internal actions and recommendations and the Committee will ensure there is a process in place to review these. The Committee's Lead Officer will be responsible for liaising with the relevant lead agencies to ensure the implementation of action points and for reporting back to the Committee on progress.

GLOSSARY

A&E	Accident & Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ADM	Agency Decision Maker
CAMHS	Child & Adolescent Mental Health Services
CP	Child Protection
CPC	Child Protection Committee
CPCC	Child Protection Case Conference
CPI	Crisis Prevention & Intervention
CPO	Child Protection Order
CPRCC	Child Protection Review Case Conference
CPU	Child Protection Unit
CSP	Co-ordinated Support Plan
DCFP	Department of Child and Family Psychiatry
FCAMHS	Forensic Child & Adolescent Mental Health Services
FCAS	Foster Care Associates Scotland (now called Core Assets)
FM	First line Manager
GP	General Practitioner
HMIe	Her Majesty's Inspectorate of Education
HV	Health Visitor
LAAC	Looked After & Accommodated Child
MHT	Mental Health Team
NHS	National Health Service
PTSD	Post Traumatic Stress Disorder
RHSC	Royal Hospital for Sick Children
RTA	Road Traffic Accident
SCRA	Scottish Children's Reporter Administration
SCIR	Significant Critical Incident Review
SLA	Service Level Agreement
SM	Senior Manager
SNAP	Stop Now And Plan
SSSW	Senior Supervising Social Worker
SVQ	Scottish Vocational Qualification
SW	Social Worker
SWIA	Social Work Inspection Agency
TM	Team Manager