CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD


# Serious Case Review

# Child AC

# OVERVIEW REPORT

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**CONTENTS**

## 1. Summary of the Learning

This Serious Case Review has identified a number of learning points for the individual agencies involved and for the Cumbria Local Safeguarding Children Board (LSCB). When considering in detail the involvement of Cumbria LSCB partner agencies with Child AC it has found:

- Agencies with a responsibility for working with children who are placed in another area need to consider how they communicate and share information with organisations outside of their usual local partnerships or networks.
- Agencies that hold a rich mix of information on children should consider how they can store that information in a format that can be shared effectively when there is an appropriate requirement.
- Where a child is subject of more than one statutory plan, it is important that the managers of each plan ensure there is effective coordination between each other and that the identified risks are being managed effectively.
- Professionals working with children who display non-compliance or passive avoidance should consider what incentive measures they may need in place to secure more effective engagement.
- Where children are placed in residential or secure centres a large distance from their homes consideration should be given to using communication technology to maximise agency engagement at meetings.
- Agencies working with children who demonstrate risk-taking behaviour should challenge themselves to consider the possible longer term consequences in respect of the risk-taking behaviour that is being displayed and how that behaviour may be managed.
- Agencies engaging with families should give consideration to the local context in which the family is operating and the wider span of influences that may be impacting on the children.

## 2. Introduction to the Significant Incident Learning Process (SILP)

2.1. The Cumbria LSCB agreed that this Serious Case Review (SCR) should be undertaken using the SILP methodology. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in Working Together to Safeguard Children 2015.

2.2. The SILP model of review adheres to the principles of;

- proportionality

- learning from good practice
- the active engagement of practitioners
- engaging with families, and
- systems methodology

2.3. SILPs are characterised by a large number of practitioners, managers and agency safeguarding leads coming together for a Learning Event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the overview report, and to make an invaluable contribution to the learning and conclusions of the review.

2.4. Working Together 2015 (page 74) states that SCRs and other case reviews should be conducted in a way which;

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

2.5. This SCR has been undertaken using the SILP model which ensures that these principles have been followed and provides a systems review of the case.

## 3. Introduction to the Child

3.1. The subject of this review is a child to be known as AC. He was 14 years old when he was killed. A criminal trial has taken place resulting in a number of convictions.

3.2. AC lived with his family. The family had regular contact with the maternal grandparents. All four children had been known to Children's Services for a number of years. The family had come to the attention of the community, the Police and other agencies. The four children were made subject of a Child Protection Plan in January 2015. In April 2015 at a Child Protection Review Conference it was agreed that AC and his older sibling should remain on Child Protection Plans whilst the two younger children should be stepped down to a Child in Need Plan. The parents were only known to the universal services provided to all children and families.

3.3. At the time of his death AC was known to a number of statutory and non-statutory agencies.

## 4. Family Structure

4.1. The child subject of this review is to be referred to as AC. Siblings will be referred to as Sibling A, Sibling B and Sibling C.

4.2. The parents of the children are referred to in this report as Mother and Father. Other family members will be referred to by their family title e.g. Paternal Grandmother.

4.3. Mother and Father lived together with the children. They were married soon after the birth of Sibling A.

4.4. The children and both parents are white British. Their only language is English. This information appears to have been accurately recorded on agency records. They have no known physical disabilities. At the time of the incident the parents were not working.

## 5. Terms of Reference

5.1 It was agreed that the timescale being considered by this review would be from the middle of 2014 to the middle of 2015.

## 6. Process

6.1. The parents were contacted to ensure their views were considered and heard as part of the review. An appointment was offered on 16th March 2016, and both parents met the lead reviewer. The key themes that emerged from both parents were that they felt fully supported by local agencies but the strategies they used to persuade AC to attend school and engage with services were unsuccessful.

6.2. The Department for Education (DfE) expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information will not be disclosed in this report. It has been written in the anticipation that it will be published, and contains all of the information that is relevant to the professional responses and contact with the family. The decision to disclose information has been taken with reasonable caution to prevent the identification of the children concerned and other family members[1], and to protect the right to an appropriate degree of privacy for the family.

[1] The murder of AC and subsequent criminal trial received significant publicity and the family are aware that it is likely that notwithstanding the measures taken that there is an expectation that AC will be identifiable.

6.3. The SCR was planned at a scoping meeting held in September 2015 with the Cumbria LSCB Serious Case Review sub-group. Terms of Reference were compiled and agency reports were requested, along with a chronology of agency involvement. A briefing meeting for agency report authors was held on 11th October 2015, to clarify expectations.

6.4. A Learning Event was held on 4th February 2016. All the agency reports were available and had been circulated in advance with the chronology. This ensured that all staff attending were able to fully understand the multi-agency information and focus of the review. The event was well attended by practitioners and their immediate managers as well as Cumbria LSCB Case Review Group members and Board representatives.

6.5. The Recall Event was held on 17th March 2016. Participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the contents and clarify their involvement and perspective. All those involved contributed to the conclusions and the identified learning from this review.

6.6. The final version of this Overview Report was presented to the Cumbria LSCB on 10th May 2016.

6.7. The other children have now all stepped down from plans and all live at the family home. Children's Services remain engaged with the family as a support mechanism.

6.8. The lead reviewers in this case are Mark Granby, who is also the author of this report and Nicki Pettitt. Mark is a retired police officer and an accredited SILP associate reviewer. Nicki was a senior manager in a local authority children's social care department, is an experienced chair and author of SCRs, and is a SILP associate reviewer. Both are entirely independent of Cumbria LSCB and its partner agencies.

## 7. The background prior to the scoped period

7.1. AC was born in 2001 and early contact with agencies was limited to universal services. He started displaying some behavioural problems at primary school and it was reported at the Learning Event that his behaviour was difficult to manage by the time he reached Year 6. The school was able to secure the services of an educational psychologist to support AC and his family and this support commenced in 2008. Third Sector Agency 1 was commissioned by the primary school to provide support for the family with a focus on AC's behaviour. This provision of early help to the family is good practice. Mother contacted the GP in February 2011 expressing concern about AC's behaviour and a referral was made to CAMHS. They attended the first appointment in April 2011 but did not attend the follow up appointment and the file was closed.

7.2. AC came to the attention of the Criminal Justice system in August 2011 when he received a final warning for trespassing on a railway. This offence was investigated by British Transport Police and the Youth Offending Service (YOS) was made aware of this incident, but in line with the protocols that existed at that time they did not engage with the family. His offending continued and he received his first court order in November 2012 from when his case was open to YOS. He completed the order in March 2013.

7.3. In July 2012 a referral was made to Children's Services by the Police in relation to AC. He had been sent by his parents to live at the address of a family member. However, following an allegation in relation to use of force a Section 47 investigation was undertaken and at a subsequent strategy meeting the parents were advised not to allow AC or his siblings to have contact with that family member. Third sector agencies were commissioned to work with the family and provide support.

7.4. Transition to secondary school in September 2012 was managed well with information sharing between the primary school and secondary school being effective. AC's lack of engagement and behaviour at secondary school was a significant problem. It was reported that he would walk out of class to go outside to smoke a cigarette. School outlined that he was not aggressive in his behaviour, but was passively defiant to rules and instructions. Information relating to AC's minor criminal activity was shared with the secondary school through the YOS and there was a school multi-agency group operating. Good efforts were made to engage with the family and Father attended some lessons with AC.

7.5. In January 2014 AC received a Referral Order; however this was revoked in May 2014 after he committed further offences. On 21st May 2014 the Court sentenced him to a Youth Rehabilitation Order with a supervision requirement. From this date there were issues with AC's compliance with the conditions of the Order and it was observed that his parents were struggling to manage his behaviour and impose appropriate boundaries.

## 8. Key Episodes

8.1. The time under review has been divided into four Key Episodes. These are periods of intervention that are judged to be significant to understanding the way that the case developed and was managed. The term 'key' emphasises that they do not form a complete history of the case but are a selection of the activity that occurred, and includes the information that is thought to be key in informing the review.

8.2. The first Key Episode covers from June to November 2014. This includes the decision to permanently exclude AC from school, his induction into the Pupil Referral Unit and the engagement with YOS prior to AC being sentenced to a secure centre.

8.3. The second episode covers November 2014 to January 2015, when AC was detained at the Secure Centre. It details how agencies responded to an allegation that resulted in a Section 47 investigation and the development of the safeguarding plans that were put in place for AC and his three siblings. It also reviews the preparation for AC's discharge from the Secure Centre.

8.4. The third episode covers January to April 2015, the period from AC's release from the Secure Centre, the Initial Child Protection Conference to the Review Child Protection Conference.

8.5. The fourth covers April to June 2015, the period from the Review Child Protection Conference to AC's murder.

**Key Episode 1:** from June to November 2014.

8.6. The first Key Episode covers from June to November 2014. This includes the decision to permanently exclude AC from school, his induction into the Pupil Referral Unit and the engagement with YOS prior to AC being sentenced to a secure centre

8.7. June 2014 saw deterioration in AC's behaviour at school and there were issues around the compliance with his Youth Rehabilitation Order. School put in place robust support mechanisms including a personalised curriculum, a behaviour coach, mentoring, an Individual Education Plan, a behaviour contract and Team Around the Child Meetings. He was offered a counsellor but declined this service and gradually chose to disengage from the other support that was available to him.

8.8. In July there were two serious incidents in school involving AC. As a consequence, the decision was made on 16th July to permanently exclude him from school. As this was just before the start of the summer holidays, the permanent exclusion hearing with governors and the local authority did not take place until 11th September. AC and his parents did not attend the hearing; the parents indicated their view was that the school had done everything possible to support their son. Governors upheld the decision to permanently exclude AC and he was taken off the school role on 2nd October 2014.

8.9. On 13th August AC had to return to Court and was breached for non-compliance with his Youth Rehabilitation Order. He was given a Curfew Order that was to run for 6 weeks. YOS made a referral to Third Sector Agency 1 for their support in working with the parents.

8.10. AC started at the Pupil Referral Unit Assessment Centre[2] on 10th September 2014. It took 3 attempts to arrange an induction meeting as the parents did not attend the first two meetings. There was close liaison between the centre and the YOS however there was no improvement in his engagement and behaviour and he absconded from the premises on several occasions and was failing to comply with the conditions of his Youth Rehabilitation Order.

8.11. A further referral to Educational Psychology was made in September and an appointment was made to see AC. However, due to his school attendance and Court commitments it did not prove feasible to make an appointment and a further assessment did not take place.

8.12. On 17th September AC returned to Court for non-compliance with his curfew. He was given a further curfew period of 10 weeks and his parents were made subject of a Parenting Order which was set for a period of 3 months. Support was provided for his parents in the form of Triple P (Positive Parenting Programme). This was supplemented by the on-going support from Third Sector Agency 1.

8.13. AC was required to return to Court again on the 8th October and his sentence was revoked. The Magistrates made him subject to a 6 month Youth Rehabilitation Order with an Intensive Supervision and Surveillance element. It was apparent that efforts were made by the third sector agencies to work with AC's parents to co-ordinate the work that was taking place. This is expected practice.

8.14. On 15th October the police attended the Assessment Centre in response to a call that AC had committed an act of criminal damage. This was unusual behaviour at the centre. The police notified Children's Services and the YOS. AC was reported to be angry about an earlier incident where he had admitted causing damage, he told professionals that three boys were involved but he was the only one to be charged with the offence.

8.15. During his time on the Good Together Programme under the section on thoughts, feelings and behaviours AC informed professionals that he did not know how to cope with his feelings.

8.16. Following his placement at the Assessment Centre, AC took up a place at the Pupil Referral Unit on 7th November 2014. His attendance was very poor and often he would fail to attend altogether, or he would attend and then abscond from the unit. The Pupil Referral Unit had good communication and co-

[2] The Assessment Centre is used to determine how well excluded pupils engage and behave before placement with the Pupil Referral Unit. The majority of pupils return to mainstream education after assessment or a short period ay the PRU.

operation from AC's parents but it was noted that the parents seemed to have very little control over him or his behaviour.

8.17. On 26th November AC returned to Court for breaching the conditions of his order. The Magistrates sentenced him to a 4 month Detention and Training Order. He was also found guilty of 5 minor offences. He was placed in a Secure Centre to serve his sentence.

8.18. This is a Key Episode as it captures the period where AC's behaviour and his compliance with services and Court Orders steadily deteriorated. It was apparent that the decision to permanently exclude him from secondary school was one that was not taken lightly and considerable efforts had been made by the school to support AC and his parents. It was acknowledged by the police that AC's offending was not of a very serious nature and YOS professionals conceded that his detention reflected his inability to comply with Court Orders rather than the gravity of his offending. There was good communication between the agencies working with AC and the family and positive and appropriate referral and commissioning of third sector support.

**Key Episode 2:** <u>from November 2014 to January 2015</u>

8.19. The second episode covers November 2014 to January 2015, when AC was detained at the Secure Centre. It details how agencies responded to an allegation that resulted in a Section 47 investigation and the development of the safeguarding plans that were put in place for AC and his three siblings. It also reviews the preparation for AC's discharge from the secure centre.

8.20. AC commenced his Detention and Training Order in the Secure Centre on 26th November 2014, with an expected release date of 26th January 2015. In line with procedures, AC undertook a Comprehensive Health Assessment within 5 working days of his admission. His physical health, mental health and any substance misuse issues were considered as part of the assessment. He subsequently received some dental treatment at the centre and was registered with a local GP. Upon discharge a letter was sent to his mother outlining the requirement to re-register AC with his local GP in the community. A specialist substance misuse screening was undertaken and this assessed AC as being at Tier 2. The Tier 2 intervention is specific to the needs of the young person and involves a focus on education, harm minimisation and early intervention. AC was offered three educational sessions in relation to substance misuse and attended one of these prior to his release. AC undertook a mental health assessment that concluded there was no evidence of an acute mental illness or a neurodisability.

8.21. The initial post-sentence meeting was held in the Secure Centre on 8th December 2014. This was within the expected timescale and the meeting was attended by the YOS case and education officers and AC's parents. Work with the parents continued in the community and although they were de-

scribed as being erratic with their engagement they did complete the Triple P course.

8.22. Whilst at the centre AC attended education daily, achieving over 25 hours a week. He was reported to have formed positive relationships with the staff and his peers and managed to achieve the highest level in the incentive scheme. His IQ was assessed and he was identified having a below average IQ. The reading assessment completed on admission to the centre provided a score of 9 years and 9 months. He was tested again on 19th January and achieved an average reading age of 11 years and 6 months. This was regarded as a huge improvement in the 7 weeks of education he had received. AC made no significant progress with Maths or Science however he did make progress with PE, ICT, hairdressing and plumbing.

8.23. AC demonstrated high standards of behaviour during his time at the centre and stayed at the highest level of the incentive scheme throughout his stay and achieved a financial reward. He was reported to have been very proud of his achievement and the fact that he liked to receive rewards for positive behaviour was shared with the YOS.

8.24. On 2nd January 2015 a referral was made to Children's Services which resulted in a child and family assessment being commissioned in relation to all four children linked to the allegations made against the oldest sibling and the parent's ability to protect them. As part of the assessment process a social worker conducted a home visit and spoke to all of AC's three siblings and his parents. A supervision meeting was held on 5th January and it was determined that a Section 47 investigation should take place. A further home visit was conducted where all of AC's siblings and his parents were spoken to again. As part of the information gathering Children's Services spoke with staff at the Secure Centre where AC was detained. He was described as always being polite and compliant and whilst he hadn't liked the routines and boundaries, he had adhered to them. It was outlined that the parents had visited AC on two occasions following his detention.

8.25. On 12th January a further home visit was conducted and the family were informed that an Initial Child Protection Conference would be held. This demonstrated expected practice in sharing information with parents to evidence the progression of concerns.

8.26. The Section 47 investigation was completed on 13th January. The social worker acknowledged that AC had not been spoken to as part of the investigation but the YOS case worker had been able to provide information. The YOS worker indicated that they would see AC again before the date of the Initial Child Protection Conference. The social worker's analysis of the situation was that all siblings were at risk of harm, linked to the allegations made against the oldest sibling and the parent's ability to protect them.

8.27. On 19th January the YOS worker met with AC at the Secure Centre for his discharge meeting. Present at the meeting were centre staff and AC's Father and Maternal Grandfather. Representatives from Children's Services, the Pupil Referral Unit and Third Sector Agency 1 were invited to the meeting, but were unable to attend. The YOS worker shared the safeguarding plan arrangements with AC and updated him on the situation back at home prior to the formal discharge meeting. It was unusual for only one agency to be present at the discharge meeting and the YOS worker did well to cover all the issues that needed discussing with AC. The plan for his licence was also discussed together with the arrangements for his education.

8.28. AC was released from the Secure Centre on 23rd January and returned to live at home. He was the subject of a Child Protection Plan, and he also remained subject to the Detention and Training Order but on a licence with supervision for a period of two months. A home visit was carried out by social workers in the afternoon to deliver the Initial Child Protection Conference report, but AC was not present despite his parents wanting him to stay home.

8.29. This is a Key Episode because it captures the impact that the period of detention had on AC. Moreover, it demonstrates the response agencies took upon receiving the allegations in respect of Sibling A. The consensus at the Learning Event was that AC flourished at the centre with positive outcomes for his health and educational achievements. He was reported not to have enjoyed his 8 weeks in custody but he coped well with the regimen and performed very well in the incentive scheme. His parents visited him on three occasions during the period albeit he made little effort in calling them. His period in detention provided an opportunity for the third sector agencies who had been struggling to engage with AC to meet with him. The fact that efforts were not made to visit AC whilst he could not abscond has been acknowledged by the Third Sector Agency 1 report writer to have been a missed opportunity. The multi-agency response to the allegations against Sibling A met expected standards and clear efforts were made to hear the voices of the children involved and to engage with the parents to ensure all the children were safe. Children's Service professionals did not have an opportunity to meet with AC but they did receive timely information from the YOS worker. The primary focus of the Section 47 investigation related to the potential risk posed as a result of the allegation within the family albeit AC's risk taking behaviour was identified during the process.

**Key Episode 3:** from January to April 2015

8.30. The third episode covers January to April 2015, the period from AC's release from the Secure Centre, the Initial Child Protection Conference to the Review Child Protection Conference.

8.31. The Initial Child Protection Conference took place on 26th January 2015. It was well attended with 8 professionals and 3 family members present. It was agreed that all four children should be subject of a Child Protection Plan. Concerns were raised about AC's return home and the management of his behaviour in the community. However, the focus remained on the issues regarding the sibling and did not prioritise AC's specific needs.

8.32. On 27th January AC met with the YOS health worker. He disclosed health needs, including sleep problems and nicotine addiction. He said he had tried cannabis but was not interested in it and he drank alcohol on occasions. These were health needs that were not being met through service interventions. There was also evidence that the school nurse had contacted the Secure Centre to enquire about health needs but they reported that he was not giving them any cause for concern, this pro-active seeking of information is good practice. He had undertaken some work on cannabis usage whilst at the Secure Centre but this information was not passed on to Health agencies. This was as a result of the assessment undertaken at the Centre not identifying AC as being at high risk or at potential risk of coming to harm from substances. AC failed to attend further pre-arranged appointments with the YOS health worker and as a consequence the issue of the unmet health needs was not progressed.

8.33. AC returned to the Pupil Referral Unit on 29th January. He made an effort for the first two weeks but then there was a decline in his punctuality, attendance and behaviour. This decline became more rapid after the half term holiday in mid-February.

8.34. Following dialogue between the YOS case worker and the social worker, AC's Child Protection Plan was updated to reflect his needs. There was a focus on his health needs and the need to prevent criminal behaviour. There would be continued third sector work with the parents; the social worker would visit every 3 to 4 weeks and the YOS worker meeting with AC 2-3 times per week, one meeting would always be at home and the others involved supervision and mentoring.

8.35. The Core Group met on 5th February and the plans were reviewed. Positive reports on his progress were given by YOS and there was also positive feedback on his progress by his parents. The school nurse records indicate that there were issues with punctuality at the Pupil Referral Unit; concerns were raised that he had a poor sleep pattern and that he may be using cannabis.

8.36. In the early hours of 18th February, AC's Mother called the Police to report that he was missing from home. He returned home at 3.30 a.m. and said he had been with two friends. The incident was referred by the Police to Children's Services and to Third Sector Agency 2 who had been commissioned to carry out return home interviews. AC declined the offer of the return home inter-

view. This was later followed up by the third sector agency that made contact with the Pupil Referral Unit to again offer AC a return home interview. A teacher at the unit spoke with AC but he declined the offer again.

8.37. On 25th February there was another meeting of the Core Group. It was reported that AC had failed to attend Court on 11th February for breaching the conditions of his licence but he had attended the following week. His licence was extended by the Court to June 2015 and a condition was added that he was not to associate with a named young person. His school attendance was noted as being poor and that his parents had been unsuccessful in getting him to school. YOS indicated that a return to secure accommodation was not an appropriate option. The Child Protection Plans were to remain in place.

8.38. A statutory home visit was undertaken by social workers on 3rd March. AC was present at the start of the visit but then left the home. An agreement was subsequently made with the YOS case worker that she would attempt to obtain his views in respect of the Child Protection Plan.

8.39. At 2.15 a.m. on 4th March AC's Father reported him to the Police as missing. He had not been seen by his family since 08.30 a.m. the previous day and had been due to attend a Police Station the previous evening for a voluntary interview in relation to an allegation of criminal damage that he had been involved in with two other young men. The Father reported that AC's behaviour was not improving and that he believed his son was smoking cannabis as he had found small packages in his bedroom. This information was shared with Children's Services. AC was found at 12.30 p.m. that day and stated he had been staying at the address of the young male he was not to associate with.

8.40. The Core Group met again on 5th March where the Child Protection Plans and progress were reviewed. It was outlined that AC was meeting his YOS worker 2 to 3 times a week and was keeping all those appointments. The concern was raised that he was using cannabis albeit there was no definite evidence of this. His school attendance was sporadic and it was noted that he was confrontational to teachers.

8.41. On 6th March an unannounced visit was made to the home address by social workers. AC was spoken to and his views on his upcoming Court appearance were sought as was an explanation about his attendance at school. Mother reported that his behaviour was deteriorating.

8.42. AC attended Court on 12th March for his breach hearing but absconded before the case was heard. The Magistrates issued a warrant for his arrest. The day before this he had been scheduled to meet with a worker from Third Sector Agency 2 for an interview but he did not attend.

8.43. On 16th March AC appeared before the Court and was bailed to re-attend on 25th March. On the same date Third Sector Agency 3, one of the third sector agencies working with the family, received a referral from the Police seeking support for AC regarding his cannabis use. It was intended for this support to be provided by a different service provider. AC and his Mother were aware of the referral. However, it was subsequently confirmed that the service provider was no longer accepting referrals. This information was fed back to Mother who told the Third Sector Agency 3 worker not to worry.

8.44. AC appeared before the Court again on 25th March for breaching his licence conditions. He received an extra 54 days of supervision. This was the preferred option for YOS as they were of the view that a return to custody would result in AC being eventually released without any form of support.

8.45. The Core Group met again on 27th March and there was a review of multi-agency involvement and progress. No additional services were deemed appropriate and there was no reported change in risk. School attendance remained a key issue and out of the potential 50 school sessions that he could have attended from 23rd February, he had attended only 5. There was evidence that AC was associating with a young man who was a known offender. As a consequence, on 30th March AC's supervision order was amended so that he was not to associate with that young man. Moreover, discussions between YOS, Children's Services and the School Inclusion Officer took place to establish the viability of a residential school to improve attendance. It was highlighted that AC did not have the form of additional needs that would warrant him being educated in a residential setting however.

8.46. On 31st March social workers conducted a statutory home visit. AC was present initially and was recorded as being in good spirits but keen to go and visit friends. He outlined that he could not be bothered with school. The parents were worried about AC's behaviour in the community, although they reported there was no anger present in the family home.

8.47. This is a Key Episode because it covers the period where more information was becoming available to agencies to demonstrate AC's deteriorating behaviour and his lack of compliance with the conditions of his licence and the challenge this presented to agencies. There was a consensus that AC had responded well to his time in detention and the challenge was to maintain the momentum upon his return into the community. There was identification of some health care needs for AC soon after his release from detention but the opportunity to address them was lost. There was also a growing concern about AC's use of cannabis but a referral made for support did not result in that support being made available due to capacity issues. Moreover, the information that was gathered during the health assessment undertaken at the Secure Centre may have proved useful, particularly given the factors in rela-

tion to nicotine addiction and cannabis usage, but a mechanism to share information between the centre and the GP was not in place.

**Key Episode 4:** from April to June 2015

8.48. The fourth episode covers the period from the Review Child Protection Conference to AC's death.

8.49. The Review Child Protection Conference took place on 16th April. The decision was taken to retain AC on the Child Protection Plan due to the problems with school attendance and criminal behaviour. It was acknowledged that the parents were working with agencies but there wasn't sufficient change. The two younger siblings were stepped down to child in need plans. The School Nurse was unable to attend the conference but submitted a report with recommendations. No health concerns were raised at the conference and it was indicated that the YOS health worker was available to the family and that they would complete a health assessment.

8.50. On 23rd April information was forwarded to Children's Services from the YOS worker detailing that AC was now on bail for new offences, all committed with the young man his licence forbade him to associate with. The intention to discuss the situation at a compliance panel was flagged.

8.51. The YOS case worker and her manager visited AC at home in the morning of 28th April. He was fully dressed in bed but refused to get up and speak with the professionals. His parents said he had been in the garden shed until 11.00 p.m.

8.52. On 30th April a statutory home visit was conducted by a social worker. AC was again in his bedroom refusing to get out of bed. He gave his thoughts on school and described how he spent his time with two friends, staying out until 10.00 p.m. The parents outlined their wish for him to comply with the order, but were unable to get him to school.

8.53. AC returned to Court on 6th May for breaching the conditions of his licence. He received 28 days extra supervision. This information was shared with Children's Services by YOS.

8.54. A Core Group meeting was held on 14th May. A concern was raised that AC had been involved in a fight and then had placed comments on social media that caused further disruption. Attendance at school was down to 16% and he continued to associate with the young man he was not to have contact with. The school were considering instigating legal proceedings against his parents over his attendance.

8.55. On 26th May social workers conducted a statutory home visit to AC. He was present but refused to speak with them. The other members of the family spoke with the social workers.

8.56. AC's licence with the supervision element came to a close on 2nd June. The statutory involvement with the YOS then came to an end; however, the service remained engaged with AC. They raised a concern with Children's Services on 8th June that he remained in bed all day and was then up all night. The request was for third sector agency engagement with the family to recommence to provide support to the parents.

8.57. The Core Group met on 11th June and it was noted that AC's licence had expired. There was concern from the agencies present that he was unlikely to engage with YOS on a voluntary basis. The school was continuing to progress the possible prosecution of the parents, who did not attend the meeting. Concern was raised about the parents disengaging from agencies as well.

8.58. This is a Key Episode as AC's behaviour becomes increasingly chaotic and his risk-taking behaviour escalates. There are episodes of him going missing overnight, refusing to engage with professionals and getting involved in some potentially violent behaviour. His licence came to a close bringing statutory intervention and supervision to an end. His parents had continued to engage with third sector support but there was a concern that their resilience was flagging and they were beginning to disengage.

## 9. Analysis by Theme

9.1. From the information extrapolated from the agency reports, from the discussions at the Learning Event, and from the meeting with the parents, several themes have emerged. These can be summarised as:

- Information sharing and communication
- The coordination of plans and parallel plans
- Challenge of non-compliance or passive avoidance
- Information sharing from secure centre and effectiveness of meetings
- Awareness of the impact of risk-taking behaviour, including cannabis use
- Family and community context

Viewed from a systemic perspective it is apparent how these themes influenced and impacted on each other and led to the circumstances which are the reason for this review.

### Information sharing and communication

9.2. Working Together to Safeguard Children (DfE 2015 – page 16) states; 'Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision'. There is

evidence of effective information sharing between local agencies in this case. The earliest example involved the work undertaken by AC's primary school and the work they commissioned with educational psychologists and Third Sector Agency 1 to support the family when AC's behavioural problems first arose. There is evidence of good engagement and communication with the parents and this was acknowledged by them to the report author. Similarly, the transition from primary school to secondary school was accompanied by effective sharing of information and good communication between the two establishments.

9.3. Once AC came to the attention of YOS there was further evidence of good information sharing and communication between YOS professionals and the Secondary School. The Team Around the Family meetings that were established by the school ensured that appropriate professionals were engaged in supporting AC and his parents. Innovative solutions were applied to try and deal with the problematic behaviour, including encouraging Father to come in and study with AC.

9.4. Following his permanent exclusion from his Secondary School, AC undertook a period of assessment prior to taking a place at the Pupil Referral Unit. The exclusion took place at the end of an academic year when AC had finished in Year 8. Notwithstanding that the transition took place over the summer holidays there was good sharing of information between the school and the Pupil Referral Unit. At this time AC was on a Youth Referral Order and again the information sharing and communication between the YOS and the Pupil Referral Unit was effective.

9.5. AC first formally entered the criminal justice system when he received a final warning for an offence of trespassing on a railway. This was administered by British Transport Police. The detail of the warning was placed on the Police National Computer and the circumstances were shared with the Cumbria YOS. However, due to the protocol in existence at the time, this did not result in YOS contact with the family. That protocol has now been revised and contact with British Transport Police will lead to the YOS Triage process which is consistent with the Cumbria Constabulary protocol.

9.6. Police contact with AC varied from managing episodes where he had gone missing from home to dealing with him for anti-social behaviour and criminal offences. There is evidence of appropriate information sharing taking place between the Police and Children's Services via the Vulnerable Child reporting system. The sporadic nature of AC's offending meant that he was dealt with by several different officers and it was acknowledged by the Police that the absence of a single officer retaining an overview of the threat that he posed is a weakness. However, it is recognised that there is a police officer seconded into the YOS who can act as a point of reference. It was also stressed that the local Police Community Support Officers worked closely with the YOS to monitor the non-association element of his licence.

9.7. The effectiveness of information sharing and communication between the Secure Centre and local agencies is dealt with later in this report.

9.8. Following the allegation that was made in respect of Sibling A there was evidence of the effective sharing of information as part of the Section 47 investigation and the undertaking of the Child and Family Assessment. Agencies at the Learning Event stated that they felt there was good sharing of information and a commitment to multi-agency working. The attendance at strategy meetings and the Initial and Review Child Protection Conferences was good and minutes and notes were usually shared quite soon after meetings had taken place. Similarly, there was generally good representation at the Core Group meetings albeit attendance did fall over the last two meetings.

9.9. The agency report from the Cumbria Partnership NHS Foundation Trust outlines that the information shown in AC's records indicates there are no health concerns, when on reflection this was felt to be incorrect. It established that there were duplicate sets of records for AC with relevant information in both, with no one practitioner seeing all the information. There were unmet health needs for AC relating to nicotine addiction and sleep problems that were identified following his discharge from the Secure Centre however a plan was not put in place in order to meet these needs.

9.10. **Findings**:

- Overall the sharing of information and communication between agencies was good.
- Agencies were proactive in seeking information, for example the School Nurse made contact with the Secure Centre to assess what information they held about AC.

**Coordination of plans and parallel plans**

9.11. AC was the subject of two statutory plans; one was the child protection plan, the other the plan around the community element of his Detention and Training Order. It was suggested at the Learning Event that had the allegation not been made within the family it was highly unlikely that AC would have met the threshold for a child protection plan with the consequent statutory engagement with Children's Services.

9.12. It was acknowledged that AC's offending did not cause him to present as a threat to the public. His offending centred on criminal damage and minor acquisitive crime and it was not the gravity of his offending that led to his period of detention rather his non-compliance with the conditions of his earlier sentence. As a consequence, the plan accompanying his licence conditions focused on the objectives of securing better engagement with

education and minimising contact with others who would act as a catalyst for him to offend. The reality is that neither objective was achieved.

9.13. The Child Protection Plan was put in place to mitigate the potential risk to AC. A key part of this plan would be the role that the parents would play in supervising contact between siblings and establishing appropriate boundaries. The information gathering as part of the child protection process would have indicated that whilst the parents appeared to possess the skills to manage the behaviour of the other three siblings; they did not have the capability to control AC effectively. It was clear that as professionals spent more time engaged with the family they saw that the risk of harm posed to AC was not coming from within the home but from his own risk-taking behaviour and the absence of a robust means to control it.

9.14. In essence, whilst the two plans were implemented for different reasons they ended with the same broad objectives. Managing the behaviour of AC to minimise the risks he posed to himself (both in terms of short term and long term health and development) and others; and supporting the parents to build the capacity to manage their son's behaviour effectively. However, there was good communication between the agencies managing the plans and the parents reported that communication with them was clear.

9.15. At the Learning Event, during the discussion on the coordination of parallel plans, the phrase 'hierarchy of risk' was used by one of the third sector agencies. This is a very useful concept and the process of professionals identifying what the risk factors are and prioritising them and allocating 'risk managers' is a good way forward. The nature of the risk helps identify the agency best placed to coordinate activity and secure clarity of purpose. This should not detract from the statutory responsibility placed on agencies in relation to specific roles in relation to child protection plans or the management of offenders.

9.16. **Findings:**

- Whilst AC was subject of separate plans the actions were coordinated well through good communication between professionals.

**Challenge of non-compliance or passive avoidance**

9.17. Non-compliance was the recurring theme that emerged from the agency reports and at the Learning Event. At secondary school it was non-compliance with the rules and policies which ultimately led to AC's permanent exclusion. Similarly, his non-compliance with the conditions imposed by Magistrates as part of his Youth Referral Order lead to the imposition of a Detention and Training Order. His poor attendance at the Pupil Referral Unit was seen as one of the risks he exposed himself to by YOS.

9.18. It was reported that in the early stages of the time under review AC displayed

passive non-compliance. He wasn't aggressive towards teachers or YOS workers, he would just resist engagement. There was also avoidance of the support being offered through the third sector agencies with AC failing to be home at the time of pre-arranged appointments or walking out of the home or refusing to talk with third sector workers.

9.19. The impact of his non-compliance or defiance was identified early on and support was commissioned for the parents to help them build the capability to challenge AC's behaviour. Notwithstanding the support that had been provided, the parents struggled in setting boundaries for their son and effectively managing his behaviour. At the Learning Event it was reported that this was a source of significant frustration to the parents who felt that their parenting skills had been effective for their other three children. AC's deteriorating attendance record at the Pupil Referral Unit had led managers to commence the process of prosecuting the parents for his poor attendance. It was recognised that this would cause resentment on the parents' behalf as they had felt increasingly powerless to manage his behaviour.

9.20. The issue of passive non-compliance presents a significant challenge to professionals and agencies, specifically when that non-compliance goes hand-in-hand with risk-taking behaviour. It was acknowledged at the Learning Event that the behaviour displayed by AC was unusual, even amongst his small cohort of fellow students at the Pupil Referral Unit. The unit made a determined attempt to engage with AC, placing him in a small class with good role models. The dilemma is compounded even further when the progress made by AC at the Secure Centre is taken into consideration. YOS were firmly of the view that detention in custody was not in the best interests of AC and this view was shared by many of the other professionals who formed part of the Core Group. However, the plans and strategies put in place when AC was in the community were unsuccessful in bringing about the intended outcomes for him. As a consequence, it is important that the strategies utilised by the Secure Centre are reviewed and considered in respect of potential suitability in the community.

9.21. **Findings**:

- The Cumbria LSCB has a good policy in place for working with non-compliant families but it needs further testing in relation to the difficulty of engaging with young people.
- Professionals working in the community find it difficult to continue engagement when a child has been placed in a Secure Centre.

**Information sharing from the secure centre and effectiveness of meetings**

9.22. The Secure Centre was over an hour's drive from the family home and the

offices of many of the professionals working with AC. This made attendance at meetings at the centre problematic for agencies and a significant amount of contact was conducted over the telephone. The YOS case worker conducted the largest number of visits to AC at the centre and Children's Services utilised this relationship to gather information.

9.23. It has previously been reported that several agencies together with AC's parents considered that he made good progress at the Secure Centre. Moreover, one of the third sector agencies that had struggled to engage with him in the community recognised that they had missed an opportunity to meet and engage with him whilst detained in the centre. It is therefore important that professionals recognise the opportunities that may present themselves during periods of detention and how these can be built upon by sharing information effectively with the centre to optimise the outcomes following discharge. The use of communication technology such as Skype and conference calling should also be considered where travel time makes contact problematic.

9.24. **Findings**:

- The YOS caseworker maintained a good relationship with AC during his time at the Secure Unit.
- Opportunities were missed for other agencies to engage with AC whilst he was at the unit and consideration should be given to using communications technology where large travel distances make personal contact more difficult.

**Awareness of the impact of risk-taking behaviour, including the use of cannabis**

9.25. The deterioration in AC's behaviour gave agencies the opportunity to reflect on the potential impact of his risk-taking. His smoking habit had been known about for a significant amount of time. Similarly there was good knowledge about his involvement in anti-social behaviour and criminal activity. The Courts had made attempts to reduce the risks he was taking by imposing curfews, barring him from associating with other offenders and directing him to attend school. The Pupil Referral Unit in particular expressed frustration at the defiance shown to these directions.

9.26. The Cumbria Partnership NHS Foundation Trust agency report flags that missing the opportunity to formally assess AC's unmet health needs resulted in the health aspect of his risk-taking being omitted from the plans. At the Learning Event it was discussed how wide-scale the use of cannabis is in the area but notwithstanding that concerns had been flagged about AC's cannabis usage and an attempt was made to commission support for him via a third sector agency. However, despite the considerable amount of information held about his deteriorating behaviour, the main concern

seemed to focus on his school attendance.

9.27. In Key Episode 4 it was identified that there were two occasions where AC had been reported as missing from home in the early hours of the morning. Home visits established that he was growing more nocturnal in his routine and there was information that he was using cannabis and associating with offenders. This lifestyle was clearly putting him into contact with older offenders, increasing significantly his risk of re-offending and compromising his long term health and educational prospects. Moreover, the disruption that was occurring in the family home will have had a negative impact on the younger siblings.

9.28. **Findings:**

- Agencies working with AC were aware of the deterioration of his behaviour and the risk-taking nature of his behaviour but found it increasingly difficult to effectively engage with him. There were some lifestyle choices, for example smoking, that were not robustly challenged.

**Family and community context**

9.29. The family were far from unique in the local area and they had a network of relations and friends.

9.30. The Pupil Referral Unit reported that AC did not form close friendships with other pupils in the unit but maintained a network of contacts in the local area. The unit was only a 5 minute walk away from the family home and often AC would appear at the school gates in company with older boys.

9.31. The Police investigation following the murder of AC generated information that was not known to professionals at the time they were working with the family. Notwithstanding this, it is of note that the three young men convicted of the murder of AC were not known to YOS prior to the incident.

9.32. At the Learning Event the emerging development of criminal gangs in the area was discussed and the impact this had in relation to drug and knife related crime. Preventative strategies are being developed and put into place but agencies must be aware of the presence of this culture within the community.

9.33. **Findings:**

- Agencies engaging with families should give consideration to the local context in which the family is operating and the wider span of influences that may be impacting on the children.

**Good Practice**

9.37. There were a number of examples identified in this case of good practice across all the agencies involved. Whilst some of these examples reflect expected standards it is nonetheless important that this positive work is highlighted. Examples include:

- Children's Services contacting the GP for relevant information as part of the Section 47 investigation.
- The persistence of agencies to continue working with the family and to maintain good family engagement, especially at a time of stretched resources.
- The continuity of the relationship between the social worker and the family.
- The continuity of the relationship between the YOS worker and AC and the family and her tenacity in trying to obtain positive outcomes.
- The provision of early help at the school was excellent.
- The Good Together Plan which brought together third sector and teaching professionals with educational psychologists.
- There was good information sharing and communication between local agencies and good attendance at Core Group meetings. This included the pro-active seeking of information.
- The involvement of the Police Community Support Officers in engaging with YOS to support the monitoring of the Order.
- The plans contained clarity of expectations on professionals who had responsibility for elements within them.
- The capacity and effectiveness of the third sector agency to provide early help.

## 10. Conclusions

10.1. This review has sought to establish whether lessons may be learned from the episodes leading up AC's death. Whilst a number of learning points for agencies have been identified, it is the author's view that it would have been impossible for agencies to have foreseen the tragic circumstances surrounding AC's death.

10.2. The review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes af-

fecting practitioner behaviour" (Woods et al[3]). It has identified the following learning points which have been built from the findings in Chapter 9 of this report:

- Agencies with a responsibility for working with children who are placed in another area need to consider how they communicate and share information with organisations outside of their usual local partnerships or networks.
- Agencies that hold a rich mix of information on children should consider how they can store that information in a format that can be shared effectively when there is an appropriate requirement.
- Where a child is subject of more than one statutory plan, it is important that the managers of each plan ensure there is effective coordination between each other and that the identified risks are being managed effectively.
- Professionals working with children who display non-compliance or passive avoidance should consider what incentive measures they may need in place to secure more effective engagement.
- Where children are placed in residential or secure centres a large distance from their homes consideration should be given to using communication technology to maximise agency engagement at meetings.
- Agencies working with children who demonstrate risk-taking behaviour should challenge themselves to consider the possible longer term consequences in respect of the risk-taking behaviour that is being displayed and how that behaviour may be managed.
- Agencies engaging with families should give consideration to the local context in which the family is operating and the wider span of influences that may be impacting on the children.

10.3. In their response to this overview report, the Cumbria LSCB will outline further changes that have been made since the death of AC. Changes have taken place in Cumbria since the date of the incident. This reflects the fact that some of the "best learning from serious case reviews may come from the process of carrying out the review" [4] The changes include:

- A more robust process is in place for securing return home interviews from children who have been missing. This continues to utilise third

[3] David D Woods et al. Behind Human Error. 2010.

[4] Brandon et al. Lessons from Serious Case Reviews. 2012

sector expertise.

- The commissioning of the schools nurse service is being reviewed and a re-tendering process is being undertaken by the Local Authority and Public Health.

## 11 Recommendations

11.1. It is recognised that actions have already been made in relation to some of the individual agency's identified learning. In addition, agency reports included some recommendations which this review endorses.

11.2. The purpose of providing additional recommendations is to ensure that the Cumbria LSCB and all professionals in the partner agencies of the Board are confident that the areas identified as learning opportunities in this review are addressed.

**Recommendation 1**

Cumbria LSCB to assure itself of the quality and effectiveness of planning for children detained in secure centres.

**Recommendation 2**

Cumbria LSCB to arrange a multi-agency event around the subject of families who do not fully engage with services and where there is deterioration in behaviour. The event should focus on strategic as well as front-line learning.

**Recommendation 3**

Cumbria LSCB to raise awareness of the risks associated with substance misuse, particularly amongst young people who demonstrate other vulnerability factors.