Learning Lessons Briefing

SCIE Learning Together Review

Background

This briefing paper concerns a young person (YP), who shall be known as 'Ben'. Ben was a looked after child (LAC) who died in a tragic motor bike accident aged 17 in September 2011. He was at that point living independently but had previously been in residential care.

The Wolverhampton Safeguarding Children Board (WSCB) decided that a review was required into the multi-agency support provided to him, recognising that he was one of a cohort of YP who were involved in increasingly dangerous behaviour associated with taking and driving away vehicles unlawfully.

A focused Learning Together case review from SCIE was commissioned in March 2012 and the final report was provided to the WSCB in June 2013. The SCIE Learning Together systems approach uses what has been learnt about an individual case to provide a 'window on the system' into how well the local multi-agency safeguarding systems are operating. It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase risk to the reliability with which we can expect professionals to achieve good quality work.

The Report provided 5 key findings which have resulted in recommendations from the Serious Case Review (SCR) committee:

FINDING 1: For older children who display challenging anti-social behaviour, the current range of accommodation options (including those for 16+) does not provide the requisite variety to fulfil Wolverhampton's Council's 'Promise to all LAC and Care Leavers' creating the risk that the youth justice system inadvertently substitutes for deficiencies in corporate parenting abilities and that those older children experience instability and frequent moves.

Recommendations

1. For the system to be 'safe', the range of LAC accommodation needs to have the 'requisite variety' to meet these needs as they manifest for different YP

2. Assessments of YP placement needs should include the impact of non-maintenance of relationship with professionals and friends and how YP could remain safe within their current home environment with intensive flexible professional support to alleviate risk

FINDING 2: For older children who display challenging anti-social behaviour, a pattern in which the competing considerations of the needs of the LAC population as a whole overrides the individual needs of a young person, risk rendering the LAC review process tokenistic for this particular group

Recommendations:

1. Any placement move should be informed by the YP's 'wishes & feelings ', the professional assessment and the identified care plan made as part of the LAC review process.

2. Where the move is as a result of an emergency, the IRO should be updated and a LAC review called within 20 days of the move.

3. LAC should be informed of the review appeal process for LAC and should be fully supported to access this via the Safeguarding Unit.

FINDING 3: In cases where the standard interventions to prevent dangerous and anti-social behaviour are not working, a pattern of using the services that are readily at your disposal rather than being encouraged or enabled to think 'outside the box' leaves practitioners continuing to layer on interventions that have already proved ineffective and leaves children at continued risk to themselves and others.

Recommendations

1. Professionals working in situations where interventions for YP with dangerous and anti-social behaviour have proved unsuccessful should call a professionals meeting to explore the range of interventions available (national and local) and alternatives that may be considered.

2. Managers should ensure that the supervision process enables practitioners to undertake 'case reflection' to ensure optimum service delivery and outcomes for YP,

FINDING 4: A pattern of minimal coordination between multi-agency forums and processes for older LAC running in parallel, lessens the effectiveness of any one.

Recommendation:

1. Corporate Parenting Board gives consideration to how the management of professional multi-agency input is co-ordinated for LAC outside of the LAC review meeting.

FINDING 5: A pattern of responding to peer groups involved in anti-social and dangerous behaviour by trying to break up the peer group risks reinforcing negative aspects of membership of the group, leaving older LAC more, rather than less, vulnerable

Recommendation:

1. Assessments of Looked after YP should take account of the emotional role and significance of the peer group and consideration given to managed contact arrangements in these instances.