

**London Borough of Hammersmith and Fulham
Local Safeguarding Children Board**

Serious Case Review

Overview Report Executive Summary

The death by suicide of Child A: a 12 year old boy in care

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1. INTRODUCTION

Circumstances leading to this serious case review

- 1.1 Child A committed suicide by hanging himself. He was twelve years old. He had been in care for eight years and was living in a residential unit. His mother had died suddenly and unexpectedly a few weeks earlier.
- 1.2 It was decided that a serious case review should be undertaken in line with Working Together 2010 as the criteria had been met.
- 1.3 The review subjects are:

Child A: male, aged 12 at the time of his death

In order to maintain confidentiality for surviving family members any information relevant to the half sister and brother will not be referred to in this executive summary.

The serious case review panel

- 1.4 A serious case review panel was appointed, chaired by Russell Wate, the independent chair of the London Borough of Hammersmith and Fulham Safeguarding Children Board. The members of the Serious Case Review Panel were:
- Russell Wate (Chair) : Local Safeguarding Children Board and Serious Cases Review Panel Chair (Police Lead)
 - Strategic Lead, LBH&F Local Safeguarding Children Board
 - Designated Nurse for Safeguarding Children, NHS Hammersmith & Fulham
 - Senior Community Services Lawyer, LBH&F
 - Assistant Director, Adult Social Care Division, LBH&F
 - Consultant Adolescent Psychiatrist, CAMHS
 - Local Safeguarding Children Board Business Manager, Kent
 - Designated Doctor for Safeguarding Children, NHS Hammersmith & Fulham
 - Service Manager Fostering, LBH&F Children's Services
 - Principal Officer for Education Welfare, LBH&F
- 1.5 Ghislaine Miller, independent consultant was appointed Overview Author and attended all the Serious Cases Review Panel meetings, with a remit to question, understand and challenge.

Terms of Reference

- 1.6 Terms of reference were agreed and individual management reviews were initially requested from:

- Children's Services, London Borough of Hammersmith and Fulham
- Children's Services, Kent
- Metropolitan Police
- Kent Police
- South East Coastal and Ambulance Service (SECAMB) (letter and chronology).
- GP involvement (across all authorities where Child A was placed).
- Central London Community Healthcare
- Chelsea and Westminster Hospital Foundation Trust
- East Kent Hospital University Foundation Trust and CAMHS (Kent)
- East and Coastal Kent Community Services
- West London Mental Health Trust
- Education, Kent
- Education, London Borough of Hammersmith and Fulham
- School 6
- ORG 1 (RES 2)
- CAFCASS
- Oxfordshire and Buckinghamshire Mental Health NHS
- Great Ormond Street Hospital
- South London and Maudsley CAMHS (letter and chronology).
- Imperial College Healthcare NHS Trust
- NHS Redbridge (letter and chronology)
- Redbridge CAMHS/North East London Foundation Trust
- NHS Hammersmith & Fulham Health Overview
- Mayday Hospital, Croydon University Hospital (letter and chronology).
- Oxford Radcliffe Hospital NHS Trust (chronology and letter)
- Res 1*
- Foster Care Associates (FCA)**
- London Borough of Hammersmith & Fulham Housing Options (2 letters)***

*on 2nd August 2010 an Individual Management Review was commissioned from Res 1, the residential establishment where Child A had lived briefly.

** The Serious Case Review Panel commissioned an Individual Management Review from Foster Care Associates in October 2010 to address issues relating to the time Child A was placed with foster carers employed by the independent fostering agency

*** a letter outlining their involvement with the family was requested from LBH&F Housing Options

Family Involvement

- 1.7 The serious case review panel gave careful consideration to the involvement of family members in the review process. Family members were contacted

and by arrangement were visited by the overview author, who would like to thank them for their contribution to the review process.

The Focus of this Report

- 1.8 The information provided for this review is extensive and covers a period of more than thirteen years when Child A and his family were known to a range of professionals. A significant number of professionals have been identified during the process as having some involvement with the case over the years. The report aims to focus on the experiences of Child A, what life was like for him, identify how interventions in the past framed more recent practice and highlight where there are current lessons to be learnt to improve practice.

2. PROFESSIONAL CONTEXT

- 2.1 The time span for this serious case review covers the move from children's social work being delivered by "Social Services" to being delivered by the London Borough of Hammersmith and Fulham Children's Services. For consistency, this report will refer to Children's Services throughout.
- 2.2 The front line services of the department have recently been inspected by Ofsted and were deemed to be "outstanding". A further Ofsted inspection is currently underway.

3. SUMMARY OF FACTS

- 3.1 Child A's early years were characterised by significant family disruption.
- 3.2 Child A's mother was the primary care giver to him and his half-sister in the early years. She had also experienced disruption in her childhood and struggled to bring up two children alone. Following the birth of a third child there were concerns about the welfare of all three children. Child A attended nursery who were concerned about his behaviour and development. He was assessed at the child development unit and diagnosed with "mild to moderate global delay and speech and language delay". The child development unit offered appointments for speech therapy and other forms of support but quite a few appointments were missed.
- 3.3 When Child A was three he witnessed the suicide of his birth father whilst his mother was in hospital. Child A's mother was offered bereavement counselling before she was discharged from hospital, but declined.
- 3.4 Over the following year there were ongoing concerns about the welfare of the children. Professionals responded to these incidents and tried to offer support.
- 3.5 Child A and other family members were referred to the local Child and Adolescent Mental Health Service for bereavement support. His mother did not immediately take this up and when she later asked the social worker to

arrange an appointment for Child A at the CAMHS service, no appointment was offered.

- 3.6 As a result of mounting concerns about the welfare of the children, an Initial Child Protection Conference was convened. The two older children were made subject to a child protection plan under the categories of neglect and emotional abuse and the youngest child under the category of neglect.
- 3.7 When he was four and a half Child A was found wandering in the street at night and the police were called. He was returned home. His mother was not aware that he was missing and thought he was in bed. There was another incident shortly after this, when Child A arrived at school with marks on his body. This was followed up by the police and Children's Services and the case was subsequently closed. A legal planning meeting was held and care proceedings were initiated on all three children.
- 3.8 Child A later set fire to his bedroom and was admitted to hospital with smoke inhalation. He was seen by the child psychiatrist at the hospital who expressed concerns about his emotional and psychological well-being as a result of the trauma of seeing his father commit suicide.
- 3.9 Child A came into care under a voluntary agreement with his mother (section 20) and went to live with foster carers. He was there for nearly three years, by which time the care proceedings had concluded. A care order was made on Child A and the plan agreed by the Children's Guardian, the Court and Children's Services was that Child A would move to a therapeutic placement, to address his troubled behaviour and help him cope with the trauma of his father's suicide and the distress he was experiencing because he was no longer living at home with his mother and siblings.
- 3.10 Although Child A was subject to a care order there was some confusion about what the long term plan was for him. The Children's Guardian was clear that he needed the help that could be provided by a residential therapeutic placement, but did not rule out the option that he might be able to return home to live with his family at some point in the future. Children's Services were of the view that Child A should be placed in a permanent substitute family who could provide him with the sense of identity and permanency that he needed. Child A was only four when he went into care and six when the care order was granted. He was by this time a very troubled boy and what he really wanted was to go home to live with his mother and siblings and did not understand why this was not possible.
- 3.11 Child A remained in the therapeutic placement for four years and during this time he had regular contact with his family staying with his grandparents, mother and siblings for the weekend once a month, and they regularly attended his statutory Review meetings. Child A benefitted greatly from the therapeutic support he received during these four years, although his behaviour remained challenging, and there were signs that he was a deeply troubled boy. During this period it is alleged that he abused another child during the period of his first foster placement. The matter was investigated

and concluded that the foster carers had not known about this at the time and could not have prevented it. Child A's family were informed about this.

- 3.12 During the four years at the therapeutic placement, Child A spent weekends and school holidays with specialist foster carers employed by an independent fostering agency. They had been matched with Child A because of their skills and experience in dealing with children with challenging behaviour. Children's Services regularly considered what the long term plan was for Child A and wanted to find him a long term foster placement when he left the therapeutic provision. Towards the end of his time there Child A's mother acknowledged that she would not be able to manage his behaviour if he were to return home and she was supported to tell Child A of this decision.
- 3.13 When Child A left the therapeutic placement he went to live with a highly skilled and experienced foster carer who was employed by the Treatment Foster Carer Scheme in the London Borough of Hammersmith and Fulham, an innovative scheme aimed at offering intensive support for children with challenging behaviour within a family setting, that would prepare Child A for moving on to live with a long term foster family.
- 3.14 This placement lasted over a year and Child A was very happy there and enjoyed the "normality" of living in a family and made friends in the local community, although he was out of school for some weeks. However, the placement broke down following an incident when it was alleged that Child A sexually abused another child. The carer showed enormous commitment to Child A in that she continued to support him after he left her home and moved to another foster home and then a small residential unit, both of which broke down quite quickly as a result of Child A's deteriorating behaviour, including absconding and placing himself at risk.
- 3.15 At this time Child A had been assessed by Great Ormond Street Hospital. The assessment concluded that he did not have Autistic Spectrum Disorder (this had previously been diagnosed during an assessment by the CAMHS service during the period when he was at the residential therapeutic placement). The Great Ormond Street Assessment concluded that Child A's challenging behaviour was the outward manifestation of a deeply troubled child.
- 3.16 A placement was found for Child A in a small residential unit outside the borough, and before he was moved there all the necessary risk assessments were carried out to be clear about the possible risks to Child A as a result of his absconding, inappropriate sexualised behaviour, and suicide ideation, and safeguarding plans were put in place.
- 3.17 When Child A moved to the residential unit within another authority he, his family and professionals were optimistic about the placement. The family spoke warmly of the staff, and have been complimentary about the role the staff played in ensuring Child A was able to continue his monthly weekend visits to his family, transporting him there. The placement was matched to

Child A's needs and the manager of the unit had over 20 years' experience dealing with young people with challenging behaviour, including those who expressed suicide ideation.

- 3.18 Child A was out of school for some weeks following his move to the unit as it was in another geographical area and it took some time to find him a school placement, despite the fact that he had a Statement of Educational Needs. He was found a place at a local independent school for children with Autistic Spectrum Disorder. However, from the outset the school found his behaviour very challenging and were concerned about their capacity to safeguard him as he absconded frequently and when he did so, they felt he was placing himself at great risk.
- 3.19 Some weeks later Child A's mother died suddenly and unexpectedly following a routine operation. Child A was devastated by the news, and although outwardly he appeared to be coping, there were signs of deep inner turmoil and distress.
- 3.20 Child A was permanently excluded from school a few weeks later, as his behaviour had deteriorated further. He was running away more and more and the school felt they could not keep him safe. On the last occasion when he ran away the police deemed it to be a critical incident and had a helicopter on standby to look for him, before Child A was found at a local railway station.
- 3.21 Professionals were so concerned about his welfare that a referral was made by the social worker in the London Borough of Hammersmith and Fulham to the Child and Adolescent Mental Health Service that was local to where he was living. It is positive that they gave him an emergency appointment within 48 hours. Child A went to the emergency appointment with his social worker from the London Borough of Hammersmith and Fulham, his key worker from the residential unit, and the manager of the unit. He was seen by two mental health nurses, fully trained in doing such emergency assessments. They concluded, on the basis of talking to Child A and to the other professionals, that Child A was not at risk of suicide and they agreed with the view that the level of supervision in place at the unit was perhaps having an adverse effect on him. It was agreed that the level of supervision in the unit should be relaxed somewhat.
- 3.22 Eight days later Child A had been out roller skating with other young people from the unit and a member of staff. When they returned to the unit both boys ran away. Child A was found quickly and was returned to the unit and went to bed. The member of staff went to look for the other boy. Another member of staff was in the unit and asleep. When the member of staff returned in the early hours of the morning having found the other boy, he looked in on Child A who was sitting on his bed. A few hours later, during a routine check, Child A was found hanging from the back of his bedroom door. The emergency services were called but he was already dead. He had left a note to his family to say that he was sorry, but that he wanted to be with his Mum.

4. KEY ISSUES EMERGING FROM THE CASE

- 4.1 **Understanding the Impact of Neglect and Emotional Abuse on Child A's Life:** It is the author's view that at the time Child A was living at home professionals did not fully understand the impact that neglect, emotional abuse and separation anxiety had on Child A's life, compounded by the trauma of witnessing his father's death and the feelings of guilt and anxiety that stemmed from this. This was practice ten years ago and there is evidence that practice today is much improved, evidenced by the recent Ofsted inspection of children's services.
- 4.2 **Effectiveness of the Child Protection Plan:** There is evidence that at the time Child A and his siblings were subject to a child protection plan that it was not robustly implemented, monitored and reviewed, but again, this relates to historical practice and there is evidence that current practice is now improved. There is currently work underway by the Local Safeguarding Children Board to increase the attendance of general practitioners at child protection conferences and there are signs of increased participation.
- 4.3 **Professional Responses to Chaotic Families:** There is a lesson emerging from this case that at the time this family was not recognised and responded to as a "chaotic family" as defined by Marian Brandon¹, and in that sense Child A and his siblings may have become "invisible children" as she describes, and their individual needs not fully recognised.
- 4.4 **"Hard to Help" Young People and Suicide:** Another emerging theme is that Child A fitted the profile of a "hard to help" young person as defined by Marion Brandon² and those young people in her study who had ended their life through suicide.
- 4.5 **Corporate Parenting, Drift and the Role of the Independent Reviewing Officer:** There is evidence throughout Child A's time in care that there was drift in achieving permanency for him that would have provided him with a sense of identity. Despite the fact that Looked After Reviews were held regularly (although some were out of timescale and real opportunity was lost to drive forward planning by bringing review meetings forward at critical incident points) there was no sense that there was a robust care plan in place that was being implemented to achieve clear and measurable outcomes for Child A. Children's Services had been placed in a difficult position at the time the Care Order was granted. Whilst they had wanted to provide him with security through permanent substitute care, given his young age, the Children's Guardian had ambivalent views about this and did not rule out the possibility of a return to his family later, depending on the outcome of the therapeutic placement. How this was to be assessed and

¹ Marion Brandon et al, Analysing Child Deaths and Serious injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.

² Marion Brandon et al, Analysing Child Deaths and Serious injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.

monitored was not made clear at the time, so the expected outcomes in terms of meeting A's identified needs were not clear. This in turn did not help Child A, who really only wanted to go home, and did not understand why this was not possible. This fed into his underlying anxiety and fuelled his emotional distress. It was four years after he came into care that it became clear that he would not be able to return home to live, and by this time his behaviour had deteriorated further and finding him a suitable long term foster placement had become even more difficult.

- 4.6 **Understanding the Impact of Bereavement:** There is evidence of some very good practice at the time Child A's mother died by the way in which he was told the news. It was handled with care, sensitivity and insight by the professionals involved. However, as the weeks passed the reaction of some professionals underestimated the ongoing impact on him and one professional involved with Child A commented that he had "coped brilliantly", when in fact there was evidence from his deteriorating behaviour that he was not coping. Professionals with an understanding of the grieving process would have understood that seeing little reaction in the initial stages does not indicate that the person is "coping brilliantly" but is symptomatic of the first stage of bereavement: shock and disbelief.
- 4.7 There is research³ to indicate that children and young people who manage best following the death of a parent are those where a number of mediating factors are in place. The factors that are likely to indicate a worse adaptation include: losing a parent suddenly; loss of a mother; loss of a less well functioning parent (linked to more anxiety, depression, and sleep and health problems); less cohesive families; families with a large number of stressors. All of these factors were features in Child A's life.
- 4.8 **Management Oversight and Supervision:** The overview author has approached the subject of management oversight and supervision from the perspective of all the agencies involved in this case and there are examples in several of the agencies where this serious case review has shown that, with hindsight, supervision practice and management oversight could have been more robust. The respective Individual Management Reviews have identified this where applicable, and have put actions in place, through their recommendations and action plans, to address this. These have been quality assured by the Serious Case Review Panel of the Local Safeguarding Children Board.
- 4.9 It has been important to explore the effectiveness of supervision and management oversight in particular from the perspective of the delivery of the Children's Service's functions, including the social work service and the corporate parenting function and the role of the Independent Reviewing Officer, given their lead role in safeguarding. There is little doubt that Child A's case would have been a "difficult" case to have on any caseload, and there is evidence that the case became increasingly complex and "difficult" as the years passed and the plan to provide him with permanency appeared

³ Worden, W (1996) Children and Grief: when a parent dies. New York: Guildford Press

to become increasingly difficult to achieve. Complex cases such as this require high levels of support and supervision, including an element of reflective practice, to assess the effectiveness of interventions as well as understanding the emotional impact of the case on the worker, to ensure safe practice⁴. Child A had the same Independent Reviewing Officer the whole time he was in care, which was positive because it provided continuity. However, there is an issue that has emerged through this Serious Case Review, which reflects a national issue and is not confined to this case: that is, that self-employed IRO's who work for the authority on a sessional basis, are not required to participate in formal supervision arrangements as a substantive member of staff would be. The reality of this was that, although the IRO chaired Child A's statutory reviews for seven years, he received no formal supervision from his line manager, which would have provided the opportunity for reflection between supervisor and supervisee on the factors that might be affecting decision making, including any personal biases and beliefs about the case⁵ and reflect on the effectiveness of interventions in achieving good outcomes for the child. An analogy can be drawn here in relation to issues raised in the CAFCASS IMR about the self employed status of the Children's Guardian and the lack of formal supervision arrangements. These are both national issues.

Information Sharing and Notifications Regarding Out Of Borough Placements

- 4.10 There is evidence that despite being organised in an emergency Child A's placement in the small residential unit outside the Borough was an appropriate one that matched his identified needs. Several risk assessments were undertaken in the period prior to his placement that resulted in additional safety and supervision arrangements being put in place to meet his complex needs. Child A liked it there and his family were happy with the placement.

However, the case has highlighted that the receiving authority had not been notified of his placement there, and although there is no evidence that this materially affected the outcome for him, it is a regulatory requirement that placing authorities should notify the receiving authority of children in care placed outside the local authority which holds parental responsibility.

Could Child A's Suicide Have Been Predicted?

- 4.11 Rubenstein developed a model of suicide risk factors⁶. With hindsight there are a number of factors that resonate with Child A's experiences. Despite significant input from the residential therapeutic placement over a four year period Child A remained a highly anxious and troubled child and the resilience he was able to develop does not appear to have been sufficient to enable him to develop his own coping strategies by the time he moved to the out of borough residential unit and his mother died. Given the suicide of his

⁴ Staff Supervision in Social Care, Morrison. T, 2001

⁵ Monro, 2008, 2010.

⁶ Suicidal Behaviour in "normal" adolescents: stress and protection in different family contexts, Reubenstein, J. et al, American Journey of Orthopsychiatry, 1998.

father, this was a real option for Child A as it had been played out in front of him (literally) at a young age. With the benefit of hindsight there were many stress factors present that would deem that his suicide was not totally unexpected.

Could Child A's Suicide Have Been Prevented?

- 4.12 There is evidence that the school, the police and the social worker were very concerned about the risk of suicide to Child A as his behaviour deteriorated following the sudden and unexpected death of his mother. The school had excluded him because they said they were unable to keep him safe and the police had deemed Child A's disappearance to be a "Critical Incident" in terms of their response on the last occasion he ran away. The social worker outlined her concerns in the faxed referral to the local CAMHS, and it was good practice that she did this so quickly after the concerns raised by the school and the police.
- 4.13 There is evidence of an over optimistic perspective taken by the staff at the residential unit and the mental health nurses who conducted the emergency CAMHS assessment, with an over reliance on how Child A presented himself verbally during the assessment, giving verbal re-assurances that he would not harm himself. They deemed that he was not at risk of suicide, and it was agreed between them and the social worker that the level of supervision in the unit would be relaxed somewhat as Child A was finding it overly oppressive. Good practice would suggest that this assessment should have been triangulated through an in depth discussion with the social worker, an analysis of the written social history and full background information. The decision to relax the level of supervision in the unit should have been made as the result of an inter-agency planning meeting.
- 4.14 It is not possible to know with any certainty whether Child A's suicide was planned or what triggered it, and in that sense it could not have been prevented. In the author's view, his suicide was an outward expression of his deep emotional distress and turmoil. Factors contributing to this were likely to have been his overwhelming feelings of distress and grief following the death of his mother and his recent exclusion from school as a consequence of his absconding behaviour. There had also been a recent allegation from one of the other boys at RES 2 that he had touched him in an inappropriately sexualised way, and on the evening before he committed suicide there was an alleged physical assault by a member of staff at the unit, who attempted to restrain Child A.

Update on Actions Already Undertaken to Improve Practice in Response to Lessons Learnt from the Serious Case Review

- 4.15 Each agency which submitted an Individual Management Review was also required to submit an action plan, based on the recommendations made. Some agencies have already completed some of the actions as deemed appropriate.

5. OVERVIEW REPORT RECOMMENDATIONS

5.1 Explanatory Note to Recommendation 1

There is evidence that Child A was a very troubled child with complex needs who had from an early age shown some disturbing behaviour including suicide ideation and fire-setting. As he became older the compounding effect of those needs, combined with life events and his experiences in care resulted in this being a very complex case in which it became increasingly difficult for professionals to meet his needs.

5.2 Recommendation 1

Local Recommendation

That the Local Safeguarding Children Board commissions, through its Quality Assurance Sub Committee, an audit of all children in care to identify whether or not there are other children like Child A, so that professional attention can focus on ensuring that their needs have been identified and that the appropriate services are in place and are being effectively engaged. The profile of “hard to help” children referred to in the report (paragraph 4.4) may help identify these children. The Children’s Trust Board should ensure that the appropriate multi-agency resources are in place for children with suicide ideation. The LSCB will monitor the effectiveness of these arrangements.

5.3 Explanatory note to Recommendation 2

There is evidence that this was a complex case that needed devoted thinking time, for reflection and analysis.

5.4 Recommendation 2

Local Recommendation

That the LSCB, together with Children’s Services should create a multi-agency forum to consider complex cases such as this, consider the issues and find a way forward, in order to achieve better outcomes for the child and discharge fully the Borough’s corporate parenting responsibilities. This forum could be used to develop a virtual “team around the child” (to include children’s services, education, and CAMHS) that would ensure integrated thinking in relation to the child’s needs. This team would maintain their collective responsibility for ensuring appropriate intervention and support to meet the identified needs of the child, regardless of the placement.

5.5 Explanatory note to Recommendation 3

There is evidence that foster carers caring for children with complex needs like Child A must be appropriately approved and receive high levels of support

Recommendation 3

5.6

Local Recommendation

That the Borough ensures that children with complex needs like Child A are placed with carers who have the appropriate skills to meet these needs that have been identified during their approval as carers, and that they are given an appropriate package of support, including support from their supervising social worker and effective mental health advice and support, either through specialist services embedded in the local authority or through the local CAMHS service. This applies to both in-house and agency carers.

5.7

National Recommendation

The matter to be taken up with the Department for Education by the LSCB Chair.

5.8

Explanatory note to Recommendation 4

There is evidence that although the Care Proceedings in 2004 resulted in a Care Order being granted, the lack of clarity and ambiguity about how the care plan could be effectively discharged by Children's Services left them in an invidious position and contributed to the difficulty in achieving good outcomes for Child A and that this remains an issue that needs resolving

5.9

Recommendation 4

Local/Regional (London) Recommendation, and National Recommendation

That the issues from this Serious Case Review relating to the Care Proceedings and the role of the Children's Guardian vis a vis the responsibility of the local authority to discharge the care plan are taken up by the LSCB Chair with Cafcass and the courts, both locally and nationally.

5.10

Explanatory note to Recommendation 5

There is evidence of drift in care planning during the years that followed Child A coming into care. There was drift in achieving the permanency that he needed and there were two factors that contributed to this drift: that is, the length of time it took for the care proceedings to conclude (2 years) and the ambivalent views of the Children's Guardian about whether or not he should return to his mother's care in the future. Over time, these issues compounded the difficulty of all other efforts to provide him with permanent substitute care, when all he really wanted was to go home to his mother.

Recommendation 5

5.11

Local Recommendation

Children's Services to ensure that the appropriate systems and guidance are in place to a) improve outcomes for children and reduce drift in care planning b) reduce the length of care proceedings and c) ensure that the Independent Reviewing Officer function in the Borough provides a robust

and effective challenge to delay in care plans being implemented

Additionally, to ensure that they and others are fully conversant with their authority (under the April 2010 Regulations, including the Independent Reviewing Officer Handbook), including use of escalation processes and other information from IRO monitoring forms to report regularly to the corporate parenting group, to ensure that the voice of children in care in the Borough is heard.

National Recommendation

5.12 The LSCB Chair to write to the Department for Education to raise the issue of delays in care proceedings and the principle of no delay (through Cafcass), and with the Ministry of Justice in the discharge of their duties with the Family Court. Additionally, that care proceedings must provide a clear outcome that facilitates a permanent solution for a child to either be returned home or placed with an alternative permanent family.

5.13 Explanatory note to Recommendation 6

There is evidence that Child A's mental health and emotional needs were not adequately reviewed in the light of changing circumstances.

Recommendation 6

5.14 Local Recommendation

That the emotional and mental health needs of children in care are fully and rigorously addressed through the Statutory Review process, including the use of information gathered through the annual health assessment and the Strengths and Difficulties questionnaire, and that systems are put in place to ensure arrangements are in place for a CAMHS professional to take the lead responsibility for the plan to meet the child's mental health needs, to monitor how those needs are met and to ensure that appropriate information is provided to the Statutory Review meetings. A virtual CAHMS for children like Child A should replicate the education model of a "virtual school", with a virtual head.

5.15 Explanatory note to Recommendation 7

On reflection there is evidence that the emergency CAMHS assessment undertaken by East Kent CAMHS on 5 February 2010 was not adequate in terms of triangulating all available information on Child A and relied unduly on his presenting behaviour, and in terms of appropriate follow up.

Recommendation 7

5.16

Regional Recommendation

That the LSCB chair will write to the chair of Kent LSCB and request that they monitor the implementation and effectiveness of the recommendations and action plan submitted by East Kent CAMHS in their Individual Management Review.

- 5.17 **Explanatory note for Recommendation 8**
There is evidence that planning and risk assessment following the death of Child A's mother could have been more robust and the impact of bereavement on his emotional wellbeing appears not to have been understood by some professionals and taken into consideration.

Recommendation 8

- 5.18 **Local Recommendation**
That the Local Safeguarding Children Board, through the named lead for Looked After Children in the CAMHS service, should ensure that advice and guidance is available for social workers and carers and other professionals, such as teachers, involved with children who have experienced a bereavement or significant loss.

- 5.19 **Explanatory Note for Recommendation 9**
There is evidence that management oversight and supervision arrangements within agencies were not robust enough.

Recommendation 9

- 5.20 **Local Recommendation**
That the LSCB ensures that all partner agencies have robust supervision policies in place (including the use of escalation) and that the effectiveness of these is audited by the QA sub-committee. This should specifically include ensuring that self employed IROs conducting statutory reviews on a sessional basis are subject to regular, formal, recorded supervision as part of their contractual arrangements. This is an issue both locally and nationally.

- 5.21 **National Recommendation**
That the LSCB Chair will write to the Department for Education to outline concerns about the supervision of self-employed IROs highlighted by this case.

- 5.22 **Explanatory note for Recommendation 10**
There is evidence of lack of robustness in identifying, investigating and assessing the risk of sexual abuse by a child to another child, and to understand the impact of this on the children involved.

Recommendation 10

- 5.23 **Local Recommendation**
The LSCB to develop a service for assessing the needs of children who demonstrate sexually harmful behaviour.

- 5.24 **Explanatory note for recommendation 11**
There is evidence that where children are placed out of Borough that notifications and the sharing of essential information about the child does not always take place. The potential difficulty of this is compounded for children

who persistently go missing.

5.25 **Recommendation 11**

Local Recommendation

The LSCB should ensure that all proposed out of Borough placements are in the best interests of the child and comply with the Care Planning, Placement, and Case Review Regulations 2010 (section 11 (2) (b)) and that effective arrangements are in place to ensure that the appropriate notifications are made when a child is placed out of the Borough, to include a checklist and full assessment with an appropriate support package that will accompany the child to ensure that all relevant agencies within the receiving authority are fully informed and able to meet the child's needs.

5.26

National Recommendation

All local authorities when they place a child in another local authority must ensure that they notify the receiving local authority of the placement and outline any specific vulnerability should they go missing or run away as part of that notification.

6. **INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS**

Children's Services London Borough of Hammersmith & Fulham

- 6.1 Put in place an effective mechanism to track and ensure the timely delivery of approved care plans for children looked after. There should be a clear relationship between this mechanism and the functions of the current permanency and resources panels and the statutory review process.
- 6.2 In conjunction with the Children's Trust, ensures effective means to deliver therapeutic input to children looked after at the time they need it.
- 6.3 In conjunction with the Children's Trust, ensures effective means to jointly fund placements within a time frame commensurate with the child's need.
- 6.4 Provides all current first line field work managers with a practice based programme of skills development in child sexual abuse and ensures their competency in this field.
- 6.5 Ensures that sexual abuse is a key component of local provision for the continuing professional development of all practitioners on the front line.
- 6.6 Establishes a working protocol that ensures an assessment of need of those children remaining in a family when a child of that family has become looked after and that the respective roles of workers in children in need and children looked after services are clear in relation to future work with children of this family.

- 6.7 Uses a standard format for recording case supervision that includes the mandatory requirement for an up to date chronology for the child and that consideration is given to identification of key associated documents alongside entries on the chronology.
- 6.8 Ensures that both electronic and hard copy records are effectively maintained to provide a full history of each child looked after and that relevant information is available to practitioners with a need to know and to the child as required.

It is recommended the LSCB:

- 6.9 Develops protocols that ensure children at risk receive the specialist services to which they have been referred. These protocols will include service providers and be integral to existing child protection processes.

Children's Services, Kent

- 6.10 No recommendations.

Metropolitan Police

- 6.11 No recommendations

Kent Police

- 6.12 Details of 'looked after children' who have been placed in Kent care homes or schools, should be passed to the relevant Police BCU Intelligence Unit. Such information should include any vulnerabilities relevant to that child. Preferably, this information should be collated by Kent Social Services and then passed to the Police rather than receiving routine lists from individual care establishments.
- 6.13 Police BCU Intelligence Units should consider collating information regarding 'looked after children' from other areas and who have been placed into residential care in Kent. Details of children with specific vulnerabilities should be placed on to the Genesis computerised intelligence database. Such action would result in more co-ordinated incident management and allow a reference point for investigation and recording.
- 6.14 The new computerised missing person management system known as 'Compact', should be evaluated to ensure it is fit for purpose and has specifically addressed the issues raised within this report. This evaluation should particularly address the issues of recording, transfer of information to the Missing Person Officer and the Child Abuse Investigation Unit, follow up visits, liaison with the Social Services Department and the acquisition of statistical information.
- 6.15 The Public Protection Unit at Force Headquarters should undertake a

thematic inspection of policy and working practice at the East Kent BCU, as it relates to children missing from residential care homes. Whilst a number of issues of concern were identified during the review, the Individual Management Review Author has been assured they have now been addressed by the introduction of appropriate remedial measures. This assertion should be confirmed by such an inspection. Such an inspection should also consider the level of police resourcing applied to the management of missing children, particularly with regard to the disproportionately large number of looked after children placed in residential homes in Thanet.

- 6.16 Investigators should be given clear instruction as to the process of taking samples from the body of a child who has died suddenly or in circumstances where the Police have become involved. Such instruction should include the management of the body's transportation to a hospital or mortuary, the type of samples to be taken, the venue and the need to obtain the permission of the Coroner. This recommendation would result in the acquisition of appropriate samples and the avoidance of obtaining material or fluids from a child's body, which are not required.

South East Coastal and Ambulance Service (SEACAMB)

- 6.17 No recommendations

GP (Hammersmith & Fulham)

- 6.18 The records of vulnerable children, children with child protection plans or looked after children should contain a summary of significant events or problems, this should be encouraged as good practice on a national basis by contact with the Royal College of General Practitioners (RCGP).
- 6.19 There should be a national process for the transfer of GP records for Looked After Children that recognises that these children often have frequent moves and that information arriving at the practice after the child has transferred should be forwarded immediately to the next practice.
- 6.20 The recommendations for general practice will be incorporated into the action plan for NHS Hammersmith & Fulham.

Central London Community Healthcare

- 6.21 CLCH should review its procedures for the transfer of records both within and outside of the borough. CLCH should at all times retain a copy of the original notes for children that are subject to Child Protection Plans, Looked after Children and families that have been identified as vulnerable. Good practice for the transfer of records should include verbal handover between practitioners and from supervisor to supervisor.
- 6.22 CLCH should provide clear guidance to staff on their role and responsibilities in record keeping, with particular reference to the location of documentation

relating to safeguarding concerns and how staff can access these easily. This review should include the LAC nursing team. The location of documentation pertaining to safeguarding supervision action plans should also be included in this.

- 6.23 The CLCH School Nursing Service should develop a procedure for timely assessment of a LAC that moves to a school in the area.
- 6.24 CLCH LAC team should work with Hammersmith and Fulham Children's Services and Chelsea and Westminster NHS Trust to develop a monthly planning meeting for LAC to aid communication around annual reviews and to avoid delays in these.

Chelsea & Westminster Hospital Foundation Trust

- 6.25 An audit of communication about children with known safeguarding concerns attending the paediatric emergency department and admitted to the wards in 2010 has been carried out. It was recommended that this be extended to Looked after Children. This focused specifically on attendance for statutory health assessments and the process for following up those who do not attend. This was done with reference to the policy- '*Guidance for the referral system for statutory health assessments for LAC (H&F social services and C&W Hospital)*' and also section 7 of the C&W Safeguarding Children and Young People policy which refers to the follow up of children who do not attend appointments.
- 6.26 All LAC medicals, health appointments, investigation appointments / other formal contact with the Trust is recorded on the Trust EPR system as a permanent record so that a system is in place to ensure that a record trail is shared and owned by the 3 key agencies responsible for LAC.

East Kent Hospital University Foundation Trust and CAMHS (Kent)

- 6.27 Clear family mental health information/history and relevant safeguarding information such as sexual risk to self/others should be sought before an urgent risk assessment is undertaken or elicited at assessment when this is not possible
- 6.28 The EKHUFT in house urgent risk assessment training should be updated to include the need to obtain family mental health information/history and relevant safeguarding information such as sexual risk to self/others.
- 6.29 A follow up appointment should be routinely booked to take place within 7 days of an urgent risk assessment.
- 6.30 For looked after children the allocated social worker (or representative) and staff from the placement or parent /carers should be in attendance at urgent risk assessments to ensure divergent and relevant views are heard.

- 6.31 The letter detailing the outcome of the urgent risk assessment should be sent to all parties within 24 hours/1 working day.
- 6.32 There needs to be further detailed teaching for relevant Health Professionals regarding the Child Death Review Process, what examinations and what samples, etc, should be taken dependent on the situation and this should be made much clearer for all those dealing with these situations.

East and Coastal Kent Community Services PCT

- 6.33 A complete Review of the LAC Service Administration had been initiated prior to this Review. This should include all LAC written guidelines / protocols. Emphasis should be placed on new guidance being user friendly, relevant and linked if necessary to other national and local guidance.

West London Mental Health Trust

- 6.34 To ensure participation in the Child Protection process, including attendance at Child Protection Case Conferences and Core Group meetings.
- 6.35 Risk to child/ren and the impact of mental ill health on the child/ren should always be explored and considered at clinical supervision.
- 6.36 The current risk assessment is in a format that is adult biased. There needs to be specific risk assessments for children.

Education, Kent

- 6.37 The training for the Designated Teacher for LAC in independent schools admitting a LAC child to request routinely – chronology, care plan, last LAC Review and any other background and risk assessment information on the child so that school is able to fully determine the suitability of the placement for the child. This information to be shared as part of the admission interview with the child. (Para 6.1 and Para 6.3).
- 6.38 Kent to revise and strengthen its notification process of OLA LAC in line with care planning placement and case review guidance (CPPCR). (Para 6.7).
- 6.39 Consider revision of the statutory guidance for school Governing Bodies to include provision of training and support and advice for Designated Teacher for LAC within independent schools. (para 7.2).
- 6.40 The Local Safeguarding Children Board Missing from Home or Care Procedures to be reinforced in the training for Designated Teachers for LAC within maintained and independent schools.(Para 7.5). (The KSCB Guidance is currently under review).

Education, London Borough of Hammersmith & Fulham

- 6.41 The Service Manager LAC the SEN Manager and the Virtual School Head establish a securely effective system of timely communication between LAC Social Workers and SEN services when a change of foster placement or change of school takes place.
- 6.42 Provide regular joint training and knowledge sharing opportunities for Children’s Social Workers and IPS Caseworkers
- 6.43 To ensure that Lead Professional responsibility is appropriately assigned
- 6.44 That the Director of School Improvement in consultation with the Director of Children’s Services consider increasing the access level to Framework–i, the electronic database, for IPS Caseworkers in those cases where a Statutory Assessment is being carried out for LAC.
- 6.45 That the timeliness, frequency, and quality of communication between authorities when a LAC child with a Statement of Special Educational Needs is moved from one authority and placed with another is improved.
- 6.46 To ensure that the voice of a LAC child is always sought and heard when changes of education placement are being considered.

School 6

- 6.47 School 6 will establish an audit protocol for monitoring the receipt of official LAC Review and other formal Reports and for reliably securing them when they have not been supplied by the responsible authority within 3 months of the review/assessment meeting having occurred.
- 6.48 School 6 senior managers will produce a policy that
 - first, will identify the range of discussions and communications about children and key events that require a note/record to be made and
 - second, will ensure that a recording, however brief, of such internal or external communications or meetings is made and preserved in its files.

School 6 will further identify and implement a solution, electronic based or otherwise, that will reliably and securely store email/electronic communications about a child placed there. This storage solution will be compliant with Data Protection legislation and with all relevant child care standards and regulations for preserving children's records.

- 6.49 As advised that it is actually engaged in doing, School 6 should establish a formal partnership with a fully registered independent fostering agency (IFA) that will enable it to offer prospective placing authorities the option of a complete 52 week “placement package”.
- 6.50 School 6 will review arrangements within its households and across the organisation for making and receiving the agreed telephone contacts

between children and their parents, siblings or carers. It will then produce a system that more reliably ensures the effective “delivery” of such arrangements, including its own active following up of failed occasions to ensure that the call is then made as soon as possible.

ORG 1 Homes (RES 2)

- 6.51 The supervision policy and training provided to all residential workers should be based upon the principles outlined within, ‘Working together to safeguard children. A guide to interagency working to safeguard and promote the welfare of children’. March 2010. This will help to enable a greater focus on the child, avoid drift, maintain a degree of objectivity and challenge fixed views, test and assess the evidence base for assessment and decisions, and address the emotional impact of work.
- 6.52 Introduce regular audits of supervision, particularly when supervision is undertaken by senior residential workers.
- 6.53 A professionals meeting should be requested by ORG1 Children’s Services when the therapeutic needs of ‘hard to help’ young people are confusing and without focus.
- 6.54 A professionals meeting should be convened by ORG 1 Children’s Services when there is a safeguarding issue regarding any young person and there is consideration by any professional involved in the care of the child of a reduction in risk management.
- 6.55 A professionals meeting should be requested by ORG 1 Children’s Services when high risk has been identified by another agency, in order to properly assess and manage risk to a young person.
- 6.56 The risk assessment policy should be a separate document focusing on risk to children and young people. Separate in depth training must be provided to all residential worker’s to include assessment as a process over time. This should be integrated into the safeguarding policy and practice within the organisation. This policy must be comprehensive, showing a model of risk analysis, and giving clear guidance on indicators of risk and significant events, reassessment, and a clear indicator of when a manager should be alerted.
- 6.57 Ensure all residential workers are aware of the current risk assessment of individual young people to enable protection of young people.
- 6.58 All residential workers should be provided with training on the profile of ‘hard to help’ young people and suicide risk. Current research into suicide and how can we know the risk is heightened. Significant events. Loss and rejection, including change. Attachment theory: behaviours typical of

disorganised maltreated children.

6.59 All residential workers must be provided training on the protocol of what to do in an emergency situation when a child is found to be harmed, or believed to be dead.

6.60 All internal door closures to be removed from the bedroom of young people placed at ORG 1 Children's Services.

CAFCASS

6.61 Existing plans to improve Cafcass file archiving to be concluded in line with case recording policy already in place.

6.62 The Head of Service to establish compliance with existing policies/usual current practice in respect of:

- Supervision (and Contract Management for self-employed contractor) including managerial oversight of active cases
- Safeguarding Framework, including ensuring comprehensive assessment of risk of significant harm for all children in families subject to care proceedings
- Case recording, including evidence of effective challenge of LAC long-term plans for all children in family.

6.63 The learning points from this serious case review to be disseminated in each Cafcass Operational Area.

Oxfordshire and Buckinghamshire Mental Health NHS

6.64 When a Looked After Child is receiving OBMH services, clinicians must be active in asking for records of Looked After Children Reviews and must endeavour to participate in reviews.

Great Ormond Street

6.65 The Social Communication Disorder Clinic should incorporate a standardised framework which allows them to request key information such as a request for a formal risk assessment from the Referring Local Authority where child protection concerns exist / or the Local Authority holds statutory responsibility. They should also discuss with the referrer the level of urgency of the referral in relation to those risks at the time of the initial referral in order to assess and agree immediacy of need.

6.66 Due to the complexity and specialist nature of the Professional assessments requested, the Clinic should ensure that, where there is social care involvement with the child, dissemination of findings is communicated to the correct level of professional management in order to ensure that the information can be incorporated into the overall plans for the child /young

person. Therefore, where social care is involved the Social Communications Disorders Clinic should request that a minimum of team manager level is in attendance and the minutes are copied to them as well as the allocated social worker.

In addition, it is important to ensure that roles, boundaries and expectations are clear within the context of the work to avoid confusion at the beginning of each assessment and to ensure appropriate representation from involved Local Authority Social Care departments who have overall statutory responsibility for the child.

6.67 The Clinic should ensure that the period between verbal feedback meetings and the report being agreed by the Clinic and sent in writing to the referrer and appropriate professionals should not exceed a period of 28 days unless there are clear and compelling reasons to do so, that are documented. This will ensure that both findings and any issues raised within the feedback meeting are reinforced within a written document.

6.68 In line with the GOSH Child Protection Training Strategy, the Social Communications Disorders Clinic will be directed to undertake bespoke child protection training at level 3 and its administrative staff should access child protection E learning at (level 2) as a minimum requirement

6.69 The Social Communications Disorders Clinic should explore the feasibility of developing and incorporating a consultative pathway with GOSH social care managers in order to add to the understanding of the appropriate processes for accepting referrals to the Clinic and of the structure/configuration of community services in terms of referrals to the service where there is a statutory component

South London and Maudsley CAMHS

6.70 No recommendations.

Imperial College Healthcare NHS Trust

6.71 In order to ensure that ICHT staff are sensitised to the challenges of equality and diversity in their medical and safeguarding practice, an audit of the compliance of consultants, therapy and nursing staff band 5 and above in ICHT Clinical Programme Group 5 (CPG5 -Women's and Children's services) with equality and diversity training - as part of statutory and mandatory training - is to be carried out by 31.12. 2010. Should this audit reveal that fewer than 80% of this group of CPG5 staff are up to date with equality and diversity training, a training drive will be implemented to rectify this by 30.06.2011. The Trust has an Equality and Diversity Manager who will support the training drive by a presentation to the Paediatric Grand Round on 06.12.2010. The presentation will focus on Equality & Diversity issues in paediatrics. A list of CPG5 staff who are consultants, therapy staff and nursing band 5 and above is available (the denominator). Staff have access to a number of means of training: statutory and mandatory training days, an e-learning programme. Training numbers are recorded

electronically via the OLM system (the numerator). Training is monitored by the ICHT Education Department. The Trust's Equality and Diversity lead will be invited to be a member of the ICHT Safeguarding Children Board and equality and diversity issues in relation to safeguarding children and young people will be a standing item on the board's agenda.

- 6.72 Information regarding attendance at hospital for all children and young people who are Looked After will be shared with the allocated Social Worker as well as the GP (and HV or school nurse where applicable). ICHT Safeguarding Children and Young People Operational Policy will be amended to reflect this by 31 December 2010. Training in relation to looked after children will be included in ICHT safeguarding children training at levels 2 and 3 with immediate effect in the case of face-to-face training and by 31.12.2010 for e-learning training. The current ICHT review of documentation, in preparation for the institution of electronic records, will be a standing item on the ICHT Safeguarding Children Board board's agenda. The Trust's Lead Nurses for Information and Technology will be invited to be a member of the safeguarding board. Consideration will be given to the provision of fields in the new electronic record to record the care status and name and contact details of the SW for all children attending the Trust.

This recommendation is to ensure that there is heightened awareness of the vulnerabilities of looked after children, means of appropriate information collection and education about the high importance of ensuring that information about the health needs of looked after children is shared with social care as well as other health agencies.

- 6.73 Standard procedure within ICHT is for discharge summaries for all children and young people attending to be forwarded to the GP, HV/SN and a copy given to the parent/carer with clear follow up plans where appropriate. Any concern about immunisation status should be explained to the parent/carer, documented in the child's hand held health record ('Red Book') where possible and clearly stated on the discharge summary. ICHT will reinforce the need for accurate documentation and processing in discharge summaries on all children and young people with immediate effect. To support this, Paediatric and A&E staff will carry out an audit of recording of immunisation status and response to lacunae therein in children subject to Child Protection Plans attending SMH, ICHT. This audit is to be presented at the Paediatric Audit afternoon in July 2011. The current ICHT review of documentation, in preparation for the institution of electronic records, will be a standing item on the ICHT Safeguarding Children Board board's agenda. The Trust's Lead Nurses for Information and Technology will be invited to be a member of the safeguarding board. Consideration will be given to the provision of fields in the new electronic record to record the immunisation status of all children.

- 6.74 Consideration, with appropriate documentation, to be given to the welfare of all children and vulnerable adults in the family of a parent/carer who is a patient of ICHT by Trust staff learning of significant adverse event in the life of that parent/carer e.g. death or serious illness, death of partner. The Adult,

Child & Young Person and Maternity Safeguarding policies to be amended to reflect this by 31.12.2010. The current ICHT review of documentation, in preparation for the institution of electronic records, will be a standing item on the ICHT Safeguarding Children Board board's agenda. The Trust's Lead Nurses for Information and Technology will be invited to be a member of the safeguarding board. Consideration will be given to the provision of fields in the new electronic record to record the carer responsibilities of all adults admitted to the Trust.

Redbridge CAMHS/North East London Foundation Trust

- 6.75 That we continue to closely monitor waiting times ensuring that we do not breach our targets particularly for looked after children.

NHS of Hammersmith and Fulham, Health Overview

- 6.76 PCT to seek evidence from provider services that effective procedures in place to follow up children not engaging with services.
- 6.77 CLCH should review procedure for archiving of children's health records
- 6.78 PCT to ensure robust partnership arrangements are in place and monitored through contract for LAC health services
- 6.79 Personal Child Health Record (PCHR) should follow the looked after child or young person to placement.
- 6.80 PCT to be assured there is a process in place in community provider for receiving information regarding placements of looked after children and young people who are transferring in or out of borough.
- 6.81 Ensure a comprehensive Child and Adolescent Mental Health Service for looked after children.
- 6.82 GPs should ensure that records for looked after children and other vulnerable children are up to date and should include a summary of significant events and health issues.

Mayday Hospital, Croydon University Hospital

- 6.83 No recommendations.

Oxford Radcliffe Hospital NHS Trust

- 6.84 No recommendations

RES 1

- 6.85 Each child at RES 1 to have planned key work sessions, which are booked in advance. (paragraph 1.9) Management to ensure that this

recommendation is implemented effective from the 11th October 2010. This should ensure that children have the space and opportunity to express their views/feelings and give them a sense of empowerment.

- 6.86 Staff to be provided with training/clinical supervision regarding children's emotional well-being and therapeutic care. (paragraph 1.8) This has already been implemented by Management. This should ensure that staff understand and respond to children's emotional needs.
- 6.87 Systems of recording and ensuring that staff read children's information provided by an outside agency at the point of admission. In addition a system of quality assuring these systems to be implemented at RES 1. (paragraph 1.7& 1.10) This has already been implemented by Management.
- 6.88 Staff to be provided with ongoing Child Protection/Safeguarding training. (Paragraph 1.6) Child protection training was provided for staff group on the 6th October 2010.
- 6.89 RES 1 to ensure that children placed at the home are provided with an 'Internal Placement Plan' within 7 working days of the placement. (Para 1.17) This is to ensure that significant needs have been acknowledged and identified and a strategy/plan to ensure overall safety and well-being is known to entire staff group at RES 1, who will work with that child. This plan should be updated at significant events and/or regular intervals. This has already been implemented by Management.
- 6.90 Hammersmith to provide S.47 training to staff who hold 'Looked After Children' cases. (Paragraph 5.8) This is to ensure that staff are able to identify and respond appropriately to S.47 incident regarding children in their case. Hammersmith LA, are responsible for this recommendation. Timescale by the end of November 2010.
- 6.91 Quality Assurance/Independent Reviewing Officer to ensure that all placement moves and changes to care plans for children have a review within 28 days of the move. (Paragraph 6.5) This is to ensure that an Independent Reviewing Officer has oversight of the case, to ensure that the Care Plan for children are conducive to their overall development needs. Hammersmith LA, are responsible for this recommendation.
- 6.92 RES 1 to ensure that when children leave the organisation, their Internal Placement Plan/Care Plan devised by the home is copied and leaves with the young person. (Para 1.17) This will ensure that there is a system of consistent parenting for the child, as this is the most difficult and complex aspect of residential care. This policy should be considered as a National Standard Policy for all children in residential placements. Management at RES 1 are responsible for this recommendation.

Foster Care Associates

- 6.93 Compliance on annual reviews of foster carers with FCA operational standards

and procedures and with national minimum standards and fostering regulations 2002.

- 6.94 Compliance on supervision of foster carers with FCA operational standards and procedures and national minimum standards and fostering regulations 2002.
- 6.95 Provision of specialist training where identified as relevant for foster carers / supervising social workers.
- 6.96 Delivery of post-registration training of foster carers and actively encouraging foster carers to access such training available.