Kevin
Harrington
Associates
Limited

MS

SERIOUS CASE REVIEW: EXECUTIVE SUMMARY

Kevin Harrington JP, BA, MSc, CQSW

On behalf of the Havering (Interim) Local Safeguarding Board
Completed 10th November 2005

1. Introduction

1.1 MS was 17 years old when he took his own life on June 3rd 2005. He was a young person in public care, looked after by the London Borough of Havering.

1.2 In these circumstances, the London Borough of Havering, and the Havering Area Child Protection Committee, felt that there should be an independent review of the actions of agencies working with MS. A Serious Case Review was initiated in accordance with the government's guidance contained within Chapter 8, Working Together to Safeguard Children (1999). The Review focussed particularly on the last 9 months of MS's life, when he was living in Havering and supported by the Havering Leaving Care Service.

1.3 This is the Executive Summary of the report from that Serious Case Review. The report finds areas where services can be improved and examples of very good practice. In line with the conclusion of the Coroner's Inquest, it finds no evidence that might have alerted staff to the risk of MS taking his own life. This appears to have been an impulsive and unpremeditated act.

2. Serious Case Review Process

2.1 On 28th June 2005 Marilyn Richards, Executive Director of Social Services and Chair of the Havering Area Child Protection Committee (and its successor body, the Havering (Interim) Local Safeguarding Board), wrote to partner agencies to advise of her decision that a Serious Case Review should be carried out.

2.2 The agencies asked to contribute to the Serious Case Review were

- Havering Social Services Department
- Metropolitan Police
- Havering Primary Care Trust
- Barking, Havering & Redbridge Hospitals Trust
- North East London Mental Health Trust
- Havering College of Further & Higher Education
- Havering Housing Department
- Quadrant Supported Living
- Mosaic Housing

2.3 MS's family were offered the opportunity to contribute to this Serious Case Review but did not respond.

2.4 A specialist independent agency, Kevin Harrington Associates Ltd, was commissioned on lead the Review and draw up its report. A draft of that report was discussed at the Havering (Interim) Local Safeguarding Board on 7th November 2005. It was agreed that the report be updated to reflect the findings of the Coroner's Inquest and re-presented to a further meeting of the Board for confirmation.

2.5 The formal recommendations of the report are attached at Appendix A

3. Summary of events detailed in the Overview Report

3.1 MS had been known to a range of statutory agencies since 1986 because of concerns for his welfare. In 1999 MS became a looked after child, by agreement with his parents, and remained in care until his death. He spent most of that time in foster-care in Kent before moving back to Havering in August 2004. He always maintained contact with his family.

3.2 In October 2004 MS moved into "semi-independent" accommodation in Havering, supported by the Social Services Department's Leaving Care Service and the housing provider, Quadrant Supported Living. In November 2004 he started attending Havering College of Further and Higher Education. He was in a stable relationship with his girlfriend. At the time of his death MS had just made arrangements to move into a permanent tenancy. There was no evidence of dangerous misuse of drugs or alcohol. MS had no criminal record.

3.3 On June 3rd MS died by hanging from the back of an internal door in his flat. He had spent the previous evening there with his girlfriend, who stayed overnight. He had a telephone conversation with his mother the following morning. There has been no evidence of anything at that time that might have led MS to be particularly distressed or unhappy. He had never previously been known to talk of suicide and there had been no history of self-harming behaviour.

3.4 A post mortem found that death was by hanging, that there was no evidence of injury or violence and there was no pre-existing natural disease. There was no evidence of alcohol consumption but some indication of cannabis usage.

3.5 Agencies put comprehensive support arrangements in place for those affected by MS's death.

3.6 The Coroner's Inquest on November 8th 2005 found that MS had killed himself while the balance of his mind was disturbed. The Coroner noted that MS was not under the influence of drugs or alcohol at the time. She described his death as a spontaneous act which could not have been anticipated.

4. Key Themes and Lessons Learned

4.1 MS had frequent, purposeful contact with the Leaving Care Service and Quadrant Supported Living. He saw his social worker on 39 recorded occasions in the 9 months before his death, and his housing support worker 19 times. That contact was both structured and, when appropriate, responsive to unplanned events. Staff worked with him on issues of accommodation, employment, training, budgeting and self-care skills. They engaged well with him and felt that they were making good progress. "Front line" staff were supervised regularly and fully supported in their work.

4.2 MS would not talk with professionals about emotional issues or family relationships. Staff broadly accepted MS's position, concentrating on establishing productive working relationships with him, through their frequent contact. This was correct and there is no criticism of individual staff. However, it may be that other ways to assess and support MS's emotional well-being could have been found. In working with young people leaving care, there can be a tendency to over-concentrate on issues of practical support. The Children's Services Department should ensure that appropriate weight continues to be given to the emotional well-being of looked after children, as they approach their adult lives.

4.3 MS also resisted attempts to discuss his use of drugs and alcohol, which agencies had identified as a potential area of vulnerability. However, there was no evidence of high levels of substance misuse, or of MS behaving dangerously under the influence of drugs or alcohol.

4.4 The Review found evidence of consistent, mutually supportive contact and liaison between the primary workers. Agencies have decided to review their arrangements for sharing information, and the extent of information shared, in order to improve their risk assessment processes, but this Review found no serious cause for concern in the ways that agencies worked together.

4.5 MS had accepted a permanent tenancy from the local authority Housing Department shortly before his death. The Review noted indications that this accommodation was of a low standard. The Children (Leaving Care) Act 2000 seeks to ensure that good quality accommodation is part of the support that care leavers have a right to expect. The appropriate agencies were asked to review their arrangements in this area.

4.6 There had only been one previous Serious Case Review in Havering, some years ago. Some agencies had difficulty in complying with the timescales and quality standards for their submissions to this Serious Case Review, and the Local Safeguarding Board is recommended to issue more detailed guidance to partner agencies about this process.

4.7 There were serious concerns for MS when he became a looked after child, He was described as having low self-esteem, he could not get on with other people and he craved attention. He had moved on significantly by the time he was 17, and his personal resilience should be recognised.

4.8 At the same time, his death calls to mind the depth of potential vulnerability in our young people, particularly those in public care, and the need to ensure that our work with them is underpinned by a commitment to promote good mental health

APPENDIX A

RECOMMENDATIONS

Introduction

A number of agencies played no significant part in MS's life in the period under review, and have therefore not needed to make any recommendations in their individual agency Reviews. Some agencies have made detailed recommendations for internal action and they are not repeated here. The recommendations detailed below have significance for all agencies, even where they are addressed to specific services.

This Review, in line with guidance contained in *Working Together to Safeguard Children 1999* seeks to ensure that

- the number of recommendations for each agency is minimised
- recommendations are directly relevant to the content of the Review
- recommendations are specific and capable of being implemented

Recommendations to Havering (Interim) Local Safeguarding Board

1) The Local Safeguarding Board should remind all partner agencies of the guidance relating to Serious Case Reviews and the requirement to comply with that guidance

2) The Local Safeguarding Board should draw up a specification for the content of individual agency Management Reviews, setting out more precisely what is expected of agencies.

Recommendation to Havering Children's Services Department

1) The Department should review its use of Pathway Planning with Care Leavers to ensure that plans are based on holistic assessments of need.

Recommendation to Havering Children's Services Department, Havering Sustainable Communities Department, Quadrant Supported Living and Mosaic Housing

1) Agencies should review their practice in providing accommodation to care leavers, ensuring that all accommodation offered is of a reasonable standard.

Recommendation to Havering Children's Services Department and Quadrant Supported Living

1) The Leaving Care Service and QSL should review their current referral and information sharing arrangements.

Recommendation to Havering Primary Care Trust

1) The Primary Care Trust should review its arrangements for ensuring that the health needs of looked after children are properly met.