Serious Case Reviews – "Olivia" and "Yasmine"
Safeguarding Adult Review – "Carol"

Executive Summary and Board Response

Background

"Carol" was a vulnerable adult who was killed in December 2014.

"Olivia" and "Yasmine" – then aged 13 and 14 – were found guilty of her murder and in April 2016 were sentenced to 15 years in custody.

Two Serious Case Reviews were commissioned by the Hartlepool Local Safeguarding Children Board (Hartlepool LSCB) and a Safeguarding Adult Review was commissioned by the Teeswide Safeguarding Adults Board (TSAB).

The reviews were carried out by two experienced independent reviewers following the Learning Together model, a nationally recognised method of undertaking these types of reviews. The method looks at what happened in a particular case and also considers the wider implications for local and national learning.

There was some delay in the review proceedings because of criminal processes which took 16 months to complete. This did not prevent early data collection, or key agencies reviewing their existing services to see what immediate action might need to be taken.

All members of each board wish to express their deepest condolences to Carol's family for their loss.

Summary

All three reviews found that no professional or agency could have foreseen that Carol would be murdered, or predicted the actions of the young people.

However, both boards are determined that the learning arising from all three reviews will be implemented to seek to reduce the risk of a similar tragedy occurring in the future.

It was decided it would be most useful to carry out the two Serious Case Reviews at the same time as the Safeguarding Adult Review to capture any shared themes or learning.

Each review sets out how it was undertaken and who was involved. The life experiences of Carol, Yasmine and Olivia are summarised and the reports then focus on the three years period before Carol's death.

The Safeguarding Adult Review shows that Carol lived a chaotic life as a result of a long history of addiction to alcohol and a personality disorder. She was well known locally and had frequent contact with workers in the mental health and alcohol services, ambulance and hospital services and the police.

Carol's Review highlights the challenges of trying to help someone with lots of complex needs, and how the committed and hard working professionals who worked directly with Carol did their very best to support her. The findings show that mental health and alcohol services need to work together closely when someone has a dual diagnosis, and that there can be confusion between frontline workers and those that commission specialist services. Workers need to be able to assess someone's capacity to make their own decisions when their capacity keeps changing as a result of their problems. The systems that keep vulnerable people safe require all organisations to work together to the same thresholds and procedures.

The Serious Case Reviews of both Olivia and Yasmine were commissioned by Hartlepool LSCB because of the serious nature of the offence and at the time it was committed, both girls were in care and had a high level of contact with local services. Hartlepool LSCB decided that although the circumstances did not meet the criteria for undertaking Serious Case Reviews, this approach provided the best framework to capture learning, and improve systems and professional practice for the future.

Individual reviews were undertaken for both Olivia and Yasmine; however the reviews are very similar in their findings for both girls.

There is no evidence that Olivia and Yasmine knew each other well until shortly before the murder.

Yasmine and Olivia's Serious Case Reviews state that: "Although we have learnt lessons about how we understand adolescent neglect more broadly, and the likely trauma it creates, we cannot predict how this will manifest itself on a daily basis or how it might interact negatively with other factors. These issues are beyond professional control."

In section two of each report there are details of the work that was being undertaken with the girls and their parents from 2012 for Olivia and 2013 for Yasmine. Both families received a great deal of support and guidance from a consistent, caring and hard working group of professionals. Neither girl had any history of violent offences although they were angry, abusive and hostile to those around them. There is considerable evidence that both Olivia and Yasmine experienced abuse and neglect which had an impact on their well being and behaviour. This resulted in the need for them to be taken into care, Olivia in September 2013 and Yasmine in October 2014.

There are five shared findings in relation to Olivia and Yasmine which revolve around the issues of adolescent neglect, the impact this has on young people and the challenges professionals face in correctly identifying and responding to this complex issue. Whilst these findings are aimed at helping workers to respond to this issue in a better way, there is also recognition of the essential role of parents and the dangers that arise when children experience neglect.

There is an additional finding, specific to Yasmine's Serious Case Review, which looks at how to identify 'fixed thinking' when working with young people and to challenge information that is received.

A shared finding - common to all three reports - highlights that those who work with adults, children and in community safety services must work more closely to share information about individuals and the community. Since 2014 there have been considerable changes in the way services work together to help vulnerable people.

All partner organisations have joined together to develop Action Plans in response to the findings and questions asked of the Boards in each review. The implementation of these plans will be monitored by the Hartlepool Local Safeguarding Children Board and the Tees-wide Safeguarding Adults Board.

Findings and Board Response

Finding 1: There is an insufficient understanding of adolescent neglect across the multi agency network and the link with complex adolescent behaviour leaving young people at risk of harm.

Summary

Professionals need to better understand how neglect can affect adolescents during this stage of their development. Adolescents need effective and warm parenting with appropriate boundaries and when this is not available to them the long term impact on their wellbeing can be significant. Professionals need to focus on the quality of care given to adolescents and how they are seen and talked about by their parents.

Professionals should examine how parents respond to support designed to improve a child's circumstances and challenge behaviour which places responsibility on the child for the parenting they receive. Neglect in adolescence is harmful and professionals need to recognise and respond appropriately to this.

Question for the Board

How will the Board seek assurance that adolescent neglect is recognised and addressed effectively by agencies?

HSCB Response

HSCB holds regular themed meetings to examine how partners are safeguarding children and young people in the local area. This has included domestic abuse, substance misuse, parental mental ill health and neglect. These meetings examine what each agency does to protect children and young people from harm. A themed meeting on adolescent neglect is planned to consider the local arrangements in the light of the findings from these reviews. This meeting will challenge all partners on their arrangements to safeguard adolescents from neglect and any identified areas for improvement will require the development of an action plan, the implementation of which will be reported to the board on a quarterly basis.
HSCB has endorsed the use of the Graded Care Profile (assessment tool) and Signs of Safety (practice framework) to make sure that those working with children, young people and their families are able to recognise, assess and intervene appropriately when working with adolescent neglect. The use of these tools will allow practitioners to measure the impact of their intervention in improving the child's circumstances. Over the coming six months, we will make sure that the whole children's workforce is properly trained in the use of these approaches and that they are consistently used in safeguarding practice. In twelve months, the Board will receive an evaluation report which assesses the effectiveness of the approach.

HSCB is keen to work with the independent reviewer to consider the best way to share the learning from these reviews across the children's workforce (this includes practitioners working in local authority, health, police, education and the voluntary and community sector) in Hartlepool and wider. We know that the practitioners and managers who were involved in the review have found the process helpful and their practice has developed as a result. It is important that the learning is shared with the wider workforce to make sure that those working with adolescents understand the impact neglect has on young people and

what work they must do with both the young person and his/her parents to address the problems and improve the situation. We will make sure that the learning that has emerged from these reviews is understood by practitioners working with vulnerable adolescents and that the workforce is better equipped to respond to the needs of adolescents and how neglect manifests itself in their actions and behaviour.

The board will measure how effective this work has been through the evaluation of training and multi agency case file audits.

Finding 2: Professionals working within the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.

Summary

Working with vulnerable adolescents and keeping them safe is challenging for professionals when dealing with issues such as running away from home or care and engaging in behaviours which will be harmful to them such as drinking alcohol, experimenting with drugs and being sexually active at too young an age. When dealing with these difficult behaviours, professionals tend to focus on the behaviour itself rather than trying to better understand what is causing the young person to behave in this way.

Professionals need to understand that these behaviours are as a result of the harm and neglect that young people have experienced and they need help and support to build appropriate relationships, personal skills and resilience. Professionals need to deal with the daily crises young people experience at the same time as tackling the harmful effects of abuse and neglect. They need to do this in a joined up way where the young person receives a caring and consistent response from those around them who are working to help them recover.

Question for the Board

How will the Board support its partner agencies to develop the multi agency workforce to be able to respond to the holistic needs of adolescents rather than relying on presenting problems in decision making forums?

HSCB Response

The challenges of supporting and responding to the needs of vulnerable adolescents are a priority for HSCB. Through the Tees wide Vulnerable, Exploited, Missing and Trafficked (VEMT) sub group, made up of senior officers from the police, local authority, health, education and voluntary sector, work is being undertaken to continuously improve the response to young people vulnerable to harm including the development and implementation of risk assessment tools and the sharing of intelligence.

Local arrangements include integrated locality based early help teams made up of practitioners from the local authority, health and police. More recently risk management meetings have been established to share information and develop joint plans across the organisations working with young people to make sure that the concerns, risks and responses are coordinated. Once these arrangements have been in place for six months, we will receive an evaluation report on the effectiveness of risk management meetings in coordinating the sharing of information and response to complex young people.

In light of the learning from this review, we will examine how effective our child protection system is to respond to the holistic needs of adolescents. This will include looking at child protection plans to make sure that these focus on the root causes of difficulties adolescents may be experiencing rather than just the

presenting behaviours. We will make sure that the expectations of parents are clearly detailed in plans including what they must do to support their child and the action that will be taken by professionals if they fail to engage with the proposed work.

We will examine best practice nationally in 'what works' to engage and support vulnerable adolescents with a particular focus on managing risk and preventing harm and deliver a training programme for the multi agency workforce focused on strengthening their knowledge and skills when working with vulnerable adolescents. Training can only go so far in helping professionals to develop their practice, therefore in implementing the Signs of Safety framework we will give a high priority to introducing group supervision for professionals working with an individual young person and using an independent professional to facilitate these.

The Board will receive and scrutinise reports on the implementation of the above actions. This will be in addition to the regular reports received by the Board on Children who Go Missing from Home or Care and from the VEMT sub group where the Board already challenges performance and makes recommendation for improvement as appropriate.

Finding 3: Parents blaming young people is not sufficiently recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.

Summary

The review found that there was a danger that professionals allowed parents to blame young people for the poor parenting they received and this caused further emotional abuse to young people. Too much regard was given to the parent's description of the difficulties the family was experiencing as being caused by the young person themselves rather than as a consequence of inadequate parenting. In this climate of blame and scapegoating, young people were left feeling worthless and their self esteem was undermined which in turn influenced how they behaved.

Question for the Board

How will the Board assure itself that member agencies have processes in place to support staff to recognise and challenge inappropriate parental blaming of children and the subsequent emotional impact of this behaviour?

HSCB Response

Through the process of this review, all partner agencies of HSCB have developed and improved practices in working with vulnerable adolescents and a record of these actions created.

Across the local area the Children's Strategic Partnership is overseeing the roll out of a 'Healthy Relationships' initiative across the multi agency workforce led by a local voluntary sector organisation. Over the coming year, more work will be undertaken to embed 'healthy relationship' approaches across the workforce which will enhance the skills of the workforce to understand the importance of relationships within a family and promote positive care, secure and loving attachments where children experience empathy and are treated justly and fairly.

The role of those who manage front line practitioners in their work is critical to supporting the workforce to recognise and challenge parental blaming of children and the impact this has on young people. We will

undertake a review of the arrangements for the support and supervision of staff across all organisations that make up HSCB and make recommendation for improvement where necessary. We will implement new approaches to strengthen the supervision and support of staff through the use of group supervision based on the Signs of Safety framework and we will review the arrangements for child protection planning as detailed under finding 2.

We will review and update our HSCB training programme in relation to working with troubled adolescents and emotional abuse in light of the findings from these reviews.

Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.

Summary

It is widely accepted that children and young people are best brought up within their family where it is safe and appropriate to do so. Services, wherever possible, work to keep families together by providing support and services to address any difficulties a family may be experiencing. Where parents do not properly or appropriately engage in the work designed to help and support them, it is almost inevitable that family breakdown will occur with a request for a child or young person to be removed from the family home.

When delivering services designed to help and support a family, it is essential that professionals consider how well parents are engaging with these service If parents fail to take advantage of the support on offer, those working with the family must consider the impact this has on the child and whether they need to take action to remove the child from this situation to prevent further abuse.

Question for the Board

How will the Board seek assurance that interventions designed to enable children and young people to remain in their families are appropriately child centred and are planned, implemented and monitored to provide the best possible outcomes for those children and young people?

HSCB Response

During the process of this review, the policy in relation to returning children to the care of their families has been updated taking into account national best practice shared by the independent reviewer. Work is underway to make sure that all staff understand the contents of the revised policy and are confident to implement this in their practice. We anticipate this will be completed within the next three months.

HSCB has arrangements in place to undertake multi agency case file audits and within the next six months, we will ensure that a minimum of six audits are completed on adolescents who are subject to child protection plans. The audits will focus on how effective the plan is in keeping the young person safe, how well parents are engaged in the actions identified within the plan that they should complete and the impact the intervention is having in improving the young person’s circumstances.

The implementation of the Signs of Safety framework has commenced and a programme of workforce development is underway. We will receive regular reports updating the board on the progress of implementation and the impact this has on improving practice, with particular reference to child centred practice and outcomes for children and young people.

We will review and update our HSCB workforce development plan in light of the learning from these reviews and national research and best practice to continue to develop the skills of the workforce to make good and safe decisions for children and young people. We will monitor the take up of training and development across the multi agency workforce through six monthly reports to the Board.

Finding 5: There is a disjoint between both children's and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.

Summary

The reviews found that the sharing of information between organisations with responsibility to safeguard children and vulnerable adults and organisations responsible for community safety was not as effective as it could have been. Not all of the information available was known to those working to protect children and the community and this important in the context of the increasing amount of time young people spend with their peers in the community without the supervision of adults.

Question for the Board

How can HSCB work in partnership with TSAB and the Community Safety Partnership to ensure that the development work currently being undertaken by the Community Safety Strategic Partnership strengthens the links for both adults and children?

HSCB response

This finding is shared across the three reviews and challenges the three partnership bodies to strengthen the links between their work. Since the reviews started, much work has taken place to improve communication between HSCB and the Community Safety Partnership. We have set up a multi agency risk management group where cases can be referred that are causing concern for any agency. The risk management group is attended by managers from across the partnership including local authority, police, health and education and provides a forum to agree actions in relation to individuals or networks that are of concern.

Multi agency early help teams are in place working on a locality basis across the town. This supports the sharing of information between organisations and makes sure that partner organisations know the vulnerable children and young people who live within these localities.

An electronic information system (E-CINS) has been implemented in the local area where professionals who are working with an individual involved in anti social behaviour can share information. As part of the future development of this system we will work with partners to use this system to share information about vulnerable young people who are discussed in VEMT or risk management meetings. The expansion of the E-CINS system will improve information sharing and the coordination of intervention with vulnerable adolescents. The effectiveness of these new arrangements will be monitored through the E-CINS Strategic Management Group and reported to VEMT subgroup and the Board.

We are currently developing a Joint Protocol between TSAB, HSCB and the Community Safety Partnership. This protocol will set out how these strategic boards work together to tackle shared agendas and avoid duplication and overlap. Through the Community Safety Partnership, work has started on creating a Community Protection Team integrating neighbourhood policing and community safety. As this develops, we will identify how this team will work with safeguarding professionals to improve the sharing of information.

Finding 6: Effective single agency and multi-agency supervision and effective processes to promote multi-agency reflection are necessary to pick up fixed thinking in a particular case. Although there has been action in a number of agencies to promote this approach to complex work it can be further strengthened, including by developing arrangements which enable multi-agency groups to come together.

Summary

Professionals working with vulnerable children and young people need to constantly review their judgment and analysis of a case when new information is received. If this does not happen, how a child, young person or his/her family are viewed becomes fixed in the mind of the worker and they will only consider new information which supports their initial judgment.

All practitioners need to be supported and challenged in their practice to constantly reassess their views on a case and professional supervision provides the most appropriate forum for this to take place. Where multi agency professionals can come together to be supervised jointly, this will be even more effective.

Question for the Board

How will the Board be assured that the impact of 'fixed thinking' and 'unconscious bias' is understood by agencies and their staff and there are effective arrangements in place via reflective supervision to challenge these?

HSCB response

Through the board, arrangements are in place for any professional to raise a concern about decision making in any case through the dispute resolution arrangements. We are not confident that these arrangements are fully understood and used effectively across the children's workforce, therefore we will undertake a survey to understand how confident the workforce feel in using the dispute resolution process, any barriers they experience and what may make the process easier or more effective. We will take action to strengthen these arrangements in light of the findings.

We are planning to introduce the arrangements for multi agency / group supervision through the implementation of the Signs of Safety framework and we will make sure that this is a priority for those particularly complex cases which are considered through the risk management and VEMT arrangements. Group supervision will bring together those individuals working with a vulnerable young person to reflect on the work they undertaking, the effectiveness of this work and challenge one another on their assessment and analysis of the needs of the young person and his/her family.

We will explore the potential to develop multi agency integrated specialist teams taking into account national and international best practice for those individuals with the most complex needs and whether this approach will strengthen and enhance the support and help they receive.