



**Executive Summary of  
The SERIOUS CASE REVIEW**  
Concerning  
**'L' d.o.b.06.08.1988**

Created for  
**SWINDON LOCAL SAFEGUARDING CHILDREN BOARD**

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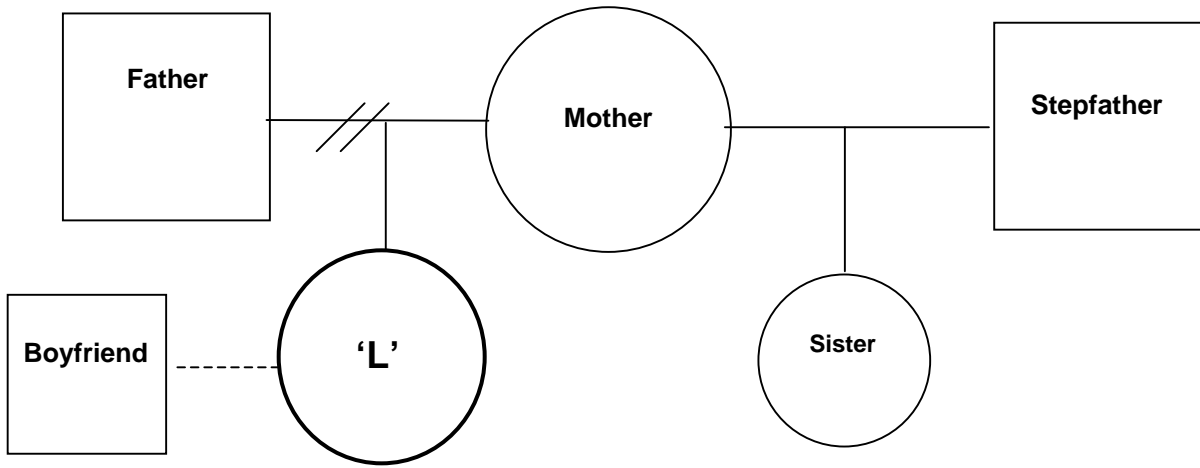


NATIONAL PROBATION SERVICE  
For England and Wales



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## 1.0 Genogram



## **2.0 Introduction and Background**

- 2.1 L was brought up in Swindon and initially lived with her natural parents. L was a white, English speaking 16-year-old young woman. It is not clear exactly when her natural father left the family home, however it is clear that her stepfather was present during a significant part of her life particularly during her secondary school years.
- 2.2 L attended Liden Primary but following a Statutory Assessment of Special Educational Needs was moved to Wroughton Primary School at the age of 9. This instigated a family move to Wroughton where L's grandparents lived. L then moved up to Greendown Secondary School following a family move to West Swindon. She was excluded from Greendown School on 27<sup>th</sup> May 2002 at the age of 13 following a history of challenging behaviour and then attended the Stratton Education Centre.
- 2.3 During her time at Secondary School L increasingly got into trouble with the Police, often for aggressive behaviour. At times she was frequently intoxicated with alcohol, which led her to sleeping rough and staying away from home. Her risk taking behaviour, regular arrests and subsequent use of heroin resulted in a Care Order and a final placement in a secure unit.
- 2.4 Only a matter of days after her discharge from Hillside Secure Unit , where she had made considerable progress, the Police received a 999 call from Ambulance Control at 5.53 am on 28<sup>th</sup> May 2005. L was found shortly afterwards collapsed on the 2<sup>nd</sup> floor of Carfax St multi-storey car park, Swindon, by the ambulance crew who attended in response to the call. L was taken to the Great Western Hospital and was certified dead at 7.35 am. The person who was with L at the time has been investigated regarding the circumstances of L's death and allegations that he may have injected her. Following advice from the Crown Prosecution Service there will be no criminal charges. The post mortem, which took place on 29<sup>th</sup> June 2005, showed that L had 160mg of alcohol and 130 mg of heroin in her system. At the time of writing this report, the Coroner's Court had not given its verdict on the cause of L's death.
- 2.5 At the time of her death L was on a full Care Order and had been placed on the Child Protection Register on the 4<sup>th</sup> November 2004 under the category of Neglect. She was still on the Register at the time of her death.

### **3.0 Criteria for undertaking Serious Case Reviews**

3.1 "Working Together" and Protocol 1 from the Swindon and Wiltshire Multi-Agency Child Protection Procedures identifies a number of factors, which should be taken into account when deciding whether a Serious Case Review should be undertaken. The Swindon Local Safeguarding Children's Board formerly the Area Child Protection Committee (ACPC) has the responsibility for commissioning Serious Case Reviews.

- Swindon is the responsible authority and is not aware of any other ACPC or Local Safeguarding Children's Board involvement.
- A case review should always be undertaken when a child dies and abuse or neglect is known or suspected to be a factor in a child's death.
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
- To identify clearly what the lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working to better safeguard children.
- The child or young person is a "Looked After Child"

### **4.0 Factors that led to this Serious Case Review being undertaken as reported by the Serious Case Review Sub Group:**

- The Serious Case Review Sub Group that commissioned the work of this Overview Panel met initially on the 11 August 2005 to consider the case. The Sub Group noted the following reasons for undertaking a Serious Case Review:
- *That L's death happened so quickly after her return from a secure unit and in a case that was thought likely to be successful.*
- *Whether assessment systems are adequate in picking up typical addictive behaviour (hidden activity, lying). It was noted that a healthy scepticism is required towards L's reports of her actions and towards claims that she had been smoking heroin.*

- *Having considered the above against the criteria for undertaking a Serious Case Review the Panel made the recommendation to the Chair of the Swindon Area Child Protection Committee that a Serious Case Review should be undertaken.*

## **5.0 Scope and Terms of Reference for the Review**

5.1 It was agreed that the case should be subject to a full Serious Case Review in order that a comprehensive picture of the practice on the case, across agencies would be available.

5.2 It was agreed that the overview panel should consist of the following agencies:

Children's Services (Education)	Geoff Wood
Children's Services (Children and Families)	Steph McQuade
Wiltshire Police	D/Sgt Jackie Barstow
Drug and Alcohol Action Team	Cath Johnston
Swindon and Marlborough NHS Trust	Dr Janet King
Housing	Mike Ash

In addition the Panel agreed to seek expert advice from Dr Brenda Moore in relation to specialist substance misuse clarification.

5.3 Chairing the Serious Case Review Panel. It was hoped that a reciprocal arrangement with the Wiltshire (ACPC) could be made with regard to chairing the Overview Panel. However this could not be agreed within the timescales. Therefore, Mike Ash from Swindon Borough Council's Housing Directorate was asked by the Sub Group to Chair the Panel. It was recognised that the Housing Service had limited involvement in this case and that other senior officers within Housing were able complete the respective chronology and Management Review for the service area, thus ensuring impartiality.

5.4 The Serious Case Review Sub Group in consultation with the Chair of the ACPC agreed for chronologies to be sought covering the period from L's birth (06-08-88) to her death (28-06-05). However the main focus of the review should be the period from the start of secondary school (06-09-99), with particular emphasis on the last few months of L's life from October 2004. The Review should look at information relating to L and her sister .

## 6.0 Contributions to the Review

6.1 Individual agency management reports and chronologies were provided by the following:

CAFCASS	Spencer Hird
Connexions	Susan Broughton
Children's Service (Education)	Nigel Pickering
Children's Service (Children and Families)	Kathleen Edwards
Druglink/Stepping Forward	David Cork
Hillside Secure Unit	Laurice Matthew
Housing	Arlene Griffin
NSPCC	Trish O'Donnell
Police	D/Insp Andy Deegan
Promis Recovery Centre	Dr Robert Lefever
Rainsbrook Secure Training Centre	Leon Thomas
Stonham Housing Association	Paula Locke
Swindon and Marlborough NHS Trust	Joanne Smith
Swindon Primary Care Trust	
➤ GP	Dr Elizabeth Mearns
➤ School Nursing            )	
➤ Child Health Service    )	Jessie Morrison
➤ Health Visiting           )	
Wiltshire Ambulance Service	James Hogg
Wiltshire Probation Service	Alan Long
Youth Offending Team	Martyn Sweett

6.2 Previous Serious Case Reviews have highlighted the need for agencies to respond to the request for information, including when they have had no involvement from the family. This was not applicable in this review.

6.3 A short response (letter dated 20<sup>th</sup> December 2005) was received from Swindon College. It was noted by the panel that due to poor attendance there was very little contact with the College. The only point of note came up in her initial interview when L advised that her only concern was not being on the same course as anyone else she knew.

6.4 After the Panel had completed its assessment of the Chronology and the Management Reviews two Panel members (Mike Ash and Steph McQuade) interviewed members of the 16+ team in Children's Services to gain a better insight into the period from L's release from Hillside Secure Unit to her death.

## 7.0 Family Involvement in the Review

7.1 The mother of L was invited to participate in the Serious Case Review and has contributed towards the findings. L's mother was visited by the Chair of the Overview Panel and the Team Manager of the 16+ Team and informed of the process. She was invited to submit her own chronology and thoughts to assist the Review. The NSPCC were commissioned to support the mother in contributing to the Review by the submission of her own chronology. Key points raised by L's Mother were taken account of within the Panel's recommendations.

## 8.0 Panel comments on Significant Facts and Events

8.1 This section draws together a short summary of significant facts and events to assist agencies in lessons that can be learned from this case.

8.2 From birth to starting at Secondary school it could be assumed that L had a relatively settled childhood. She made good progress at Primary school. She did receive support for her special needs and had a Statutory Assessment of Special Educational Needs, which enabled her to progress onto Secondary school with few concerns. The Panel noted the withdrawal of her Statement in Year 7 (her first year at Secondary School) and given other significant events in her life at that time the continuation of the Statement may have benefited her.

8.3 On 15/12/99 L receives her first exclusion (3 days). The chronology also notes she is smoking at the age of 11, the Panel have drawn attention to research<sup>1</sup> linking this to the misuse of other substances and behavioural difficulties in adolescence. She then goes missing from home for the first time on 18/07/00, sleeping rough at the age of 12. It is also reported that she is offering kisses and touches adult males in exchange for cigarettes, but this does not trigger a Section 47 Enquiry<sup>2</sup>. On 23/07/00 there is an incident of domestic violence, followed on 14/02/01 where L alleged she was hit by her stepfather. This was a further opportunity for a Section 47 Enquiry.

8.4 By October 2001 she has been arrested 3 times within 14 months this time for stealing alcohol. There are then repeated alcohol related incidents up to February 2002. By May 2002 she is permanently excluded whilst in Year 9 and is placed at the Stratton Education

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<sup>1</sup> **"The Substance of Young Needs", Health Advisory Service (2001 Review)** sites the following on **page 11** as risk factors that may determine vulnerability to substance misuse:

"Individual risk factors most often described include early and persistent behavior problems, academic problems, early onset of tobacco or other substances, low commitment to school and early peer rejection, affiliation with like-minded peers, low religiosity, alienation and rebelliousness, aggression and impulsivity."..... "Further risk factors include early age of use....."

<sup>2</sup> When a child is found to be exposed to significant harm, physical injury or neglect, specific agencies have statutory duties under Section 47 of the Children Act 1989, to undertake investigations into allegations of child abuse.

Centre. At the point of exclusion there is no multi agency strategy meeting or a meeting of professionals.

- 8.5 On 24/07/02 an Ambulance crew and A&E attend to L who is intoxicated and beaten. It is significant that L is now the victim amongst her peers, yet she sees no action against the perpetrators, L's injuries cause her to be taken to A&E for attention. By this time a pattern is developing between alcohol abuse and her outbreaks of anger. By December 2002 she is arrested whilst intoxicated for being in possession of a dangerous weapon. In March she is arrested again on suspicion of robbery and at the age of 14 detained in Police cells overnight. The Panel recommendation (10.5) relates to the care of a young person in custody.
- 8.6 The first Strategy Meeting is finally called in June 2003 when bail conditions are breached, however this does not lead to the planned Child Protection Conference. At this point the Youth Offending Team (YOT) become heavily involved, it appears they take a lead agency role but this is only an assumption by the other agencies involved. 10/06/03 YOT worker advises Social Services of concerns that L is now associating with an adult male (boyfriend) known for supplying vulnerable girls with drugs and taking earnings from prostitution.
- 8.7 By the autumn of 2003 there is evidence of L taking Class A drugs but she is only referred to the school nurse. She goes missing, and is made the subject of Police Protection, then ends up in A&E for drug and alcohol misuse, again there is no Section 47 Enquiry. At Rainsbrook Secure Training centre she receives her first physical and mental health assessments. Prior to her release there is no plan or assessment of Child Protection Risks. Throughout 2004 her physical and mental health conditions deteriorate. There is a further missed opportunity for a Strategy Meeting when arrested in October 2004. After going missing she is placed on the Child Protection Register on 04/11/04 (Neglect).
- 8.8 L is remanded into Local Authority Care in November 2004, a pattern has begun to develop whereby the Criminal Court proceedings are dictating L's future. After a brief stay in Supported Housing, which failed because of her behaviour she appears to become submersed in the Swindon sub culture of sexual exploitation and drug misuse. At this point she appears to have no other accommodation options. She is again the subject of Police Protection and later she runs away from the Social Services offices. She is arrested the following day and the Local Authority obtain an Interim Care Order. She is sent to the Promis Recovery Centre, but there appears to be no assessment of how this establishment will meet L's needs.
- 8.9 24/12/04 she is reported missing from Promis. Police believe her boyfriend has collected her from Promis. She attends a needle exchange in Swindon on 26/12/04 and there are various sightings on

30/12/04 describing her deterioration. Social Services agree to fund a 72hr secure placement when found. 3/01/05 Police find her and take her to A&E where she is prescribed diazepam. At Hillside she is admitted under a 72 hour Secure Order. She begins to make real progress although the appropriateness of prescribing more opiates and the lack of a structure or detailed planning to her detoxification programme was a concern. An expert witness makes an assessment of L, which influenced L's continued stay in Secure Accommodation and planning following her release.

## **9.0 Summary and Conclusion**

9.1 What is clearly apparent in this case is that there was little to indicate any concerns about L's vulnerability before she started secondary school. All the evidence suggests that L had a relatively settled way of life up to the age of 11. The Panel therefore had to ask the question why was this so? From the information made available to the Panel it became clear that there were three factors that played a significant part in the change evident in her life at this time.

- The move from Primary school to Secondary school. L had made considerable progress at Primary school and all the signs were that this should continue with the appropriate support. Her transition to Secondary whilst for most children can be a stressful experience, for L it was complicated by the fact that not only had she just moved house but her Statutory Assessment of Special Educational Needs came to an end in Year 7. There was little evidence to suggest why this had occurred and there was clearly no information sharing between the two schools.
- At the age of 11 she began smoking, and by 12 she was misusing alcohol, which coupled with her difficulty to control her anger soon got her into trouble. At this stage she was also smoking cannabis.
- Her relationships with her family and close friends deteriorated, no doubt related to the first two factors, to the point that at the age of 12 she was sleeping rough.

9.2 It is important to note here that L's misuse of alcohol was rarely seen as a key issue that needed to be addressed. Agencies highlighted her difficult behaviour and later her misuse of drugs as areas requiring support and yet it was often her misuse of alcohol that impaired her judgement, reduced her ability to control her temper and resulted in arrest after arrest.

9.3 In 2003 there is clear evidence of her regular use of class A drugs, a sign that her life and needs were getting increasingly complex. From June 2003 the Youth Offending Team (YOT) became increasingly involved because of her offences. This curiously brought with it an assumption that the YOT were the lead agency with key worker responsibility for L. However this was only an assumption and was

never clearly communicated particularly between the YOT and the respective Social Care and Education teams.

- 9.4 2004 was a particularly difficult year for L both emotionally and physically. From this period on it was apparent to the Panel that Criminal proceedings were dictating L's future. L herself, her family and the agencies supporting her had little influence on her life. L had many stays in custody and this brought into question the care of such young vulnerable people whilst in short term custody, particularly in meeting their health needs. At the end of 2004 the Court decided to place her in a Secure Training Centre a decision the Panel got the impression was received by many with a sigh of relief. In November L was finally placed on the Child Protection Register and remanded into Local Authority Care. L had by this time firmly entered a growing Swindon subculture of drugs and sexual exploitation, identifiable in Swindon by intravenous drug misuse. Evidence supporting the presence of this subculture are the increased case load in the last 18 months of the Social Work team; research ("*Sex Workers and Crack Study*") conducted by the Swindon Drug and Alcohol Action Team<sup>3</sup>; and "*Children Exploited Through Prostitution*"<sup>4</sup> which concluded:

*"...this survey has identified a significant number of children and young people in Swindon who are extremely vulnerable to exploitation. It is likely to appreciably underestimate the numbers involved..."*

- 9.5 At Hillside Secure Training Centre in 2005 L begins to make real progress. L is comfortable with the regime and can see the progress she is making herself. Her only concerns relate to her release and contact with former associates, particularly her boyfriend where she is aware of the risks involved. Her detoxification programme makes good progress although the Panel indicated some concern over prescribing opiates and the lack of structure to the programme. Medication on such programmes appears to vary and the Panel have made a recommendation about reviewing this.
- 9.6 During her stay at Hillside a decision needed to be taken as to L's immediate future; was she to remain in Local Authority Care and should she receive a further period in Secure Accommodation and what would happen on her final release from Secure Accommodation? To assist the Court in coming to a decision an expert witness report was called for. This became highly influential in determining her future. The concept put forward by the expert witness was a simple one; any plan after her release must be with the agreement of L, it recommended a stay away from Swindon in some form of half way house and an offer of this in Plymouth was rejected by L.

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<sup>3</sup> **Sex Workers and Crack Study (Swindon)** – Druglink Survey - comparisons 2002 and 2005 "...2005 still shows an alarming number of young girls coming into prostitution under the age of 18..."

<sup>4</sup> Results of a survey commissioned by the Forum (a Sub-Group of the LSCB) June 2006.

- 9.7 L's decision to return immediately to Swindon was received with some dismay from those working with her. It is worth noting that at this point she was no longer a responsibility of the YOT and the weight of responsibility rested now with a relatively small and increasingly stretched Social Care team due to the growing caseload as stated in 9.4. The Social Work team attempted to come up with a compromise by offering her a foster care placement in Trowbridge, but it became apparent that L wanted to return to Carers she was familiar with in Swindon. L wanted ongoing rehabilitation support from the workers she had developed successful relationships with at Hillside, and to the credit of these workers they found ways of keeping in touch with L albeit at long distance.
- 9.8 On her release a Care Plan was in place and being acted upon. L had support from Hillside and around the clock support from her Social Workers with whom she also had positive relationships with. L even asked to meet the external Inspectors from CSCI (Commission for Social Care Inspection) whilst on site during the 2004 Inspection of Swindon's Social Services (this she did) to explain how strong the relationship was between herself and her Social Worker. The dedication of her assigned Social Worker particularly during the last few days of L's life is highly noticeable and is commended by the Panel. L had indicated to her Social Worker that she did not want to go back to her old ways and knew the risks associated with taking drugs and re-establishing relationships with former associates. Once again it was her misuse of alcohol that may have ultimately impaired her judgement and took her back onto the streets where she was to receive a fatal drug overdose.

## **10.0 Recommendations of the Overview Panel**

- 10.1 The Panel recommends that for those children in Year 6 of Primary School who have a Statement of Special Educational Needs that this is maintained as a minimum throughout Year 7 to assist the transition from Primary to Secondary School. **(Services to Children and Young People)**
- 10.2 The Panel recommends that for children permanently excluded as early as Year 9 there should be a multi-agency planning meeting to consider the immediate needs of the child. **(Services to Children and Young People)**
- 10.3 The Panel recommends that Children's Services reinforce the National Guidance on the involvement of School Governors in exclusion decisions where there may have been personal contact with the child that could prejudice the decision. **(Services to Children and Young People)**

- 10.4 The Panel recommends that where there is evidence of alcohol misuse in a child under the age of 16 that health and social issues are considered alongside punitive measures. This may for example require support for anger management, specialist youth health workers. In addition specific training should be delivered to all agencies involved with children and young people to help identify the signs and deliver interventions for alcohol misuse. **(Children's Services)**
- 10.5 Panel recommends that a multi-agency protocol be drawn up on meeting the needs of a young person (under 18) held in custody and the agencies to consider the appropriate support to a young person particularly if held overnight. **(LSCB)**
- 10.6 Panel recommends that where a young person in the Care of the Local Authority is a known substance misuser and is placed out of Borough, an assessment of their medical health needs should form part of the Care Plan. **(PCT)**
- 10.7 Panel recommended that guidelines should be drawn up on needle exchange (under 18), to ensure other agencies are engaged with the exchange policy. **(Community Safety Partnership)**
- 10.8 Panel recommends that vulnerable young people should be able to be received into a suitable, supervised and safe facility at times of crises and is accessible to all relevant services. The Local Safeguarding Children's Board should seek out best practice across the Country on this issue. **(LSCB)**
- 10.9 Panel recommends that formal liaison is established between local services and services outside the Borough received by vulnerable young people. A named local medical worker should be responsible for overseeing a child's medical care whilst placed out of Borough particularly where there are substance related needs. Any treatment programme should follow the Clinical Guidance issued by the National Treatment Agency for Substance Misuse. **(Children's Services/ PCT)**
- 10.10 The Panel recommends that the Local Safeguarding Children's Board consider a range of tiered options for the care and support of young people leaving secure accommodation with a history of drug misuse, which should include a Safe House in order that young people may continue their rehabilitation. **(LSCB)**
- 10.11 The Panel recommends that a Protocol be established to seek ways in which to better protect vulnerable young people from the abusers and the Swindon sub culture of drugs and sexual exploitation. The Local Safeguarding Children's Board in liaison with the Multi Agency Public Protection Arrangements Management Board responsible for the

arrangements was identified as best placed to complete this work.  
**(LSCB/MAPPA)**

- 10.12 The Panel recommend that records transferred between schools should include and highlight Child Protection concerns. **(Services to Children and Young People)**
- 10.13 The Panel recommends that a formal process should be established to ensure there is appropriate liaison between Health Visitors when families who are living in temporary accommodation and move house resulting in a change of General Practitioner. **(PCT)**
- 10.14 The Panel recommend that the PCT examine the potential role of the school medical service in the early assessment of vulnerable young people with multiple problems. **(PCT)**