

SWINDON AREA CHILD PROTECTION COMMITTEE

SERIOUS CASE REVIEW

‘J’

EXECUTIVE SUMMARY

July 2005

Serious Case Review

J

1.0 Introduction

- 1.1 J was found dead on 7 September 2004 at his accommodation in Swindon, a shared house used by the local authority to place homeless people. He was a white, English speaking 17-year-old young man. The post mortem established that he had died from natural causes (1.a diabetic coma). The exact date of his death is not known but it was determined he had lain undiscovered for at least five days. At the time of writing this report the Coroner’s Court has not yet given its verdict.
- 1.2 J was brought up in Swindon and lived with both his birth parents until he was estranged from them 6 months before his death. He was originally placed in supportive lodgings by Swindon Social Services. This lasted till end of July 2004 when J was then provided with accommodation for homeless people, where he lived alone until his death.
- 1.3 As a child and teenager, J suffered from ill health. He had asthma as a young child and diabetes was diagnosed in 1993 when he was 6 years old.
- 1.4 In the last year of his life J had 28 admissions to Hospital (GWH) mostly with Diabetic Keto acidosis or DKA. He was last admitted to Hospital on the 13 August 2004, where he remained for his 17th birthday, leaving hospital on 17 August 2004.
- 1.5 There is no indication that he had contact with any agency again. He was found dead at his accommodation on the 7 September 2004.

2.0 Criteria for undertaking a Serious Case Review

- 2.1 “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.
 - To establish whether there are lessons to be learned form 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 and to better safeguard children

- 2.2 The Serious Case Review Sub-group met initially 30 September 2004 to consider the case. Having considered the criteria for undertaking a Serious Case Review the Sub-group made the recommendation to the Chair of the Swindon Area Child Protection Committee (ACPC) that a Serious Case Review should be undertaken.

3.0 Scope and Terms of Reference for the Review

- 3.1 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 the agencies would be available. It was agreed that the overview panel should consist of the following core agencies:

Education
Housing
NSPCC
Police
Social Services
Swindon & Marlborough Trust
Swindon PCT

- 3.2 It was originally agreed that the Review would consider the period from the point of diagnosis of J's diabetes. It was agreed that the Review should be completed within the 4-month time scale. The review was extended to allow time for the health chronologies to be completed due to the extent of contact. The review commenced December 2004 and was completed May 2005.

4.0 Contributions to the Review

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

Connexions	Connexions Co-ordinator
Education	Social Inclusion Manager
The Foyer	Foyer Housing Manager
Housing	Housing Needs Manager
Police	D/Sgt, Vulnerability
Swindon & Marlborough NHS Trust	Senior Nurse, Children's Services

- admissions to the paediatric ward. When diagnosed diabetic he became insulin dependent.
- 6.2 In October 1993 J was admitted to hospital with control issues around both his diabetes and asthma. He continued to have frequent admissions and by 1998 a pattern of admissions emerged.
 - 6.3 In August 2002 J began to be missing from home for short periods of time and the police became involved in searches for him.
 - 6.4 In January 2003 J was admitted to hospital via A&E. His blood sugar was unrecordably high. These admissions to hospital for diabetic crises and potentially life threatening states continue to be frequent and ward staff were concerned for his well being and mental health. In February 2003 he was seen on the ward by Consultant Psychiatrist who assessed J as having no obvious psychiatric disturbance.
 - 6.5 13 December 2003 J was admitted to hospital, he had not had insulin for 3 days and was very unwell. S&MNHST contacted Social Services before he was discharged. A worker from the Independent Living Team was allocated and visited J in hospital, offering practical support. The records show that he was not taking insulin or eating properly. He was aware that he would end up seriously ill if he did not take his insulin.
 - 6.6 Social Services completed an initial assessment and formulated a plan to monitor him while he moved to independent living. The assessment did not include previous information or the extent to which his behaviour put himself at risk.
 - 6.7 24 December 2003 J was admitted to hospital in an emergency for 'social/medical reasons. He had not been eating or drinking, had no food or heating . He was discharged to the family home 26 December 2003. 21 January 2004 Social Services closed the file as J has remained living at home and their intervention had been through the Independent Living Team.
 - 6.8 March 2004 J was admitted to hospital for DKA. J was seen as 'extremely vulnerable due to inability to manage medication without supervision'. Social Services 16+ team responded. In March 2004 J was seen by consultant psychiatrist but no formal psychiatric illness was diagnosed
 - 6.9 J stayed with an extended family member while Social Services found supported lodgings which he moved to in March 2004 and remained there until the end of July 2004.
 - 6.10 17 June 2004 his care in hospital was handed over to the adult team. His emergency admissions to hospital continued.
 - 6.11 In July 2004 J was given 2 weeks notice to leave his supportive lodgings and there was no similar placement available.

- 6.12 On 28 July 2004 J completed an accommodation questionnaire which placed him at 'high risk of moderately serious danger'. Accommodation was found for him at a house in multiple occupation.
- 6.12 J was admitted to hospital 8 August and again 13 August 2004.
- 6.13 17 August 2004 J was seen by Diabetic nurse, from the Adult team on the ward. He was discharged
- 6.14 6 September 2005 2004 Adult Diabetic nurse contacted SSD as they had no contact or admission since 17 August.
- 6.15 7 September 2004 J was found dead at his accommodation.

7.0 Overview Panel Comments on Significant Events

- 7.1 The Overview Panel have analysed the merged chronologies. The panel deemed a number of events as significant, some of their own standing but many because they need to be seen together to give the picture and the patterns that emerged through J's life. The panel believes these patterns were set at a very early stage and were uninterrupted and unchallenged by the agencies.
- 7.2 There was frequent and significant contact with health professionals. There was little evidence of co-ordination between the primary health services at the time.
- 7.3 The panel considered that there was a lack of an identified lead health professional that could take an overview of this level of contact and coordinate and review services and consider indicators of underlying problems
- 7.4 J was seen as a non-compliant patient whose self-harming and self-destructive behaviour became predictable. He was not seen as a child in need or when his self-harming was acute, as a child/young person in need of protection. Consequently no referral was made to Social Services for an assessment.
- 7.5 J was transferred to adult health services at a time when he was alienated from his family. The panel considered that there should be an agreed transition process for children and young people who have chronic illness.
- 7.6 J did want to try and be independent, but there was no distinguishing between which needs he could have managed himself and those he would benefit from having support. When he was admitted to hospital on Christmas Eve 2003 for 'social/medical reasons' there was no referral to Social Services for an assessment.
- 7.7 When an Initial Assessment was prepared by Social Services it was based on information given by the young person alone, and was not a multi agency assessment.

- 7.8 The panel considered that J received some good and appropriate medical services throughout his life. There was evidence of good follow up when he missed appointments. There was evidence of the agencies working together to provide the coordinated responses to keeping him in education, and then training. When his final training/work placement at Taurus was jeopardised by his behaviour, a coordinated effort meant he was still given a chance to maintain the placement.
- 7.9 When J became homeless the level of his vulnerability was shared between Housing and Social Services. The accommodation he was offered and accepted due to lack of suitable alternatives at the time, did not meet his needs as a vulnerable young person. Since September 2004 Housing has increased resources and J would now have been able to benefit from a floating support officer service.
- 7.10 With regards to J parents, the panel noted the gradual break down of the relationship in the last 2 years of his life. There was evidence that his mother maintained contact with the agencies involved with him and continued to ask for help for J.

8.0 Summary and Conclusion

- 8.1 The Overview Panel have identified what it considers to be key elements of this case review. It considers that there were lost opportunities by the agencies in working preventatively with the family from an earlier stage and further lost opportunities in assessing the vulnerability of the young person J and the risks he posed to himself.
- 8.2 As he became an older teenager he was left with more responsibility for managing his health, without there being any indication that he was able to. His age led agencies to allow a degree of self-determination, which they may not have done with a younger child.

9.0 Areas of Good Practice in Multi Agency Working Together

- 9.1 The panel commended the attention and service J received from the CCNT who advocated on J's behalf with other agencies as well as within SMNHST.
- 9.2 There was good practice in working together to maintain J in school and respond to his chronic health problems by a number of agencies, including the school, the CCNT, the school nurse and the Education Behaviour Support Team

- 9.3 The Connexions Service made links internally and with other agencies and were persistent in their attempts to engage J. Taurus, Social Services and Connexions were able to recognise J's complex needs with regard to training. There was evidence of the agencies working together to provide the coordinated responses to keeping him in training.
- 9.4 The Social Services 16+ team gave thorough practical assistance, that J required and supported his training needs through interagency cooperation
- 9.5 The School Nurse and the Education Welfare Officer set up a school diabetic group in response to needs.
- 9.6 The couple who provided supportive lodgings for J provided assistance in accessing and maintaining contact with the necessary agencies.

Recommendations of the Overview Panel

The panel recommended for ACPC agencies

1. All records should show whether child/young person was seen & spoken to and who accompanied the child/young person.
2. A transitions process, similar to that for disabled children should be put in place for the transfer from paediatric to adult services, for all children/young people with chronic /dependent conditions

The panel recommended for S&MNHST & Swindon PCT

3. A system is developed to identify chronic conditions which require a lead health professional to be identified that would link across the health agencies including CAMHS with a view to coordinating services, and establishing regular multi professional reviews.
4. Multiple referrals and frequent presentation to hospital or health professionals should trigger lead professional involvement and multi disciplinary review with consideration of referral for an Initial Assessment.

The panel recommended for S&MNHST

5. CAMHS develop and implement a policy for dealing with failed appointments and frequent referrals and considers whether a referral should be made to Social Services for an Initial Assessment.

- 6 Discharge plans are used, which show who is responsible for agreeing the discharge and copied to all relevant professionals involved with the young person.

The panel recommended for the Swindon PCT in reference to GPs

- 7 All future GP management reviews are carried out by a GP

The panel recommended for the Education Service

- 8 Pupil records are transferred on the pupil's transition from primary to secondary school and are retained by the secondary school
9. Head Teachers and Governors are reminded of the agreed procedure for SCR by the issue of clear instructions about the process, as required in Working Together
- 10 Permanent exclusion of children from school be a trigger point for referral for Initial Assessment

The panel made the following recommendations for the ACPC Serious Case Review Process

- 11 The chronology is revised to show the form of contact, e.g., visit, letter, and whether child/young person was present.
- 12 In compiling chronologies and management reviews, the role and name of the professional is given, to be anonymised in the Overview report.
- 13 Management reviews are completed by an agency representative of sufficient experience in safeguarding who is independent of the line management and is not reviewing their peers

**Trish O'Donnell
Chair of the Overview Panel
NSPCC
July 2005**