Comments on the Overview Report concerning Name Redacted

Review Panel comments page 6

Very appropriate comments concerning the early failings in this case.

Review Panel comment page 7

There is a comment that the school responded promptly and appropriately to Name Redacted's unhappiness in DPA 2000. However, Name Redacted had told a professional that she had attempted suicide. Would this not merit at least further exploration and possibly referrals to health professionals and/or Social Services? (In fairness, the issue is picked up in paragraph 5.6 on page 41 as an example of the recurring theme of insufficient attention being paid to what Name Redacted was saying.)

Review Panel comments page 13

Pertinent points in both para 2.73 and 2.74

Para 2.81

There is a comment that the preferred option for Name Redacted a foster care placement, was not available. It is not clear from the report whether this only refers to the social services department fostering resources, or whether it includes independent provision. This has implications for the SSD's commissioning strategy.

Para 2.85 and subsequent review panel comment page 15

On reflection it seems extraordinary that the Health Team failed to prioritise Name Redacted's case. The recommendation that the relevant PCT develops a prioritisation system is welcome.

Review Panel comment page 16

There is no comment about the disclosure by Name Redacted of her rape by a boyfriend and whether this should have been referred to the police.

Review Panel comments page 17 (para 2.110

The panel comment that residential staff used the process for responding to significant events inconsistently – preventing both field staff and the Operational Manager from getting an accurate overview of what was happening. However, this begs further questions about the extent to which managers at various levels aquainted themselves with how the unit was functioning. Were adequate systems in place?

Review Panel comments page 20

There is no comment about para 2.130, which states that Name Redacted was allowed not to attend school but reportedly to drink alcohol and sleep with her boyfriend. Would this be seen as appropriate?

Review Panel comments page 20 (para 2.134)

Given the scale of the mismanagement of the strategy meeting detailed in para 2.133 – and its consequent failure to address Name Redacted's needs, is there not a training issue for the chairs?

Review Panel comments page 22

The comments in para 2.144 seem right in acknowledging the failure to develop a strategic response to incidents in the home and the need to review whether Name Redacted was receiving an appropriate response. One might go much further and recognise that it was very clear by this point that, faced with repeated serious assaults Name Redacted was in need of protection. Had she been the recipient of this level of violence in the community would it be likely that she would have been left in such a situation?

Review Panel comment page 24 (para 2.156)

There is a comment that the occasion referred to in para 2.155 was the first time Name Redacted had talked about harming herself. This is not strictly true, as she had, in DPA 2000, said she had attempted suicide.

Review Panel comments page 28

The panel is rightly critical of the attempt to close Name Redacted's bed. The issue may also raise questions about the culture in which such an approach to the care of a very vulnerable young person can develop.

The panel rightly raises issues about the extent to which middle managers from both divisions of children's services were getting hold of this case in a strategic sense.

Name Redacted's use of the Complaints Procedure – paras 2.185 to 2.188, page s 28-29

The complete failure of the departmental complaints procedure in this case seems extraordinary. The review panel notes that there was a failure to adhere to timescales and to address all aspects of the complaint. It might have gone further and asked :

1. Why, given the seriousness of the allegations about the unit and the clear reference to Name Redacted feeling very depressed, was the matter referred to the unit at the informal resolution stage rather than being placed in the formal process involving an independent person, as provided for by the Children Act?
2. About the adequacy of the complaints service's own QA processes and
3. Whether the department needs to review, in the light of this, the effectiveness of its complaints procedures and services for children and young people

Role of Managers (page 40)

Paras 4.5.1 to 4.5.3 helpfully refer to the fact that team manager, unit manager and review chairs failed to take concerns about Name Redacted's inappropriate placement and care plan to senior managers in Social Services. The reasons why they did not do so are not explored. Potentially, this is important. Presumably it is the absence of a protocol which is seen as

the cause (see recommendation 6.6). However, if the reasons for this failure were of a different nature, this particular recommendation may prove insufficient.

Conclusions (page 41)

The comment that "no single action by a person or agency on or immediately before DPA DPA 2002 could have prevented Name Redacted's death; nor could it have been forseen that she was going to kill herself on that particular evening" is no doubt true. However, the evidence presented in the overview strongly suggests that there was a high probability that it would happen soon.

The comment in paragraph 5.3 perhaps encapsulates the central issue in this case : "a recurring theme of paying insufficient attention to what Name Redacted was saying and her behaviour, resulting in often reactive and sometimes poorly planned responses to her care". Whether, as the review suggests, this comment can only be made with the help of hindsight is, given the evidence set out, debatable in my view.

Recommendations (pages 42-44)

Given the scale of bullying which was evident in this case, would it not have been relevant to focus some recommendations on this issue eg review of policy on bullying; improved training?

Ian Whitehead

Inspector

SSI East Midlands

.