Child A

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

Child A was in local authority care when he took his life just three months before his 18th birthday. He had been living with committed foster carers for the past four years. By the time of his death, Child A had been experiencing a high level of uncertainty about his plan towards independence and had demonstrated significant worries about what would happen once he turned 18 years old.

Circumstances of, and challenges faced by the individual

Child A had been placed in local authority care at the age of two years having experienced severe physical and emotional abuse and neglect. He was placed into foster care and diagnosed with attachment disorder, his behaviour was described as aggressive and very challenging. The foster parents legally adopted Child A (aged six) in November 2005. At the age of nine years he was considered to have attention deficit hyperactivity disorder behaviours and as he reached the age of 10, the relationship broke down. Child A was accommodated by the local authority though the adoptive parents retained parental responsibility.

An independent adoption support agency was commissioned to provide an holistic and in-depth assessment to identify a care pathway for Child A.

Throughout his latter years, Child A was cared for by experienced and supportive foster carers who made a significant commitment to him as their foster son. Whilst in this placement, the review felt confident that Child A felt wanted and cared for.

What happened?

Child A consistently told all the professionals around him how scared he was about leaving care. He felt ill-prepared and was highly anxious about a situation in which he was out of control and could find no answers. Child A presented his views about living independently very eloquently, both verbally and through his behaviours. He asked about the laws in Wales having changed (under the newly launched Social Services and Well-Being (Wales) Act 2014, looked after children could remain with their foster carers post-18 years (Part 6 Code of Practice (Looked After and Accommodated Children) for which the local authority needed to develop a scheme). Without answers, in the form of a positive, effective and adequate pathway plan to enable Child A to transition into successful adulthood, Child A was unable to live with the fear, uncertainty and anxiety this provoked in him.

Why it happened?

Child A's life had been well documented throughout his life due to his placement in local authority care at the age of two years. However, despite the fact that his latter years were supported by a small and consistent team wrapped around his care plan and despite effective advocacy in relation to his post-16 educational statement, despite his clearly expressed views and anxieties, the available information was not effectively considered by professionals in care/pathway planning. The professional group closest to Child A appeared powerless in influencing decisions that would have enabled a stepped approach to adulthood.

A lack of evidence-based needs assessment and pathway planning since Child A was 16 years old, including a lack of robust legal advice and guidance in relation to Child A's care leaving status, poor misunderstanding of the principles underpinning "When I Am Ready", all resulted in a series of missed opportunities to be creative about Child A's pathway to adulthood and form a plan that would allay his fears.

The missed opportunity for joint planning within the looked after child reviews pre- and post-16 years resulted in a disconnection between a care plan that was forward looking and informed by Child A's daily lived experience. In particular, the approach to practical skills for independent living was based on chronological age and without due consideration for the special educational needs and disabilities assessment of the difficulties Child A experienced in cognitive, emotional and educational functioning.

In addition to the challenges for professionals in meeting Child A's needs, there were issues in communication with his adoptive parents. They were highly anxious to see their son receive the support they perceived he needed. This created a fractious relationship between the parents and professionals at times. A professionally-held view was created that perceived Mr and Mrs A as difficult and overlooked their understandable level of worry about their son.

Specific issues which affected Child A included: a lack of challenge from the independent reviewing officer (IRO), despite the fact that all agencies outside the local authority looked to each other to find answers but overlooked the need to resolve professional difference with the local authority, to hold the local authority to account, or to call them to action. The role of the IRO was critical yet failed to escalate concerns to a senior level. The opportunity was missed to challenge the progress of agreed actions and escalate for resolution.

Report recommendations

1. **Improvements in transition planning to include:** Local authority and multi-agency training in "When I Am Ready", evidence-based assessments to inform care planning, legal framework for children in care. Active involvement of young people in training delivery and quality assurance. Implementation of management systems to support "When I am Ready" good practice guide; good practice guidance to ensure focused supervision of practitioner based on high challenge and high support. Evidence the IRO challenge to achieve good outcomes for looked after children.

2. **Improvements in escalation and challenge to include:** Local authority audit of the effectiveness of supervision; a mechanism to capture IRO quality assurance and scrutiny of care planning; performance information which tracks good outcomes for children with better data reporting; an assurance mechanism for reviewing the effectiveness of commissioned services.

3. **Improvements to corporate parenting to include:** Use of multi-agency performance information to track good outcomes for children within the local authority and across multi-agency partnerships; monitoring mechanism to measure the effectiveness of the Resolving Professional Difference policy.

4. **Improvements to participation and the child's voice to include:** A review of the effectiveness of regionally commissioned service to advocate for looked after children; all agencies? reporting to CYSUR on how the child's voice influences their ability to ensure good outcomes for looked after children, taking into account the child's lived experience; consider the value of children and young people delivering training and participating to quality assurance practices across all agencies.

Citation

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