Bath & North-East Somerset Community Safety & Safeguarding Partnership

Local Child Safeguarding Practice Review

Skye

Executive Summary

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Background

A statutory Local Child Safeguarding Practice Review (LCSPR) was commissioned by Bath and North-East Somerset Community Safety and Safeguarding Partnership (BCSSP) following a serious incident notification of the death of Skye, a 17-year-old white British girl. Skye was made subject to a full care order to Bath & North-East Somerset (B&NES) local authority aged 15 years. Skye was found unresponsive in her bedroom in the commissioned residential home where she lived in Scotland. This LCSPR sits alongside the parallel process of the Coroner's Court where Skye's cause of death will be determined.

Foreword

To those who read this forward, it is written to remember Skye and her life. Skye was a much-loved daughter and sister, and her parents have shared many memories of Skye throughout her childhood. In listening to these reflections, it is evident that Skye was undoubtably cherished. It is impossible to put into words the loss and heartbreak felt by all those who knew and loved Skye. A family and professional community have been left devastated.

Skye is described by many as a kind and caring young person, who could articulate her own needs well. She is described as a "*force of nature*" and as having the "*biggest heart*". Skye's family dynamics were complex. The family relationships Skye established were important to her. Skye worked hard at keeping her connections with key family members; she doted on her nieces and nephews. Skye had many talents and was an intelligent young woman; her social worker remembers her beautiful singing voice and the lyrics she wrote and performed. Skye's compassion for others was seen with her volunteering for foodbanks, learning to crochet and making woollen hats for premature babies at the local hospital in Scotland. Towards the end of her life, Skye aspired for a career in midwifery and returning back to her local area in the southwest of England.

Skye was almost 18 years old when she died. Skye was in a significant transition period of her life as she navigated what she hoped her adult life would be and what others thought best and most appropriate for her. This review will explain that Skye had a range of needs which were often seen through her behaviours to herself and others. Skye's emotional well-being and mental health fluctuated, and this was a concern for her family and professionals. Skye often felt overwhelmed, and her levels of desperation are seen in her expressed intentions and actions. Although described as being more settled when living in Scotland than she had ever been, Skye continued to experience many distressing episodes with her mental health.

This review will consider how agencies tried to support Skye in the months prior to her death. It will provide a professional perspective on what was trying to be achieved and how the family felt about this. It will consider the system barriers to ensuring a positive outcome for Skye as she headed towards her 18th birthday.

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Through a judicial process and enquiries, the Coroner's Court will investigate and determine the cause of Skye's death. Skye's death has significantly impacted a range of professionals involved in this review process. The strength of feelings shown by those who worked alongside Skye demonstrates the care and love felt and how missed she is by all those who knew her.

Our final thoughts are with Skye, her parents, and her family whose lives were forever changed.

Methodology

The review identified 3 key lines of enquiry and set out to analyse the following factors over a 12 month period from March 2022 – March 2023:

- How agencies understood Skye's daily life and how her views, wishes and feelings influenced decision-making
- Whether the home identified & the care provided to Skye was sufficient and able to meet her needs and keep her safe
- When concerns for Skye's mental health increased, whether risk assessments were adjusted to keep her safe
- How transitional arrangements were put into place ahead of Skye's 18th birthday and how Skye's and her family participated in these plans.

These form the basis of the findings, key learning, and recommendations under three areas in this report which are:

- Understanding a child's world
- Support and protection for children in care
- Transitional arrangements

Family Involvement

Skye's dad met with the independent reviewer to share the family's reflections on the support and services offered to Skye. This proved invaluable to understanding the practice and system barriers and forms the basis of the key learning.

From a family perspective, Skye's dad summarises the following as key contributory factors to his daughter's difficulties during the period under review:

- The geographical distance was significant in maintaining close and face to face time with family
- The Care Home "did wonders in supporting Skye" to begin with but in the last few months family concerns were raised about whether the home could continue to meet his daughter's range of needs
- Skye's physical and psychological needs were not addressed by services in a way that helped

- Skye's neurodiversity and mental health needs required earlier diagnosis and intervention
- Skye was "bored" a lot of the time and had too much time to "think about things". Skye's dad said his daughter was "let down" by the education system
- Despite individual professional effort seen by some agencies, there was drift and delay in achieving a multi-agency transition plan with Skye – "it should have started much sooner"
- Not knowing what the plans were as Skye moved to 18 years old was significant and caused her great anxiety. Skye felt embarrassed by the high staffing levels and wanted more freedom post 18
- Skye held onto a hope shared at the last CIC Review that she would have a "menu of options" post 18 years and she was excited to come home and live more independently. Skye told her dad she was working hard at getting herself well
- Once Skye knew the plans in March 2023 to remain in Scotland post 18 years and then to move back to a similar high support arrangement in the southwest of England, he describes Skye as being devastated. "My daughter was broken hearted". She told her dad she did not want this plan and felt "trapped and stuck with the same situation"
- Skye's dad escalated his concerns for his daughter's welfare two weeks before her death with the residential provision and Children's Social Care.

Skye's mum wrote the following tribute to Skye for inclusion in this report:

"When I think of my beautiful daughter Skye, the first thing that comes to mind is how selfless she was. She donated her lovely long blonde hair to the little princess charity, which is for children that has lost their hair through illness. I am so proud of my daughter. As she also learnt to crochet, so she could make hats and blankets for premature babies and the elderly, Skye was constantly thinking and putting others before herself. She had such a beautiful heart and soul and touched the hearts and lives of so many even at such a young age, my daughter decided on her own that she wanted to be an organ doner, so with Skye's wishes, when she sadly passed, she donated all her organs giving 5 other people another chance of life, so they could live on through her."

Understanding a Childs World

The LCSPR reviewed how Skye's lived experiences were understood by the multi-agency network of professionals working with her. It considered how relationships were built, and how time was spent with Skye in a variety of settings and through various communication means, so as to understand her world and actively listen to her views, wishes, and feelings

Finding One:

Much of Skye's day to day lived experiences were known by statutory agencies and professionals who worked with Skye in the home she lived in. Relationships were

established and professionals showed care and love, through practice which was grounded in compassion.

Outlined in the Government's strategy and vision[1] under 6 pillars of reform there is a commitment to put love, relationships, and a stable home at the heart of being a child in care. This important focus has arisen from listening to many children and adults who have grown up in various care homes and who have rightly asked for love to be at the centre of practice and systems.

This review paid particular attention to the quality of Children's Services, Skye's Independent Advocate and Residential Workers' connections to Skye to understand her day-to-day experiences. It is found that these professionals showed attentiveness and respect to Skye and listened to her worries and fears. Professionals were sensitive to Skye's requests for things to be different regarding levels of supervision and when they could not be adjusted due to ensuring her safety, it was explained to her in a straightforward and caring way from the records reviewed.

Despite the good practice seen regarding relationship-based work, Skye felt confused at the end of her life. As explained by her advocate, Skye felt agencies were not communicating with her about what was being done to find her a new place to live, and she felt that nothing was being done. Skye would share with her advocate and social worker how one person would say one thing, then another person said another thing, and this left her feeling uncertain about what her future held.

Support & Protection for Children in Care

The corporate parenting principles of feeling loved, cared for and to feel and be safe, as embedded in statutory guidance, applied to Skye's situation as a child in care. Most systems designed for children in care should aim to ensure the question of "would this be good enough for my child?" is at the centre of practice.

The review considered how Skye's range of day-to-day needs were considered, checked, and met, including how plans were adjusted when concerns escalated for her well-being.

Finding Two:

The national shortage of suitable homes for children who are in care had a significant impact on local care planning for Skye. The resultant geographical distance between the local authority and where Skye lived in Scotland meant

[1] Department for Education (2023). Children's Social Care: Stable Homes, Built on Love: Government Consultation. https://assets.publishing.service.gov.uk/media/650966a322a783001343e844/Children_s_Social_Care_Stable_Homes__Built_on_Love_consultation_response.pdf

different laws applied, with barriers seen for the multi-agency partnership in ensuring a coordinated approach

Finding Three:

Although Skye's day to day experiences and world were known and care and compassion shown across the safeguarding system, this was in itself not enough as the procedural structures that surround a child in the care of a local authority were not always met or challenged in the way that ensured support and protection for Skye.

Finding Four:

Specialist risk assessments were not always understood in relation to past trauma and present challenges and risks. The CAMHS assessments in South Lanarkshire were not coordinated sufficiently with Southwest Forensic CAMHS to consider the increasing risk towards the end of Skye's life to ensure safety.

Finding Five:

The difference in the nation's education jurisdictions regarding education health care plans impacted on education service provision and support to Skye. Skye did not enjoy and participate in any meaningful education provision during the period under review.

Transitional Arrangements

Transition to adulthood can be a particularly challenging time for some young people. Learning from Safeguarding Adult Reviews and Serious Case Reviews/LCSPRS has highlighted how ineffective transitional planning can contribute to young adults "slipping through the net" or facing a "cliff edge", sometimes with tragic consequences. It is known to be vital to share information between multiple services, including health, social care, and education in a proportionate and timely way so that young people receive access to guidance, information, and advice they will need as adults. It is also generally accepted and expected that the young person should be fully involved in decision making and be at the heart of the transitional arrangements.

It is also acknowledged that children's and adults' systems are conceptually and procedurally different, and are governed by different statutory frameworks, which can make the transition to adulthood difficult for young people facing ongoing issues and a complexity of needs. Nice Guidelines[2] helpfully set out overarching principles to consider when supporting young people through any transition from children to adults' services which promote fluid and responsive systems which work together. Both the Children and Families Act 2014 and the Care Act 2014 deal with support for young people with care and support needs preparing for adulthood. These two

[2] Nice Guidance Transitions. https://www.nice.org.uk/guidance/health-and-social-care-delivery/service-transition/products?GuidanceProgramme=guidelines

pieces of legislation provide the context in which transition practice occurs. This legislation, along with policy and procedures were applicable when supporting Skye towards her adult years, given her level of need. It is well documented that early and comprehensive identification is key when undertaking transitional planning from children to adult services.

There is a corporate joint responsibility to ensure both plans undertaken by ASC and CSC align to ensure a good transition for children in the care of a local authority. This means that collectively children's and adults services ensure a child is prepared during the transition period and following various assessments (which involve the child and their family), all parties are kept updated on progress of planning options and through adult commissioning services the agreed final plan is resourced in a timely manner.

This review examined how Skye was prepared and how her safety and wellbeing were supported during the transition period in moving towards the legal milestone of 18 years, including how Skye was involved in her plans to move back to the local area once decided.

Finding Six:

Despite CSC Children in Care Team completing a timely referral for Skye aged 16 years, there was ASC drift and delay in completing the Care Act Assessment and identifying appropriate accommodation for Skye post 18 years.

Finding Seven:

CSC did not ensure compliance with procedures as Skye did not have a needs assessment or pathway plan. This meant it was difficult to review assessments and plans in a way that ensured positive outcomes with Skye and this was not raised effectively by the Safeguarding & Quality Assurance Team.

Finding Eight:

Skye was not helped by specialist services, CAMHS and FCAMHS to prepare for adulthood as she was not supported through specialist interventions with her range of mental health needs in the months prior to her 18th birthday. Skye remained confused and anxious in the run up to her 18th birthday.

Recommendations

Recommendation 1: B&NES CSC Principal Social Worker reviews the Practice Standards Guidance regarding the recording of visits to children based upon the good quality records seen in this LCSPR. This will support practice to ensure records are written in a language that cares, and which evidences the views, wishes and feelings of a child.

Recommendation 2: With the support of the commissioning team, the BCSSP Chair writes to the National Panel to highlight placement sufficiency issues in individual

local areas upon individual children with a complexity of needs and when children are placed at a distance, with different legislative jurisdictions.

Recommendation 3: CSC Senior Leadership Team provide a report to the BCSSP and the Corporate Parenting Panel, which provides data regarding compliance of procedural requirements for children in care and when leaving care. The report should also include support & supervision arrangements to professionals in children's services who are visiting children at a distance and ensuring a relationship-based approach to interventions.

Recommendation 4: In line with the NHS Long Term Plan, Oxford Health (CAMHS) provide an action plan to the BCSSP which addresses:

- When children with a complexity of needs are placed out of area, how information sharing translates into a coordinated single agency and multi-agency risk assessment and plan, including which specialist service leads on this written plan.
- The therapeutic approach to young adult mental health services for those reaching 18 years who require specialist interventions so as to be supported in the transition to adult services.

Recommendation 5: BANES Virtual School new tracking system for those children placed Out of County who are Not in Education, Employment or Training, is relayed to the Governing Body (Local Authority) and CSC Senior Leadership Team on a termly basis to ensure educational outcomes are progressed for children who are in care and have a complexity of needs.

Recommendation 6: The newly introduced Safeguarding & Quality Assurance Team tracking system (which includes completion of mid-point review and a reviewed Local Dispute Resolution Procedure) for all children in care is audited within 6 months of this LCSPR being published to ensure impact for children in progressing care planning when concerns are highlighted by IRO's.

Recommendation 7: Independent Scrutineer for the BCSSP to consider implementing an action plan that ensures the effective use of the escalation procedure by all partner agencies and focuses upon ensuring impact for children.

Recommendation 8: The BCSSP establishes a Transitional Planning Task & Finish Group which pays particular attention to children with complex needs and the need for work to start at 15 years or earlier. The work already underway by the Preparing for Adulthood Project Group will need to feed into the BCSSP Group to ensure a coordinated approach.