CHESHIRE WEST AND CHESTER SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW INTO THE DEATH OF BRYONY

PERIOD UNDER REVIEW

MARCH 2011 – FEBRUARY 2015

FINAL DRAFT OVERVIEW REPORT

CONTENTS

CHAPTER 1

1. INTRODUCTION AND CONDUCT OF THE SERIOUS CASE REVIEW

1.1 Acknowledgement

The Review Team offer condolences to Child B's family and friends on their tragic loss. The generosity they have shown in contributing to this Serious Case Review at such a difficult time is very much appreciated.

1.2 Confidentiality

It is usual in Serious Case Review reports to anonymise the gender of the child upon whom the review is focused. As many of the child's experiences are directly related to gender, the Review Team believe it is important that these are not obscured or minimised by the requirement for a 'gender neutral' report. The Review Team discussed this aspect with the child's mother, who agreed that the report would refer to gender. In addition the child's mother agreed that a pseudonym name would be used throughout the report. The child will be called Bryony from this point forward.

All other personal information relating to Bryony will be fully anonymised, as well any references to members of their family, friends and others, including professionals who came into contact with Bryony.

1.3 Incident Leading to the Serious Case Review

On a date in February 2015. Bryony was found in her bedroom at home by her mother's carer, she was lying on her bed and appeared to be lifeless. The ambulance service was called and Bryony was pronounced deceased.

A post mortem found that Bryony had died from an overdose.

There were no suspicious circumstances surrounding Bryony's death; a note was found in Bryony's bedroom in which she spoke of her distress and her desire to take her own life.

At the time of writing this report the Coroner's Inquest has not yet taken place, this report does not therefore refer to a cause of death.

1.4 Key People

Person	Referred to as:
Bryony	Bryony
Mother of Bryony	Mother
Father of Bryony	Father
Boyfriend of Bryony	Boyfriend
Sibling of Bryony	Sibling
Ex-Partner of Bryony's Father	Ex-partner
Maternal Grandmother	Grandmother
Maternal Grandfather	Grandfather

1.5 Foster Placements FF1 and FF2

Foster Family 1 Female	FF1F
Foster Family 1 Male	FF1M
Foster Family Child	FF1 Child
Child placed with FF1	Child Z
Foster Family 2 Female	FF2F
Foster Family 2 Male	FF2M
All other children will be referred to as children placed with FF1 or FF2	

1.6 Learning from the Review

Taking into account all of the information available the review team concludes that had there been different practice in this case the tragic outcome for Bryony may not have been averted. There is no evidence to suggest that Bryony's decision to take her own life was directly related to any intervention or event covered by this review. It is recognised by the review that the majority of professionals worked to respond to challenging events and circumstances, however, there were a number of important missed opportunities to work differently with Bryony and her family.

The Review has found that practice could be improved in specific areas, the analysis set out in Section 4 of this report, and the findings set out in Section 5 go into further detail about

each area of practice and where there are opportunities to learn and modify practice emerging from this review, as well as areas in which good practice should be enhanced and maintained.

No single professional or agency should feel responsible for the tragic outcome for Bryony, however, there is a collective responsibility amongst practitioners and managers at all levels and in all services to learn from this case, both in relation to developing and maintaining good practice and improving practice and systems in the areas highlighted by this review.

The review findings fall within the following areas:

- Professional understanding in relation to risk and vulnerability
- Working with troubled adolescents
- Coordinated multi agency planning and the role of the Care Plan
- Listening to and being guided by the voice of the child
- Managing family dynamics; family consultation
- Appropriate use of tools and statutory powers
- Responding to serious incidents and crises
- Single and multi-agency communication and information sharing systems

The Review has also found that agency compliance with the requirements of Working Together to Safeguard Children in relation to Serious Case Reviews needs to be strengthened, particularly the quality of information submitted and the securing of agency records.

Early Implementation of Learning from the Review

The LSCB has worked closely with the review team to ensure that early adoption and implementation of learning from the process takes place.

Work is already in place to strengthen systems, processes, procedures and understanding of roles and responsibilities between Adult Social Care and Children's Social Care which will strengthen safeguarding of vulnerable children and adults in the future.

Arrangements in relation to Virtual School have been strengthened by the appointment of a full time Virtual Head, the post overseas the co-ordination of Personal Education Plans for Looked After Children.

The early help strategy and arrangements for a greater focus on the family has been strengthened through Team Around the Family (TAF).

The system for recording decisions made in relation to referrals to CSC has now been strengthened by recording of a rationale for the decision in every case.

1.7 Rationale for conducting the SCR

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a Local Safeguarding Children Board (LSCB) to undertake a review of a serious case in accordance with the procedures that are set out in chapter four of *Working Together to Safeguard Children (2015*).

An LSCB should always undertake a serious case review when a child dies or has been seriously harmed and abuse or neglect is either known or is suspected and there is cause for concern as to the way the authority, the Board or other relevant persons have worked together.

The purpose of the review is to establish what lessons can be learned from the case to improve safeguarding in the future, to improve inter-agency working and to better safeguard and promote the welfare of children in Cheshire West and Chester.

This serious case review has been conducted under the guidance set out in Working Together to Safeguard Children (2015)[1].

The principles underpinning the review are that it:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations; involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The review was conducted on the basis that the overview report would be published in full.

1.8 The scope of the SCR

The period under review is from March 2011 when Bryony began to display specific vulnerabilities and risk taking behaviours until her death in February 2015. Relevant background and contextual information prior to March 2011 is referred to in this report.

[1] Working Together to Safeguard Children, Department for Education (Revised 2015)

1.9 Agencies Participating in the SCR

The following agencies have provided information and contributed to the SCR in accordance with *Working Together to Safeguard Children (2015)*, Chapter 4 and the associated LSCB guidance and relevant learning and improvement frameworks.

Agencies in Cheshire West and Chester

- Children's Social Services
- Adult's Social Care
- Countess of Chester Hospital NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust - School Nursing Services, CAMHS and Safeguarding Team Children in Care Nurses
- GP1
- Cheshire West, Halton and Warrington Youth Offending Service
- Young Carer's Service
- High School 1
- High School 2
- High School 3
- High School 4
- Provision 1 – Short Stay Provision
- Local Authority Services Educational Welfare
- Safeguarding Unit
- Caring to Care Service (Barnardo's)
- Cheshire Police – CSE Team
- Catch 22 – Young People's Missing from Home Team

Agencies in North Wales

- National Fostering Agency (a national agency for whom FF1 and FF2 provided services)
- North Wales Safeguarding Board
- North Wales Police
- Safeguarding Team and School Nursing Service – Betsi Cadwaladr University Health Board
- GP2
- Conwy Children's Services
- Flintshire Children's Services

1.10 Pseudonyms for Professionals participating in the SCR

ASC – Adult Social Care	ASW1 – Social Worker
CSC – Children's Social Care	SW1 – June 2012 – May 2013 SW2 – May 2013 – January 2014 SW3 – January 2014 - January 2015

CAFCASS	CG – CAFCASS Guardian
CAMHS 1 –West Cheshire CAMHS 2 – North Wales	C1 C2
Catch 22 – Missing from Home Co-ordinator	C22W
Cheshire Police – Missing from Home Co-Ordinator	PO1
Education Welfare Officer	EWO
Cheshire Young Carers	CYC1
GP1	GP West Cheshire
GP2	GP North Wales
Schools	High School 1 – September 2011 – January 2013 High School 2 – May 2013 to April 2014 High School 3 – June 2014 to date of death High School 4 – Preferred Choice when returning to the local area Provision 1 – Short stay provision October 2012 to January 2013
School Nursing 1 – West Cheshire School Nursing 2 – North Wales	SN1 SN2
NFA (National Fostering Agency) – Foster Family Social Workers	NFASW1 NFASW2
Independent Reviewing Officer – CWAC	IRO
YOS – Youth Offending Service	YOS1

1.11 Methodology

The review was commissioned by Cheshire West and Chester LSCB, however as Bryony spent a considerable period of time in foster care in North Wales, joint work has taken place between the CWAC LSCB and North Wales Safeguarding Board.

Work began on compiling a multi-agency chronology in March 2015. From the collated chronology the initial meeting of the review team identified initial research questions. These were updated as the review progressed with the following terms being agreed:

1.12 Research Questions

Systems reviews do not set specific terms of reference. The following research questions were posed by the Review Team to assist in providing focus to the review and constructing and shaping the findings.

1. Is there evidence of timely and robust risk assessment that underpins decision-making?
2. Is the voice of the child evident and does it inform practice and outcomes?
3. Were responses by agencies undertaken in a timely fashion when safeguarding concerns were apparent? *(Response to incidents)*
4. Did safeguarding processes, including recording systems support information sharing and decision making in this case? *(Agency to agency systems; tools to support professional judgment)*
5. How well did agencies communicate with each other to share and seek information from other agencies? *(Agency to agency systems; tools to support professional judgment) – See Finding*
6. Is there a clear rationale for the change in the care plan?
7. There are significant gaps in education during the period under review – how was the child supported to achieve and what role did the virtual school play in this
8. How did parental disability impact how agencies responded to the family? How was this supported?
9. Is the CAMHS response to adolescents who are experiencing behavioural difficulties, and who do not have a diagnosis of mental illness, robust and effective?
10. Do professionals across and within agencies have the necessary skills and tools to objectively assess adolescent risk taking behaviours?
11. Did professionals demonstrate sufficient understanding of the interface between risk and vulnerability?
12. Has the SCR identified issues of a conduct or disciplinary nature and are there systems to manage this?
13. How did the family dynamic influence professional practice and how was this managed?
14. Are there examples of good practice in this case that can be replicated?

Summary responses to these research questions are provided in Chapter 4 of this report.

1.13 Review Team Members

A serious case review team was convened consisting of senior and specialist agency representatives from Cheshire West and Chester to oversee the collation and analysis of information and outcomes of the review. The review was co-ordinated and managed by an independent lead reviewer with appropriate experience and training.

Position	Organisation
SCR Chair Designated Nurse	NHS West Cheshire Clinical Commissioning Group and

Safeguarding Children (Chair)	Vale Royal Clinical Commissioning Group
Business Manager	CWAC Local Safeguarding Children Board
Team Manager, Access to Resources Team	CWAC Children's Services
Senior Manager, Integrated Early Support	CWAC Children's and Young People's Services
Detective Constable, Major Crime Review Team	Cheshire Police
Senior Manager Safeguarding and Quality Assurance	Safeguarding Unit, CWAC Children's Service
Legal Safeguarding Manager	CWAC Children's Services
Designated Doctor Safeguarding Children	NHS West Cheshire Clinical Commissioning Group and Vale Royal Clinical Commissioning Group
Safeguarding Children in Education Service Manager	CWAC
In Attendance	Independent Lead Reviewer

The independent lead reviewer attended every meeting of the review team and case group meetings. The Review Team was chaired by the Designated Nurse for Safeguarding Children. The review team met on seven occasions to oversee the process, analyse data, report to the LSCB, draw conclusions from the material analysed and oversee the production of draft and final reports.

The review team had access to legal advice from the Head of Legal Services at Cheshire West and Chester Council. The team also had access to other specialist advice if it had been required.

Written minutes of the review team meeting discussions and decisions were recorded by the LSCB Business Support Officer.

The review has used a systems based approach to analysing information and presenting the findings in the final chapter using recommended best practice in identifying improvement and learning.

The review had significant complexity arising from the involvement of several services in two local authority areas in England and Wales. Information emerged during the review in relation to previous investigations around the allegations of inappropriate behaviour against FF1M. Information from these investigations was considered by the review and where safeguarding concerns remained unresolved the review team referred these to the appropriate bodies via the LSCB Business Manager. One matter remains outstanding

regarding the incident that took place at the home of FF1 in March 2013 and the review makes a recommendation in this regard.

The review team identified information to be provided by individual agencies. This included all relevant documents and reports from services working with Bryony and her family in regard to assessments, plans and interventions.

The review team identified the services and individual practitioners that would provide information and participate in the review. A briefing was held in early May 2015 which was followed by a programme of individual conversations with practitioners from Cheshire West and Chester and in North Wales.

In July 2015 the Lead Reviewer and LSCB Business Manager met with the North Wales LSCB Business Manager and Conwy Service Manager Quality Standards to update them on progress of the review and discuss provision of further information.

The lead reviewer supported by the LSCB Business Manager conducted a conversation with the National Fostering Agency in August 2015.

A short report was requested from North Wales Police and a senior officer from Cheshire Police held a meeting to discuss their involvement in interviewing Bryony following allegations made relating to FF1M.

Bryony had two foster care placements in North Wales. Bryony was placed with FF1 from January 2013 until January 2014 when the placement was terminated due to Bryony making allegations of inappropriate behaviour against FF1M. Bryony was then placed with FF2, also in North Wales, from January 2014 until May 2014.

FF1F was interviewed by the Chair and Lead Reviewer in October 2015. Information provided by FF1F is referred to throughout this report.

FF2F was interviewed by the lead reviewer and the LSCB business manager in August 2015. Information provided by FF2F is referred to throughout this report.

1.14 Coronial Matters

The death of Bryony is the subject of a coroner's inquest which is due to take place in December 2015. A copy of the final draft of this report was provided to the Coroner prior to the inquest. The LSCB agreed that the report would not be published prior to the Coroner's Inquest.

1.15 Home and School Brief Chronology

Due to the complexity of Bryony's living and schooling arrangements, a brief chronology is provided below.

Date	Description	School
January 2012 – July 2012	Bryony was living at home with her mother. In July 2012 her mother agreed to S20[2] and Bryony was accommodated in a respite foster care placement. Bryony self-harmed by taking an overdose three days after entering the placement and returned to live at home with her mother	January to March – attended High School 1 March to December – No attendance at school, some home tutoring
August 2012 – January 2013	Bryony was living at home with her mother. Bryony's vulnerabilities and risks continued escalate. Bryony spent time away from home living with other family members and continued to go missing from home. In November/December Bryony stayed with a female who was a known risk factor by CSC and police.	No school attendance at High School 1 October 2012 Provision 1 – sporadic attendance Some home tuition
January 2013 – January 2014	Bryony's mother signed a section 20 and Bryony was accommodated with foster carers (FF1) in North Wales.	No school attendance (or home tuition) until Bryony attended High School 2 in May 2013. Bryony was at home with FF1 for the first four months of her placement
January 2014 – May 2014	Bryony was accommodated with a second foster carer (FF2) in North Wales	Bryony continued to attend High School 2
May 2014 – February 2015	Bryony lived at home with her mother.	Before Bryony returned home to her mother discussions took place re schooling. Bryony expressed a preference for a school outside her

[2] http://www.legislation.gov.uk/ukpga/1989/41/section/20

		home area but was not given her first choice. Bryony went onto roll at High School 3 in June 2014 but did not attend until September 2014. After one day at High School 3 Bryony took an overdose. For the remainder of her life Bryony did not attend school and received some home tuition

1.16 Involvement of Family, Friends and Significant Others

Bryony's mother met with members of the review team on five occasions, she was accompanied by one of her daughters on four occasions. A record was kept of three of these meetings which was sent to Bryony's mother for approval.

Bryony's mother asked a number of questions about the review process and about professional involvement which are set out below. She also provided significant insight into Bryony's behaviours and feelings, and into the family's interactions with services during the four years under review.

The views of Bryony's mother are represented throughout the report and in the analysis of key practice episodes. A draft of the review was shared with Bryony's mother prior to submission to the National Panel and discussed with her prior to publication.

A letter was sent to Bryony's father in July 2015 inviting him to participate in the review to which no reply was received. A further letter was sent on conclusion of the review to which Bryony's father replied and advised that he had not received the original letter. In March 2016 the Chair and Independent Author of the review met with Bryony's father to receive his comments on the draft report and to give him an opportunity to contribute to the review.

Bryony's boyfriend also contributed to the review. He was interviewed at home by the lead reviewer and the LSCB Business Manager. His contribution enabled the review to see everyday life from Bryony's perspective, particularly whilst she was in foster placement in North Wales. He provided insight into Bryony's personality and into some of her fears and anxieties. He also provided an invaluable insight into Bryony's relationship with her father.

The Review Team invited the two foster families with whom Bryony was placed in North Wales (FF1 and FF2) to contribute to the review. A decision was taken by the Review Team to delay the approach to FF1 until such time as any parallel processes in relation to the

allegations made by Bryony were fully and properly discharged. Legal advice was sought from CWAC LSCB's legal advisor in this regard.

CHAPTER 2

2 BACKGROUND

2.1 Bryony

Bryony was described by those closest to her as a bright, vibrant, strong willed, caring and very vulnerable young person. She was an enthusiastic gymnast and also enjoyed reading, drawing and writing poetry, for which she was said to have a real talent

Bryony's mother asked that the following excerpt from a letter sent by one of her teacher's be included in this report to illustrate Bryony's compassionate and caring nature which was so often unseen by professionals.

Dear Sir/Madam

My name is XXXX and I am a teacher at XXXXX in North Wales. A student of mine, Bryony, will soon be enrolling at your school and I felt compelled to write to you to tell you a little about the wonderful individual your school will be gaining.

In our profession, we have the privilege of working with so many incredible young people during our careers but with the passing of time, their faces and names fade. However, there are some instances where we encounter a student that leaves an indelible mark on our careers and minds, whose face and names will remain with us. Bryony is one of those students.

I teach a small class of boys with various needs, one of which has Downs Syndrome. Some months ago, Bryony joined a lesson due to timetable change on the proviso she helped me with the class. What followed was one of the most magical moments of my career. She sat with the young man with DS and he worked like I had never seen him do so before. There was an instant mutual respect and understanding between them and Bryony's ability to deal so sensitively with his needs meant that the progress he made during that hour was astonishing. Such was the impact of what I had witnessed, I spoke to the Head of Year with a view to making Bryony a Teaching Assistant in the English department, working with those in need of support. Since then, Bryony has worked in our department during her free periods with pupils from Year 9 and Year 10 and has continued to work closely with the young man with DS. It transpired that Bryony had been researching his condition and she tutored me about his linguistic skills and the additional needs he has. Witnessing this level of care, empathy and commitment in someone so young has left a great impression on the other Teaching Assistants and myself and it is with a heavy heart we bid her farewell.

I hope that Bryony's undoubtable talent can be nurtured and utilised in her new school and I wish her well with her future.

Kind regards, Teacher

Bryony was the only child of her parents, who separated when she was around 4 years of age. Bryony's parents had a turbulent relationship characterised by disharmony and domestic abuse, police were called to the family home on a number of occasions and a police officer expressed concern for Bryony's wellbeing when she was 2-3 years old. Bryony's father was reported to drink heavily on occasions which resulted in disputes with Bryony's mother, some of these disputes resulted in physical violence.

Within a short time of Bryony's birth her mother was diagnosed with a condition of the spine. This resulted in decreasing mobility and an increasingly high level of need in relation to daily care requirements. Bryony spent a lot of time looking after and caring for her mother.

Bryony has three older half siblings. Following the separation of her parents Bryony continued to live with her mother and half-siblings. Bryony's father remained in contact in her early years and throughout her adolescence, although the relationship was unstable and difficult and there were periods of time where contact was not maintained by father. Bryony's father told the review that he worked as a contractor and spent long periods away from home during Bryony's childhood. He said that when she was around 6 or 7 years old he returned to the UK because he wanted to spend time with her however he said that he could not obtain long term employment so had to work away after that.

In 2009 Bryony began to experience non-specific abdominal pain which was reported to GP1. Following tests no physical cause was established and the pain was deemed to be anxiety related. A recurrence of these symptoms in 2011 resulted in Bryony being referred for medical treatment and to CAMHS.

Those who knew her best saw a marked change in her from the age of around 12 when it was said she 'transformed' from being described as a caring and considerate child who would do anything for her family, into a 'disturbed' and 'complex' girl who could be aggressive but who also showed affection and vulnerability.

The behaviours displayed by Bryony during her twelfth year and beyond were exceptionally challenging to her mother, her family and friends and to professionals. This challenge was felt particularly strongly by those who knew Bryony in her earlier years.

The Review Team has seen evidence that Bryony experienced turmoil in her life which caused her emotional distress leading to feelings of hopelessness and helplessness, angry outbursts and challenging and unregulated behaviour – often directed towards her mother. She suffered low self-esteem, and self-harmed and was hospitalised on two occasions following deliberate overdose.

The specific reasons for Bryony's distress have been difficult for the Review Team to establish. With hindsight it is apparent that the underlying causes for her behaviours was never fully understood by the professionals with whom she came into contact, although many professionals did try to encourage Bryony to talk about her fears and anxieties, and the experiences that may have caused them.

Bryony's family, her mother in particular, struggled to cope with Bryony's behaviours, alternately relying on her instincts and skills as a parent to try to resolve problems and challenging behaviours; and then turning to professional help and support – including the use of statutory powers when her efforts did not result in positive change.

Between March 2011 and her tragic death in February 2015 many services and professionals were involved with Bryony and her family.

2.2 The Views of Bryony's Family and Friends (No judgment is made about these views and they are recorded in this report as they were expressed to review)

The Lead Reviewer and LSCB Business Manager met with Bryony's mother on five occasions (one of Bryony's siblings was present at four of these meetings). Bryony's mother and sibling described Bryony as someone who had many anxieties and fears and as a disturbed, vulnerable, caring and complex person. The relationship between Bryony and her mother was described as being very special; Bryony was a demonstrative and loving girl and was openly affectionate with her mother; she often asked for cuddles. Mother said that even when things became difficult they didn't argue and that Bryony's angry outbursts would often be diffused by hugging and reassuring her. Bryony grew up in a loving family, although the relationship between her parents had broken down due to domestic abuse. The family had a close circle of friends. Bryony enjoyed her primary school and moved onto high school with her long established friends.

From the time Bryony joined Army Cadets, in late 2011, her mother saw a marked change in Bryony's demeanour and behaviour. It was at this time that Bryony's behaviour changed from being a loving and caring child, to a child who was angry, hostile and violent at times. Bryony's mother has reflected on this period in her life and says she feels that something happened to Bryony at this time which caused her trauma. Bryony's mother feels that this may have been a sexual assault by one or more boys/young men.

Bryony's relationship with her established peer group began to change at this time, Bryony had posted a message on Facebook that she had been pregnant and then had a miscarriage. Her peers reacted badly to this and Bryony received negative comments on social media. Bryony's mother tried to intervene to mend these relationships but Bryony became alienated from her established peer group.

At this time Bryony first began to go missing from home; her mother was actively involved in working with police and the missing from home service to monitor Bryony's movements and connections. She was aware of the risks identified by the police and was attempting to do everything she could to minimise them.

Mother described how her relationship with Bryony became more and more difficult over time and how she sought the support of services to try to get to the bottom of why Bryony had changed so much in her presentation and how she could rebuild here previously good relationship with Bryony.

2.3 Bryony's Mother's View on what could have been done differently

Bryony's mother felt that she and Bryony had been let down by some services. She said that she felt the relationship with the first two social workers was difficult and that she was seen as being obstructive by social workers and social work managers. Her view was that she was trying to repair her relationship with Bryony and would have done anything to enable this to happen which is why she often challenged processes and decisions.

She felt that this difficult relationship with some professionals was particularly noticeable once Bryony had been taken into foster care with FF1. Bryony's mother felt that she should have been more involved in Bryony's life and that contact could have been more frequent. She was concerned that Bryony did not go into education when she went to live in Wales and that it took more than four months to provide Bryony with a school place.

The initial care plan for Bryony was that rehabilitative work should take place to resolve the difficulties between Bryony and her mother, however no such work was put in place and Bryony's mother could not understand how their relationship could be rehabilitated if they there was no attempt to bring them together.

Bryony's mother felt herself to have been excluded from planning for Bryony's care in foster placement. She expressed the view that the implications of agreeing to S20[3] were not fully explained to her (this view is not shared by CSC) and that subsequent decisions made in relation to Bryony's ongoing placement and the application for a care order[4] were taken without her involvement. She was unhappy with the way the placement with FF1 was managed and felt that she should have had more influence and involvement in decision making about Bryony's day to day life whilst she was in placement.

Bryony's mother was concerned that self-harming behaviour appears not to have been seen as a major risk factor for Bryony. She felt that two previous overdoses would indicate that Bryony may be at future risk.

Bryony's mother commended the police for their work when Bryony was perceived to be a risk of CSE and the work of Catch 22 who engaged with Bryony. She also felt that the change in Social Worker in January 2014 was a turning point for the family as she felt that they were listened to for the first time.

2.4 Conversation with Bryony's Father

Bryony's father spoke to the review Chair and Independent Author in March 2016 after having read a final draft of the report. He did not agree with some of the information provided by mother and Bryony's boyfriend and gave his version of events, which are set out below. Bryony's father has highlighted a number of events and incidents that he was not aware of that have been reported to the review. The review recognises that communication between Bryony's mother and father was at times poor and that the

[3] http://www.legislation.gov.uk/ukpga/1989/41/section/20
[4] https://www.citizensadvice.org.uk/relationships/looking-after-people/children-and-local-authority-care/

majority of professional contact took place with Bryony's mother. The review makes a recommendation in relation to professionals ensuring that disputes between parents do not impact on the need to involve both parents in communications and actions relating to the child.

Bryony's father said that she came from a loving family and was a happy child. He said that as she got older she became more anxious and seemed to find life difficult at times. He felt that there was a lot that happened in Bryony's life that he didn't know about or was not consulted about by other father members or agencies, this included Bryony's self-harming and her episodes of going missing from home.

He said that Bryony spent a lot of time looking after her mother and that she tended to do most of the caring for mother throughout her childhood.

Bryony's father said that as she got older she became more difficult to understand, he witnessed her 'losing control' on two occasions, when she seemed to become hysterical, he said he didn't know why she became like that and that at the time he didn't know how to deal with it. He asked her several times what was 'wrong' with her but she couldn't explain.

Father talked about a number of incidents that he felt needed to be clarified for the review. He said that there were a number of things involving Children's Social Care that he did not know about; he said he was not consulted about the decision to put in place a S20 order which resulted in Bryony being placed in foster care; he did not feel he had been consulted about Bryony remaining in foster care (he said that he only knew that she was in foster care with FF1 because his partner at the time (a Social Worker in Flintshire) told him about an incident that took place when she visited the home of FF1. He felt that Bryony should have stayed in foster care with FF2 rather than be allowed to return to her mother, he felt that she was doing well with FF2 and that she was happy and settled. He said he made this known to SW3 at the time.

When Bryony told him that she was being prescribed anti-depressants he asked why she needed them and she said it was to help her sleep. He said when he saw her he tried to cheer her up, he couldn't understand why she felt the way she did.

Father agreed with the learning point made by the review in relation to the safe storage of medication.

He spoke about an incident that took place whilst Bryony was on holiday with him and said that the events described by Bryony's boyfriend and mother, which led to an altercation between father and boyfriend were not entirely accurate. The detail of these events are not pertinent to this report however the author has agreed to include reference to father disputing the accuracy of the accounts given by boyfriend and mother.

He said he could not understand why Bryony had 'done what she had done' and that it had been a terrible shock to him.

2.5 Conversation with Bryony's Boyfriend

Bryony met her long term boyfriend at High School 2, they met shortly after she joined the school in May 2013.

Her boyfriend described her as being a strong character with a great sense of humour. She had a vulnerable side to her character although she was not really seen as being vulnerable by others as she could appear assertive. He said she was drawn to 'the darker side of life' and enjoyed risk taking and was rebellious, although he stressed that she was also very caring and protective of others, especially those that she considered to be less fortunate than herself.

He had met Bryony's mother whilst Bryony was placed with FF1 and had a good relationship with Bryony's family who were supportive of the relationship. He had seen FF1M but did not know either of the foster carers. However FF1M had formed an opinion that Bryony's boyfriend was 'bad for her' alleging he was taking drugs and thus prevented Bryony from having contact with him. Boyfriend's father challenged FF1M about this accusation in a telephone conversation.

Bryony's boyfriend said that Bryony had told him that she was not happy in the placement with FF1, although she did not make any specific allegations or disclosures about inappropriate behaviour by FF1M.

2.6 Information provided by Foster Carers FF1 and FF2

2.6.1 Conversation with FF1F

FF1F met with the Chair of the Review and the Lead Reviewer in October 2015. FF1M was unable to attend the interview due to work commitments.

FF1F described Bryony as a complex character. When Bryony first came to the placement in January 2013 the foster carers were aware that she had been experiencing difficulties and had been missing from home on occasion, and that her relationship with her mother had become difficult. Bryony had previously been referred to FF1 in July 2012 however she was not placed with them at that time (she was placed locally and took an overdose shortly afterwards).

FF1F said that they were not told that Bryony had been using drugs and with hindsight felt that she may have been withdrawing from drugs when she first came to the placement.

Bryony settled into the placement fairly well and got on with the foster carer's daughter (FF1 Child) and another child in placement (Child Z). FF1F described the care that was taken in ensuring that all medication and knives were kept safely as they knew that Bryony had self-harmed and taken an overdose previously.

Arrangements for Bryony's schooling were handled by CWAC; although FF1 would usually have been proactive in arranging a school place for children placed with them, because Bryony was an 'out of area' placement, this was left with CWAC to organise. Due to delays in finding a school for Bryony she did not have a school place until early May 2013. During

this time she was with FF1 at home without any schooling. FF1F said that Bryony would go out with them sometimes; they would occasionally go on shopping trips or to other activities.

FF1F talked about Bryony's friendships; when she first came to placement Bryony had had a couple of friends over from the local area (on separate occasions). A contract had been established with Bryony's mother setting out some requirements for FF1 to find out more about Bryony's friends to ensure that she was not associating with people from the local area who may increase her vulnerabilities.

FF1F recalled that when Bryony went to school she made friends and spent time with them. Bryony began a relationship with an older boy at the same school in the summer of 2012. FF1F said that they did not approve of the relationship as they had heard rumours about him that they were uncomfortable with. They tried to discourage Bryony from seeing him, but suspected that Bryony's mother was supportive of the relationship and that he was allowed by Bryony's mother to attend contact visits.

FF1F said that relations between Bryony and her mother remained unstable whilst she was in placement. FF1 heard arguments on the phone and when on contact visits and Bryony would often be upset at these times. However FF1F said that Bryony loved her mother and it was Bryony's wish to return home at some point.

FF1F was asked about some specific incidents of which the review had been made aware, these were related to Bryony having chronic head-lice infestation; an incident involving with a Social Worker from Flintshire who had been the previous partner of Bryony's father and the allegations made by Bryony in relation to FF1M that led to her leaving the placement in January 2014. FF1F's views on each of these are shown below.

FF1F said they were aware that Bryony had a problem with head lice when she first came to the placement. FF1 bought lotion for Bryony's hair but Bryony didn't want them (FF1) to apply it so she did this herself (or with the help of her mother on one occasion). The problem recurred a number of times whilst Bryony was in placement.

In March 2013 two social workers visited the home of FF1 to return a child who had absconded from placement. During the visit there was an altercation between Bryony and her father's ex-partner in which Bryony became very upset. FF1F recalled that she did not hear what was said between Bryony and the ex-partner but that the ex-partner approached FF1F before leaving and told her that Bryony was 'trouble'. (Some elements of this account conflict with other sources of information set out on Page 29).

Whilst in placement Bryony went on several holidays, firstly to America in March 2013 with the whole family, then to Devon in May to a family wedding and then on several shorter trips in Wales. On the trips in Wales FF1F did not attend as she was looking after her mother who was elderly and very unwell.

In October 2013 the relationship between Bryony and her foster carers began to deteriorate. FF1F attributed this deterioration to the local authority decision to apply for a care order, which was granted in October 2013. Bryony was very unhappy about this and

made her feelings known to SW2. Bryony stated clearly that she wanted to go home to her mother. FF1F felt that this was a turning point in the placement and said that Bryony became uncooperative and difficult at this time. Bryony's mother had told Bryony that she would move to Wales to be closer to her which FF1F felt was an unrealistic promise that unsettled Bryony. FF1F said that Bryony was also truanting from school at this time.

Over Christmas 2013 and into the new-year Bryony was unsettled and somewhat withdrawn (she later disclosed that she had felt that she wanted to kill herself at this time).

In January 2014 at a contact visit with her mother Bryony made an allegation that FF1M had touched her inappropriately and that he had facilitated her having a large tattoo on her back whilst on holiday in America in March 2013. FF1F said that as far as they (FF1) were concerned the allegations were totally untrue. Following this allegation Bryony was removed from the placement.

2.6.2 Conversation with FF2F

FF2F was met with the lead reviewer and the LSCB Business Manager in August 2015. FF2M was not present at the interview due to work commitments.

FF2F described Bryony's demeanour when she first came to the placement as being closed and distant. FF2F had been told by NFASW1 that Bryony had made allegations about FF1M in relation to inappropriate behaviour of a sexual nature and that FF2 and their family should be vigilant and ensure that Bryony was not left alone with adult males in the family. FF2F was also told that Bryony had alleged that, whilst on holiday in America during March 2013 FF1M had facilitated her receiving a tattoo to her back.

FF2F exercised caution but was adamant that she felt Bryony posed no risk whatever in this regard and she found it unnecessary to 'police' Bryony's interactions in this way.

When Bryony arrived at the placement with FF2 she was described as being 'infested' with head lice. FF2F described her hair as being matted and she had sores on her head and had a highly visible skin condition as a consequence. FF2F saw 'hundreds' of head lice on the pillow of Bryony's bed and on items in the bathroom that Bryony had used. FF2F said she was horrified that such a significant problem had gone untreated and that it must have been apparent to the previous foster carers.

FF2F asked Bryony's mother to assist in the treatment of the head lice which were eradicated after several weeks of treatment and care from FF2F and Bryony's mother.

Within a short time of entering the placement with FF2 Bryony began to relax and engage with FF2 and their child. Bryony participated in family life and was described as being a joy to be around. Bryony remained 'closed' in relation to things that had happened to her in the past, but she did open up to FF2F about wanting to go home to her mother and her aspirations in life. FF2F told the review about Bryony's extraordinary ability for writing poetry which she said was beautiful.

At this time Bryony's relationship with her boyfriend was allowed to flourish. FF2F told the review that he appeared to be a caring and responsible young man and that he and Bryony

were never problematic or difficult with her, showing respect and consideration when spending time together at FF2's home.

FF2F said that Bryony continued to attend High School 3 during the placement, however Bryony was very focused on returning home to her mother and began to withdraw somewhat from school life.

CHAPTER 3

3 AGENCY INVOLVEMENT WITH BRYONY AND HER FAMILY 2011-2015

3.1 2011

In February 2011 Bryony's mother contacted CAMHS directly and spoke to the psychiatrist who had seen Bryony previously. Bryony was given an appointment for a home visit in March when she was seen by a clinical psychologist. Bryony said that she didn't feel that CAMHS would be of benefit to her

In March Bryony again presented to her GP with abdominal pain (she had previously presented in March 2009 when extensive tests were undertaken and Bryony was referred to the Consultant Paediatrician. Bryony told a Healthcare Assistant that she did most of the work at home and was the main carer for her mother. The Consultant Paediatrician explained that there was no sinister pathology associated with the pain and that the symptoms Bryony was experiencing could be intensified by anxiety. The Consultant made a referral to CAMHS in June of that year).

Bryony was admitted to Countess of Chester Hospital (COCH) for a diagnostic laparoscopy to remove an ovarian cyst. Professionals noted some tension in the relationship between Bryony and her mother, specifically that Bryony felt that mother had not responded appropriately to her pain and that she appeared 'angry' with mother about this. She was discharged five days later.

Bryony was seen again by CAMHS in April and reiterated that she did not want to engage with the service. Later that month Bryony's mother rang the service to say that Bryony had been 'scratching her wrists'. CAMHS spoke to Children's Social Care (CSC) about their concerns, they noted that Bryony was self-harming. During this period there were two missed appointments with CAMHS.

In May CAMHS conducted another home visit and agreed to make a referral to CSC to obtain support for Bryony and her mother in the form of outreach workers. CAMHS were concerned about Bryony's feelings of anger, social isolation and hopelessness about her situation. The referral was made early in June and CSC responded in writing saying that the case did not meet the criteria for outreach interventions and that the Young Carers Service were best placed to work with Bryony.

In late June CAMHS closed the case due to non-engagement.[5]

In September Bryony transitioned from primary school to High School 1. The transition was later described by CAMHS as being 'difficult' for her, however she settled into High School having moved with a small group of close friends with whom she shared interests in and out of school.

[5] NSPCC Fact Sheet CAMHS Engagement

Later in the year Bryony joined the local Army Cadets[6]; around this time her mother told the Review that she noticed a big change in Bryony's behaviour. Bryony began to associate with a different peer group. The review team learned later that Bryony had made an historical disclosure of having been raped by the brother of a friend at Army Cadets. NB: This disclosure was made to her boyfriend some 2/3 years later both privately and again in the presence of her mother and a family support worker. No action appears to have been taken in relation to this disclosure.

Towards the end of the year Bryony's challenging behaviours intensified. She was angry with her mother and rebellious at home and at school. Bryony's attendance at school had, until this time, been 100% and her application in school was good, however, within a very short period of time her attendance fell dramatically (to around 78%) and she began to lose her long term friends. Around this time Bryony posted on Face-book that she had been pregnant and had had a miscarriage, this alienated many of her peer group and she began to associate with a new friendship group from outside of the school. There is reference in conversations to Bryony being targeted by an older boy at this time; despite enquiries it is not clear whether this boy was a pupil at High School 1.

3.2 2012

In January Bryony's mother contacted GP1 to discuss her concerns about Bryony's behaviour. She reported that Bryony was angry all the time, had intense and erratic moods and was refusing to go to school. Mother also reported that Bryony's father (who did not live at the family home) was finding it difficult to deal with her.

This consultation was followed by what was described as a very difficult consultation with Bryony present. It was noted that there were tensions between Bryony and her mother, Bryony said that she had not benefited from CAMHS as she did not want to reflect on her low moods and erratic behaviour, but she reluctantly agreed to be re-referred to the service.

GP1 made a referral to CSC and followed this with a telephone call in which Bryony's presentation was discussed. No further action was taken as a result of this referral as it was not considered to meet the threshold for statutory social care intervention.

At this time Bryony had been involved in activity of a sexualised nature on Face-book and was known by her mother and some professionals to be smoking cannabis. She had begun to experience problems at school and had been subject to temporary exclusions.

Bryony was seen by CAMHS in March at which point there was multi-agency involvement and a CAF was put in place, this was led by the Head of Year at High School 1 who had developed a good relationship with Bryony.

By the end of March 2012 Bryony had become a school refuser. CAF (Common Assessment Framework) meetings continued and although Bryony was not engaging with the CAF

[6] This is an Independent sector organisation that still operates in Chester. Police interviewed regarding Bryony's allegations. The organisation was cooperative and keen to develop safeguarding practice.

process mother was actively involved and engaged with professionals, she was supported by maternal grandparents. The Education Welfare Service (EWS) was becoming involved in an attempt to try to get Bryony back into school. Bryony appeared to establish a good relationship with the Educational Welfare Officer (EWO).

Bryony was now engaging with the Young Carer's Service (YCS) and was beginning to form a relationship with her key worker. She was involved in a group for young women and was sharing some of her feelings about being a young carer.

Bryony went missing from home in late March (concerns were later noted that mother did not contact police but mother denies this and says she contacted police who said that due to receiving text messages from Bryony she was not classed as 'missing'[7]).

YCS were involved in the CAF and were aware that Bryony's mother was struggling to maintain parental control, and that on one occasion when Bryony first began to go missing from home, her mother had not reported this to the police. This caused the YCS worker some concern which she shared with Bryony's mother. She informed mother that it was her intention to make a referral to Children's Social Care.

In early April a Multi-Agency Referral was received from YCS. The referral highlighted that there had been four exclusions from school during the previous month due to deterioration in Bryony's behaviour. It also noted Bryony's vulnerabilities in relation to going missing from home and the deterioration in her relationship with her mother. Bryony was reported as saying that she couldn't cope and previous self-harm in 2011 was noted in the referral (scratching arms and cutting hair).

CSC received the referral and decided that it required no further action by CSC due to the involvement of other agencies and the CAF. The referral was closed two days after it was received.

Following this referral Bryony's mother withdrew her consent for any further involvement with the YCS. The service could therefore no longer work with Bryony as they are a consent based service.

In early May Bryony's mother contacted police to report an altercation with Bryony. An officer went to the family home and found the situation calm, however Bryony refused to discuss the incident and was dismissive of the officer. In the police officer's notes it was recorded that Bryony's mother appeared unable to control Bryony's behaviour and that Bryony was not attending school.

At a CAF meeting at the beginning of May, which was attended by Bryony's mother and grandfather, a discussion was held about Bryony's behaviour escalating in terms of violence, aggression and involvement with police. It was agreed that High School 1 would make another referral to CSC, which they did later in May, it appears that there was no consideration of using the LSCB escalation procedures.

[7] The Missing from Home Protocol has been updated subsequently and the Review has confirmed that under the revised protocol Bryony would have been classed as missing even if she was in contact by text

Over the next two weeks Bryony went missing from home on several occasions; when spoken to about this Bryony was uncommunicative and angry. On one occasion she was arrested but not charged for a public order offence. Police made three CAVA referrals to CART (Contact and Referral Team) during this period none of which resulted in further action. Again it appears that no consideration was given to escalation. Police were concerned that Bryony may be exposed to risk of Child Sexual Exploitation (CSE)[8], although they could find no firm intelligence that linked Bryony to known CSE perpetrators.

Later in May a second referral was made to CSC, this was from High School 1. The referral requested additional support for Bryony and her mother. Reference was made to Bryony taking drugs and alcohol and engaging in sexual behaviour with a sixteen year old boy.

A home visit was undertaken by CAMHS and mother and Bryony were seen. Bryony's emotional distress was noted and reference was made to witnessing domestic violence as a child.

EWO had attended a CAMHS session with Bryony where she said that she wanted to 'work on her anger' she was calm at this session. It was noted that Bryony 'wanted to go to school but does not want to return to High School 1', the reason for Bryony's reluctance to go back to her original school is not recorded, although a subsequent professional conversation identified that there were concerns of a sexual nature involving a boy who had a connection with the school. Bryony's second choice of school was High School 4 where there was said to be capacity, placement at this school was to be discussed at the next CAF meeting, however there is no record of either the discussion or the outcome, and Bryony remained out of education. Had Bryony's preference been provided she may have returned to school at this point.

Following the referral from High School 1 an Initial Assessment conducted by a Social Worker who has since left the authority concluded that risk factors were minimised due to input from other agencies and a CAF being in place and identified mother and family as 'vital protective factors'. The outcome of the Initial Assessment was no further action from social care because universal services were supporting the family. The assessment noted that Bryony had said to CAMHS that she does have emotional issues and they were working with her to address these. It was also noted that mother had been made aware that she needed to parent her daughter in an appropriate manner and engage with all relevant services. There is an inherent contradiction in the professional viewpoints that cite mother as a vital protective factor but also suggest that she is parenting inappropriately.

Towards the end of May police were called to an incident at Bryony's home following an alleged assault on mother by Bryony in which she is said to have held her mother down by her wrists and threatened to break them. Officers attended and saw Bryony assaulting her

[8] Definition of Child Sexual Exploitation, National Working Group for CSE https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-exploitation/what-is-child-sexual-exploitation/

mother. They arrested Bryony and made referrals to CART and to Youth Offending Service (YOS).

Bryony became subject to a Final Warning following the assault on her mother and was referred to the YOS. The YOS worker described Bryony as 'coming out of the blue', she had no previous offences and her family profile was not one that was usually seen within the YOS cohort, family members were described as being pro-social.

At the initial meeting with the YOS worker Bryony was difficult to engage, she presented in an aggressive but child-like way, quickly becoming agitated and distracted. The YOS worker established that EWO was involved regarding non-school attendance and made contact with them.

The initial work with YOS was focused on setting boundaries and improving behaviour, Bryony was difficult to engage but there were one or two good sessions that involved Bryony and her mother.

In June the case was allocated to SW1 who was recently qualified. SW1 began an initial assessment following which a Child In Need (CIN) plan was put in place that involved family support and outreach workers engaging with the family, the focus of the work was to try to establish parenting boundaries with mother and to build up Bryony's relationship with her. At one point the Family Support Workers (FSWs) were going into the home three times per week. SW1 found Bryony hard to engage; the relationship between them was difficult from the outset with Bryony being verbally aggressive and hostile.

In July the YOS worker made a referral to Adult Social Care (ASC) as Bryony's offending related to her mother and there were clear risk factors. ASW1 went out to see Bryony's mother and conducted an assessment. She also reviewed the direct payments being made to mother, particularly to support her in having activities for herself and time away from Bryony. Following the assessment payments were increased however it was noted by ASW1 that mother did not take up any of the suggested activities.

From her assessment ASW1 concluded that multi agency discussions appeared to focus at that time on Bryony's risks to herself and not on the risk that she presented to her mother. It was noted by ASW1 that mother was in fear of Bryony and that there was a high level of aggression and intimidation towards her. ASW1 considered her role as being to safeguard mother. She found communication with Children's Social Care to be difficult and felt that there was an imbalance in the focus and the emphasis. She felt that the CIN plan that was in place was unclear and kept changing, she knew that S20 had been discussed but that this had then been changed in favour of multi-systemic therapy.[9] This did not directly involve Bryony and was a missed opportunity to work with the whole family.

Bryony remained out of school during this period, work was ongoing to try to re-engage her but this was unsuccessful. A medical needs application for home tuition was discussed at multi agency level and supported by CAMHS, although CAMHS did not submit this until

[9] http://www.mstuk.org/

June. (The request was initially declined by the education service but was subsequently reconsidered and approved in September).

Bryony was staying with maternal grandparents at this time and her behaviour appeared to stabilise when she was with them.

CIN meetings took place and were of the view that Bryony was continuing to put herself at risk in the community and the missing from home episodes continued. Bryony's mother was finding it difficult to cope and respite and S20 accommodation were discussed as possible options at CIN meetings. Bryony's grandparents were going on holiday in early July which was a concern for Bryony's mother who did not feel she could cope with Bryony's behaviour at home.

During July several incidents occurred in quick succession. The EWO became very concerned following a phone-call from Bryony's mother saying that Bryony had become hysterical and was blocking mother from leaving the home. The EWO rang CART who advised that she contact CAMHS. CAMHS advised that the EWO should re-contact Social Care who in turn told her that the case was now open. The advice given the nature of the concerns should have been to contact the police. The following evening Bryony went missing from home.

Later that month Bryony was arrested and charged with possession of an offensive weapon and two charges of criminal damage. This offence involved Bryony threatening her mother with a knife for which Bryony received a six months referral order.

Bryony's mother spoke to professionals and said that she could not cope with Bryony and needed respite, S20 was agreed and Bryony was placed foster care in the local area at the end of July. After one day in placement she was placed with another foster carer.

After four days in placement Bryony took an overdose of paracetamol tablets and was admitted to the Countess of Chester Hospital (COCH). She remained in hospital and a discharge planning meeting was held six days later at which Bryony's mother decided to withdraw Bryony from the S20. This was against the advice of Social Care and Health professionals.

Bryony appeared in Court the day after being discharged from hospital and received a six months referral order. She had not yet completed the final warning work with the YOS and the work that had begun in July continued. The YOS worker reported that Bryony struggled to engage with the referral order, she didn't see herself as a young offender and didn't like the panel elements of the order. The YOS arranged for different panel members to be in place for Bryony and worked hard not to criminalise her further for non-compliance.

A CIN meeting took place in early August where input to the family was discussed including frequent sessions from family support workers, YOS interventions and substance misuse

work, adult social care support for mother and involvement with Catch 22 regarding Child Sexual Exploitation (CSE) risks. [10]

On the same day as the CIN meeting Bryony saw the CAMHS Psychiatrist. It was recorded that there was no formal mental health diagnosis but acknowledgement that Bryony was experiencing emotional distress that is 'hard to regulate'. The psychiatrist noted no expressions of suicidal ideation (thoughts) or plans and there was no evidence of current self-injury. A follow up appointment was arranged to discuss risks and complexities.

Bryony attended the CAMHS follow up appointment with her mother in late August, she said that she did not want to be there and felt that she is 'made to come'. Bryony was uncommunicative in the session with mother saying that key issues were that Bryony's father is always letting her down (this is contested by Bryony's father); that Bryony is resentful of mother having a child with father and that she is resentful and feels guilty about mother's disability. The session ended with another appointment being offered and liaison with other services if Bryony chose not to engage with CAMHS.

At the beginning of September the case was closed to EWS as they judged that there 'was not an expectation that Bryony would be in school at this time'. By this time the EWO that had worked closely with Bryony had left the Authority. Bryony was referred for short stay education provision in September which was approved, however the first meeting to discuss this was not attended by Bryony, therefore her mother discussed the recent difficulties that she and Bryony had experienced.

Bryony began to attend Provision 1 in October. She struggled to attend as planned and her timetable was adjusted to two half days per week, although it is recorded that she never accessed both days at any time during the provision. She actually completed 7 sessions during the ten weeks that she was registered. Provision 1 had concerns about Bryony's high levels of anxiety and anger. Provision 1 liaised with the Family Support Workers regarding these concerns and were also in contact with the YOS worker.

At a CIN meeting in mid-September concerns were discussed in relation to Bryony remaining at home with her mother. The view of the multi-agency meeting was that Bryony's mother was unable to exercise parental control due to continuing concerns about Bryony's risk taking behaviour, and that this placed both Bryony and mother at risk. Discussion took place regarding foster placement (a place had been identified) but it was decided to continue with other interventions and review at the next CIN meeting.

Between the middle of September and middle of October there were several incidents in which Bryony was missing from home. She was spoken to by police and other professionals but refused to say where she had been and what she had been doing. The relationship with her mother continued to be difficult and professionals expressed concerns about the risks that Bryony was exposed to, primarily around CSE and the risks that Bryony presented to her mother. YOS and Catch 22 were continuing their input to increase understanding of risk of CSE with both Bryony and her mother. Bryony's mother was asked to find out as much

[10] http://www.nwgnetwork.org/who-we-are/what-is-child-sexual-exploitation

information as possible about where Bryony was going and who she was with in order to support the efforts to identify any links to CSE. Bryony's mother was in regular contact with police and Catch 22 at this time and was supportive of their efforts to engage Bryony.

A further CIN meeting took place in mid-October which was chaired by a manager in CSC. The meeting heard reports of Bryony not living at home and that she had periods of staying with family members and with friends.

A further CIN meeting took place in November at which concerns in relation to missing from home episodes and missed appointments were discussed. It was noted that there appeared to be improvement in Bryony's risks and vulnerabilities at this meeting although with hindsight this view is not supported by information provided to the review.

At the end of November Bryony presented with her mother at COCH having consumed a large amount of alcohol and 'white powder'. A senior nurse assessed Bryony and concluded that this was not an overdose or intended self-harm incident. No checks were made on the substance that Bryony had taken, and no links were made to Bryony's previous overdose. Bryony was discharged to the care of her mother.

At the end of December Bryony's mother reported her missing. Bryony was found to be staying with an older 'friend' who was known to police and CSC (her children were subject to Child Protection Planning). Both agencies had recorded their concerns about her lifestyle and associates. The person was not known to Bryony's mother but she was aware that Bryony was staying with her.

The Catch 22 and YOS workers went to visit Bryony at the friend's home and were concerned about Bryony's presentation. They notified CSC that Bryony was staying at the address and expressed their concerns that CSC had not picked up that Chid B was living there, although it is not clear how they would have expected CSC to know this without notification by Bryony or her mother.

3.3 2013

Following the contact from Catch 22 and YOS a social worker made an unannounced home visit to the address but could not gain access. A note was made to return to the address, however there is no record that this visit took place. In early January it is recorded that the social worker made a visit to the friend's address and that Bryony was 'seen'. Two days later Bryony was seen by the social worker at her home address.

At the beginning of January a CIN meeting took place where Bryony's continuing exposure to risk and the deterioration in the relationship with her mother and ongoing risk factors were discussed. Mother was struggling to implement any boundaries with relation to Bryony. The need for immediate placement in foster care due to escalating risks at home was agreed. Funding had been secured and foster carers had been identified in Conwy.

Following the CIN meeting mother agreed to Bryony being accommodated under S20 and Bryony moved to Wales to live with FF1. Although mother was reluctant to do this she

could see no other way to alleviate the current situation and saw this as a temporary solution.

In January 2013 Provision 1 received information that Bryony had moved out of the area into a foster placement. GP1 was also informed that Bryony was had moved to a foster placement in North Wales.

The Catch 22 and the YOS worker were involved in Bryony's move to the placement which they described as being very traumatic for Bryony.

The placement was in a rural area in North Wales which was deemed by professionals to be helpful for Bryony as it was felt that this would break the connection between her and the lifestyle and peers that were placing her at risk in the local area. The initial plan was that Bryony would remain in the placement for around six weeks during which time she could achieve some stability and rehabilitation work could begin which would facilitate a return home to her mother.

At the end of January YOS worker visited Bryony at her placement and found her to be benefiting from being away from her home area, she said she felt safer and she engaged in the session**.**

In February the IRO (Independent Reviewing Officer) conducted the first LAC (Looked After Child) Review. This took place in two parts as mother had difficulty finding the placement address and arrived very late; the IRO noted that Bryony appeared to be benefiting from the placement, she said she was missing her mother but seemed to be settling down and her risk taking behaviour had ceased. She also appeared calmer and less anxious. It was agreed at this meeting that Bryony was benefitting from the placement and that it should continue. A further LAC review was scheduled for April.

In March 2013 Bryony had her first appointment with GP2 in North Wales. The GP observed that there was no eye contact and that it was very difficult to form any kind of rapport and that Bryony was 'very disinterested in being at the Doctors'. GP2 noted a number of concerns raised by Bryony, including her mental/emotional health although Bryony did not discuss this in great detail. GP2 referred Bryony to North Wales CAMHS in March (she was seen by them in June).

In early March whilst Bryony was at the placement address two social workers from Flintshire Social Care visited to return a child who had absconded from placement. One of the Social workers was known to Bryony as she was the ex-partner of Bryony's father. FF1F recalled the incident, she thought that Bryony may have heard the ex-partner's voice and recognised it and come out of her bedroom to see what was happening.

FF1F told the review that a verbal altercation took place between Bryony and the ex-partner. It is FF1Fs recollection that after the altercation with Bryony the ex-partner went into the kitchen and told FF1F that Bryony was 'trouble' and that she should be careful. FF1F said that she then notified NFA (National Fostering Agency) about the incident; however the review has found no record of this following contact with the NFA. The review did not speak

to the ex-partner however in a separate enquiry by her employer she disputed the accuracy of FF1F's account of these events.

NFA reported that they notified Flintshire Social Services and CWAC Children's Services, however Flintshire Social Services advised the review that they had no record of this contact. As a consequence the review group has referred the matter to Flintshire Social Services. NB: The review has heard conflicting accounts of this altercation from Conwy Children's Services, FF1F and the NFA in relation to the content of the argument between Bryony and the ex-partner and who was present when it took place. Because of this the review has been unable to include it as a key episode. The review recommends that any subsequent LADO or investigative process looks into the detail of this event.

Shortly after this incident Bryony went on holiday to America with FF1, Child FF1 and Child Z. NFA and CWAC CSC were consulted and gave permission for this holiday. *NB The allegations made by Bryony in January 2014 relate to incidents alleged to have occurred during this holiday.*

A LAC review took place in April at which the IRO noted that no assessment had been completed in relation to work required to rehabilitate the relationship between Bryony and mother. The IRO was therefore unable to discuss the plan with mother. Bryony spoke to the IRO about the tension that she felt between wanting to be with at home with her mother, whilst not wanting to return to the local area and to her previous lifestyle.

Mother remained unhappy with the plan and felt she was not consulted about Bryony's needs. She expressed concern to the IRO and to SW1 with the way things were going, she said she did not feel involved and a separate meeting was held to discuss the placement. The IRO requested that a clear plan needed to be made available and discussed with mother as a matter of priority. There is no record that this meeting took place.

At the beginning of May Bryony started at High School 2, almost five months after being placed with FF1. The deputy head of school 2 recalls Bryony's first day at the school saying that she was 'almost feral' (angry and hostile) and that she didn't want to come to school. Bryony had a gradual introduction to the school, going in for a few days at first. Following the long summer holidays Bryony returned to school in September. Her behaviours had improved and she was said to have developed a good relationship with FF1 Child who was a year younger than Bryony.

In May Bryony attended the wedding of a member of FF1. During a conversation at the wedding Bryony told a member of FF1's family that she had been raped in the past. The family member told FF1M who reported the allegation to a manager in CWAC Children's Services.

In June Bryony attended a CAMHS appointment where she was accompanied by FF1M and SW1. Bryony spoke about her previous experiences and that she felt she was beginning to feel more positive and in control of her feelings and behaviours. The CAMHS practitioner spoke to CP1 in in the Cheshire West CAMHS Service regarding Bryony's involvement with them. The appointment was followed up with a further appointment four days later, which

Bryony attended with FF1M. They discussed whether Bryony wanted to attend any psycho-therapeutic sessions. Bryony said that she didn't feel she would benefit from this as it might disrupt the progress she was making by stirring up difficult emotions. Bryony was discharged from the service with no further appointments made.

A few days after the CAMHS appointment SW1 conducted a visit to the placement to talk to Bryony about the allegation of rape that she had made to FF1's family member. This was almost a month after the allegation was made. Bryony was angry about being asked to discuss the allegation. SW1 asked Bryony whether she had made the allegation and whether she wanted to say anything else about it. Bryony said that she did not want to talk about it and that she had already told CAMHS that she didn't want to talk about her past as she didn't want to have any more nightmares. She told SW1 that the person she had spoken to had 'got things mixed up'. SW1 accepted Bryony's explanation and the allegation was not pursued any further. It is the view of the review team that this allegation should have resulted in a strategy meeting being held.

In June the school nurse for High School 2 received the Child Health Record, although Bryony had been in North Wales since January 2013, this was a cause for concern to her as Bryony was a Looked-After Child with vulnerabilities and an immediate transfer of the record would be expected.

The Nurse Specialist from CWP (Cheshire and Wirral Partnership NHS Foundation Trust) had attempted to contact the Nurse Specialist in North Wales in January to inform them that Bryony had moved to North Wales but was still attending High School 1 and that the school nurse for High School 1 would continue to provide the school nursing service. This communication does not appear to have been received by the school nurse at High School 2.

In June the school nurse at High School 1 informed the Nurse Specialist that Bryony had left High School 1 and was now on roll at High School 2. The records were transferred to North Wales by the CWP Safeguarding Department. On receipt of the record the school nurse at High School 2 wrote to FF1 and offered to make a separate appointment if there were any identified health needs of which she was not already aware, none were identified by FF1.

In early July SW1 handed the case over to SW2, they conducted a joint visit and met with Bryony and FF1.

That same month Bryony's mother signed a written agreement giving the foster carers designated authority regarding Bryony accessing friends. Bryony's mother later questioned whether this was needed however it remained in place.

Later in July the social workers for Bryony and FF1M held a conversation regarding a request from FF1M to take Bryony and Child Z on holiday for two weeks without FF1F being in attendance.

SW2 spoke to FF1M regarding potential vulnerability to Bryony making allegations. SW2 recorded the detail of her conversation with FF1M who said that he had no concerns in this regard. NFA approved the holiday and it went ahead as planned with FF1M taking Bryony

and Child Z. The only change to the plan was that they stayed in a cottage rather than going camping. There was no record of a corresponding discussion about potential risks to Bryony presented by this scenario which illustrates a skewed perception of risk to adults rather than to the child.

Bryony's mother continued to express her dissatisfaction at various aspects of the care plan. She was concerned that no rehabilitation work was taking place to bring herself and Bryony together and reconcile their difficulties, and she was asking for more frequent contact visits with Bryony. She also requested more unsupervised contact. Following one of her telephone conversations with SW2 Bryony's mother made a complaint to the local authority about SW2. This complaint was considered to be without foundation by SW2's manager.

During September the Local Authority took legal advice at a meeting to discuss initiating proceedings. A decision was taken not to inform Bryony's mother of this until court papers were issued due to concerns that she would attempt to 'sabotage' Bryony's placement.

Bryony's mother raised concerns at this time about the relationship between Bryony and FF1M. FF1M had bought Bryony two pairs of trainers because she could not decide which ones she wanted. FF1M had also bought clothing for Bryony which her mother considered to be inappropriate for her age. SW2's manager noted the concerns and spoke to FF1 about them. There is no record of the response given by FF1 or any action taken by FF1 in this regard.

SW2 wrote a chronology and statement to the Court that contained information about the family and expressed the view that Bryony's mother was uncooperative and was not working with the Social Care to make the placement work. The report focused heavily on a lack of co-operation by Bryony's mother as the rationale for changing the plan from temporary to permanent care. There appears to have been no additional assessment of parenting capacity nor any reference to rehabilitative work that should have been taking place as part of the care plan.

High School 2 noted that Bryony had started a relationship with a boy who was an ex pupil of the school. FF1M was said to be very unhappy with the relationship and High School 2 noted that the relationship between Bryony and FF1M began to 'go off' at this time.

A third LAC review meeting was held in early October. Bryony's mother was still unhappy with the plan and did not feel that any reconciliation work had been undertaken (the IRO substantiated this when talking to the review). FF1 had suggested to Social Workers that they needed to share parental responsibility to increase Bryony's stability.

The IRO noted at this meeting that FF1M had changed in his appearance; he had dyed his hair, which was previously white/grey and was wearing 'younger' clothes.

The IRO noted the change in Bryony's demeanour and presentation and asked Bryony what she could do to assist her. Bryony did not make any disclosures at this meeting however she did say that she was not happy in the placement and that she wanted to go home to her mother. Bryony told the IRO that people 'don't understand' although she did not go into any detail about what she meant by this.

The IRO was uncomfortable about the dynamic between Bryony and FF1M and raised this with her manager in supervision.

Following the application for a care order, the CAFCASS guardian received a referral from the court in early October. She arranged to meet with Bryony to discuss her views on this. When she first met Bryony she found her to be verbally aggressive and distracted. At this point the Local Authority had completed a parenting assessment (which the review has not seen) that concluded that Bryony's mother was not able to manage her daughter's behaviour and thereby safeguard her.

The CAFCASS guardian was aware that the relationship between mother and SW2 was not constructive, that mother did not want Bryony to remain in care and that by this time Bryony wanted to return home to her mother.

The placement with FF1 was beginning to show signs of breaking down with FF1 reporting problems to NFA and Bryony saying to SW2 and the IRO that she was not happy. Bryony's mother was trying to get increased contact with Bryony and she told Bryony that she had thought about moving to Wales to be close to her if the placement became permanent. This was perceived by SW2 and her manager to be disruptive and unsettling for Bryony.

In late October SW2 met with Bryony's father; he said he had not seen Bryony in over a year but that he wanted to renew contact and intended to make himself party to proceedings.

In a discussion with NFASW2 FF1M reported that Bryony's behaviour was causing tension in the home and that she had said that she wanted to punch him. There is no record that Bryony was asked why she felt this way and why her behaviour had deteriorated.

In December NFASW1 spoke to FF1F following information that Bryony had cut clumps out of her hair and it was recorded in the NFA notes that Bryony had head lice.

3.4 2014

Bryony saw GP2 in early January where she reported anxieties about ongoing issues from her past. She said that she was tired all the time and that she had thought about self-harm in December. Bryony had previously said that she did not find sessions with CAMHS helpful however GP2 referred back to CAMHS following a discussion with FF1M and the Head of Year at High School 2.

In January High School 2 spoke to CWAC CSC to say that Bryony had taken medication home over the Christmas 2013 holidays as they did not want it on school premises, and that Bryony had been in low mood. Two days later at a statutory visit between FF1 and SW2 information was shared that Bryony had thought about taking her own life on Christmas Day 2013, she said she had been planning this for three months but that she could not access medication in the carer's home. The NFA Social Worker notified CWAC CSC however it appears that no further action was taken.

Two days after this Bryony disclosed to her mother during a telephone call that, whilst on holiday in America in March 2013 FF1M had taken her for a tattoo for which he had paid;

she said he had told her that she should keep this a secret and that he had not informed his wife.

SW2 had by this time left the authority and the case had been reallocated to another social worker SW3 who picked up the case on the same day that Bryony made allegations about FF1M.

SW3 met with her manager and arranged to go out to see Bryony immediately. The meeting was arranged to take place at High School 2. The meeting was a volatile one, Bryony was very unhappy with her mother for sharing the disclosure she had made. Due to the nature of the allegations the foster children placed with FF1 were removed pending investigation. Bryony was upset that her disclosure had disrupted the lives of the other children in the care of FF1.

Bryony was placed with another foster carer in North Wales, FF2. FF2F was told by the NFA Social Worker that Bryony might present a risk to the family in the form of making allegations about inappropriate behaviour by the male foster carer and that she should exercise caution in this regard. FF2F said that she found exercised caution but soon realised that Bryony presented no risk.

Within a day of Bryony being placed with FF2 it became apparent that she had a significant head lice infestation. FF2F said that she was shocked when she went into Bryony's room and saw 'hundreds of head lice' on the pillow.

It was apparent that this had been the case for a number of months and FF2 learned that it had been raised with FF1 by Bryony's mother who had been told by FF1 that it was not their responsibility to treat the problem and that they had acquired lotion for Bryony to use.

Following the move to FF2 Bryony underwent a routine health assessment as she had been in care for 12 months, the community paediatrician found Bryony to be in good physical health overall but noted that Bryony required ongoing support with emotional wellbeing and mental health. As a result of the assessment Bryony's GP made a re-referral to CAMHS in North Wales.

A LADO Part IV[11] meeting took place in January which made recommendations that further information should be gathered from all agencies and that a Section 47 investigation should be undertaken.

In relation to the allegations about FF1M North Wales Police undertook an Achieving Best Evidence (ABE) interview during which Bryony gave details of the tattoo parlour in America where she said she had been taken to be tattooed.

Bryony provided a detailed account of the location of the tattoo parlour, and how the tattooist had been told that FF1M was Bryony's father. Bryony also provided details of how

[11] Local Authority Designated Officer http://gov.wales/topics/health/socialcare/safeguarding/?lang=en

the tattoo had been paid for with cash withdrawn from a local cash machine. These particular lines of enquiry were not pursued by North Wales police.

North Wales police followed up the ABE by interviewing FF1 Child, Child Z and FF1F however none of them corroborated Bryony's allegations. Police spoke to FF1M who denied the allegations and said that they were several hours' late back from a trip because his mobile phone had broken.

In March a further meeting was held at which it was agreed that the allegations made by Bryony were unsubstantiated. A letter was sent to FF1 in early April by the Child Protection Coordinator in Conwy informing them of the outcome of the investigations.

At this time the CAFCASS guardian and SW3 were liaising and had discussed the possibility of Bryony returning home to her mother; they were both in agreement that this was desirable and that with a clear plan and support it could be achieved. SW3 conducted a parenting assessment with Bryony's mother and spoke to Bryony about her wishes and feelings. It was clear to SW3 that Bryony wanted to return to her mother, and that Bryony's mother wanted her to return home.

Another looked after review took place in March 2014 which the IRO noted as being a very different review to the previous one held in October 2013. By this time the LA were working with CAFCASS regarding the final plan in relation to care proceedings and to Bryony returning home on a care order which SW3, the Guardian and IRO agreed would be in Bryony's best interests. Communication with FF2F and Bryony's mother was good and everyone was working together with an agreed purpose.

In April the CAFCASS Guardian prepared a final report for Court proposing that Bryony be returned to the care of her mother on a care order. The Court agreed to this proposal and arrangements were made for Bryony to return to her mother, which took place in May. These arrangements did not go smoothly initially as Bryony expected to return immediately after the Court judgment, however there were some delays which resulted in some distress for Bryony, one of these delays was in relation to identifying a suitable school place in CWAC.

High School 3 was approached in June to take Bryony onto roll as part of the plan to move her back to live at home. The school believed that a place with them was not in Bryony's best interests, however, the move was agreed, but by the time this happened there was only one week of school left. It had been decided that Bryony would join school and repeat the school year (without any of the pupils being aware). It was planned that Bryony would come in for two 'short days' to familiarise herself with the school.

During the summer Bryony and her mother received ongoing support from the Family Support Worker and SW3. Although there were some issues with Bryony settling into home, the relationship between Bryony and her mother appeared to have stabilised. Bryony said she was happy to be home and wanted things to continue to be calm and 'normal'. She said she was looking forward to going back to school.

In September Bryony attended High School 3 on the first day of term. The following day she was hospitalised having taken what was described by clinicians as a 'significant' overdose. She had taken paracetamol, Cocodamol and Diazepam tablets. Bryony was assessed in A&E and remained in hospital for medical care and assessment by CAMHS following which she was discharged to the care of her mother. She was discharged home with a CAMHS follow up appointment in September which Bryony attended. It was assessed that her mood was low and deteriorating, Bryony was prescribed Fluoxetine by CAMHS and given a follow up appointment.

In September the Social Worker of Child Z, who was now placed in a different local authority placement in England, reported that Child Z had made a disclosure about FF1M's alleged inappropriate behaviour towards Bryony whilst they were both placed with FF1 during 2013. The disclosure was that Child Z confirmed what Bryony had said about inappropriate behaviour whilst on holiday in August 2013 and that he had seen FF1M rubbing the inside of Bryony's thigh and that FF1M had bought alcohol for the children. The disclosure resulted in a LADO Part IV investigation and was found to be substantiated. This resulted in FF1 being de-registered as foster carers.

Bryony remained out of school at this time and discussions were held as to how best to ensure Bryony's continuing education. Funding was arranged by which she could be tutored at home and a personal education plan was put in place to provide education at home.

A Family Support Worker continued to visit Bryony and her mother at home and there was ongoing involvement with SW3. There was some deterioration in the relationship with Bryony and her mother, with arguments becoming more frequent and Bryony's mother expressing concerns about coping with Bryony's behaviour. The Family Support Worker had been told by Bryony's mother and boyfriend that Bryony had confided in them that historically she had been raped by the brother of a friend at Army Cadets.

At a two part meeting in late September SW3 expressed concern that Bryony may not be able to remain with her mother, and noted that a referral would be made to the Access to Resources team, there is no record of this referral having been made.

In late October NFA held a meeting with FF1 to discuss the substantiated allegations made by Child Z. During this meeting FF1M was asked whether he facilitated any of the foster children drinking alcohol. The response was that when on holiday in Devon (in August 2013) FF1M had bought beer and wine but that he didn't think either Bryony or Child Z drank any of this. Child Z's disclosure included information that FF1M bought alcohol for both Bryony and Child Z and allowed them to consume it, and that FF1M had touched Bryony inappropriately. FF1M's statement that he had purchased alcohol which 'may' have been consumed by Bryony and Child Z was not followed up as a safeguarding issue by NFA.

At the beginning of November a CAMHS review took place at which integration into school at some point in the future was discussed although Bryony felt overwhelmed by this and had concerns about meeting up with old associates in the local area.. At this time Bryony was being prescribed Fluoxetine to help with symptoms of low mood. Bryony's mood had

improved and although she had occasional thoughts of self-injury she said she had no plans to harm herself. She spoke of feeling left out and marginalised by her family.

Bryony was referred to the Adolescent CAMHS service provided by Caring 2 Care (Barnardos) which is a service for children in care, however there was a waiting list for the service and it was hoped that Bryony would be seen sometime in the early part of the new-year.

Bryony saw her father on a number of occasions during this period and it was discussed with mother that Bryony and her father may take a holiday together.

3.5 2015

Bryony had a further appointment with CAMHS in January 2015 where her medication was again reviewed. It had been reported that things had been 'up and down' over Christmas at home. It was recorded that Bryony was responding well to her medication.

In early January SW3 made a request to the CWP Nurse Specialists for the annual review health assessment due in February to be arranged. Bryony's school health record was not available to the school nurse so she made a request for and received a copy of the 2014 review health assessment from the Social worker.

Towards the end January a contact was made by SW3 with Barnardo's Caring 2 Care service. Bryony had spoken to the Social Worker saying that she had 'had a breakdown' the night before and had cut herself with knives. Police had been called to the incident at Bryony's home by mother who said that Bryony was attempting to harm herself with a knife. They found Bryony was in a hysterical state but unharmed, an ambulance had been assigned but was not required.

Bryony said that she was not taking her medication properly and Police discussed going back to GP (Bryony was not registered with a local GP at this time) and to CAMHS with Bryony's mother. Bryony's sibling was also present and police noted that Bryony was willing to speak in front of her mother and sibling. It was confirmed that contact would be made with SW3 the following day.

The incident was rated as low risk as Bryony was with a supportive parent and sibling; police were not aware at this time that Bryony was subject to a care order and they were made aware that Bryony was in contact with CAMHS and with a Social Worker. The vulnerable person assessment box was ticked on the form rather than the child welfare box, this did not affect the processing of the referral as it was rated low risk. By the time the vulnerable person assessment was submitted Bryony had died.

In January an earlier approach made by Bryony's father to CSC to ask whether he could take Bryony on holiday to celebrate her birthday was discussed by SW3 and her manager. Whilst it was acknowledged that there were potential risks associated with this request (there is no evidence that a formal risk assessment was conducted) it was felt that on balance, if they refused to allow Bryony to travel with her father that she would be at liberty to go anyway.

Bryony's mother told the review that she was not happy about the holiday but that she didn't feel she could prevent Bryony from going. This conflicts with information from SW3 who said that Bryony's mother was happy for her to go on holiday. In early February Bryony's mother rang CAMHS to say that she was unable to attend her appointment, however no reason for this was given (Bryony was in fact on holiday with her father at this time).

Bryony went on holiday with her father as they had arranged. Bryony had made arrangements for her boyfriend to join her on the holiday but it is not clear whether Bryony's father was informed; this appears to have been a source of disagreement between Bryony and her father.

Bryony's boyfriend told the review that he and Bryony were arguing and that Bryony's father intervened and then assaulted him. Bryony retaliated and her father then assaulted her.

Father was charged by the local (Spanish) police and given a suspended community sentence. Enquiries made at the request of this review revealed that the Spanish authorities had forwarded the details and documentation to ACPO (the Association of Chief Police Officers) and that they were in a queue to be uploaded onto the Police National Computer (PNC).

Bryony and her boyfriend contacted Bryony's mother who arranged return flights to the UK for them and met them at the airport. SW3 had advised Bryony's mother that professionals would need to consider if it was safe for Bryony to continue living at home in light of the incident. Bryony's mother said that Bryony asked her whether she would be taken into care again and mother was truthful with her and told her that this was a possibility. She said this made Bryony extremely anxious.

When Bryony returned from the holiday she was in low mood, the following day Bryony spoke to her boyfriend on the telephone about their relationship. He told her that he did not feel that the relationship could continue.

The following morning Bryony's mother's carer found Bryony lifeless in her bedroom at home. Paramedics were called to Bryony's home and Bryony was pronounced dead at the scene.

CHAPTER 4

ANALYSIS AND LEARNING

4. KEY PRACTICE EPISODES AND ANALYSIS

The Review has identified thirteen key episodes or pivotal points in the case using the information from the conversations and other evidence provided. These key episodes are highlighted in the narrative set out above and are described and analysed in further detail in this section. The key episodes are as follows:

1 Referral by CAMHS to CSC in June 2011
2 Referrals to Children's Social Care in March by GP, April by YCS and May by High School 1 2012
3 S20 placement and subsequent overdose July/August 2012
4 Placement with FF1 January 2013
5 LAC Review and Change of Plan April 2013
6 CSC Enquiries into disclosure made by Bryony regarding an historic rape - June 2013
7 Local Authority apply for and are granted a care order[12] September 2013
8 LAC Review Meeting in October 2013
9 Allegations made by Bryony in relation to FF1M and subsequent enquiries January 2014
10 Bryony's placement with FF2 in January 2014
11 Bryony's overdose in September 2014
12 Disclosure by Child Z in September 2014
13 Decision to allow Bryony to go on holiday with her father in February 2015

The findings in section 5 of this report use an adaptation of the framework developed by SCIE[13] to highlight learning.

4.1 Key Episode 1 – CAMHS referral to CSC in March 2011

Following an appointment with CAMHS in early March 2011 the service made a referral to CSC. Whilst CAMHS could find no evidence of mental illness, they had concerns about Bryony's emotional wellbeing, her feelings of isolation and anger in relation to her role as a young carer and her feelings of hopelessness about her situation. The referral contained information that Bryony had been self-harming and that she was experiencing low mood and low self-esteem.

It was the view of the referrer that Bryony would benefit from support in dealing with her feelings of isolation and that this could be achieved by the provision of outreach services.[14]

[12] http://www.legislation.gov.uk/ukpga/1989/41/section/31
[13] http://www.scie.org.uk/publications/ataglance/ataglance01.asp
[14] http://cwpcamhscentre.mymind.org.uk/?page_id=11

CSC telephoned CAMHS to discuss the referral, this was followed by a letter informing CAMHS that there was no role for CSC and that Bryony should receive support from the Young Carer's Service.

4.1.1. Analysis of Practice

The information contained in the referral was sufficient to warrant assessment based on two key factors, firstly that Bryony had said she was experiencing feeling of hopelessness and isolation and that she was self-harming. This also warranted the continuing involvement of CAMHS, however Bryony did not want the service.

This was a missed opportunity to conduct an assessment which would have considered Bryony's needs in relation to early help. It would also have provided an opportunity to address emerging difficulties in the relationship between Bryony and her mother.

4.2. Key Episode 2 – Referrals made to CSC in March, April and May 2012

During March, April and May three separate referrals were made to CSC.

Bryony and her mother had presented to GP1 on two occasions in February and March 2012. Bryony's mother was very concerned about her erratic behaviour and displays of anger and aggression. GP1 made a referral to CAMHS following the first presentation and to CSC following the second presentation. GP1 followed up the referral with a phone call to CSC who informed that they would be taking no further action.

A CAF was in place at this time which was led by High School 1. Bryony's school attendance and behaviour had deteriorated significantly during the first three months of 2012 and by the end of March she was considered to be a school refuser (i.e. she was not attending school at all). She had engaged with the YCS and had begun to talk about her feelings of anger and isolation and her low self-esteem.

Both High School 1 and the YCS were concerned about Bryony and felt that the case should be open to CSC. Mother was engaging in the CAF but Bryony was not, and it was apparent to school and the YCS that there were difficulties in the relationship between Bryony and her mother. Bryony had been subject to a number of school exclusions and by the end of March had stopped attending school altogether.

4.2.1. Analysis of Practice

GP1 was alert to mother's concerns regarding Bryony's behaviour and responded by referring to CAMHS based on assessment of clinical needs, followed by a referral to CSC. There is no record of why CSC took the decision for no further action.

Concerns for Bryony were escalating, both the YCS and High School 1 felt that the case required CSC involvement due to the level of risk that Bryony was exposed to. Bryony had begun to engage in the YCS which was a positive step however engagement with the service was fragile due to her continuing risk behaviour. When YCS made their referral to CSC they were aware that Bryony's mother would withdraw her consent for Bryony to attend the service as she had told them that she would do this, thereby removing an important means

of support to Bryony in her role as a young carer. It is not clear whether YCS informed CSC of mother's withdrawal of consent nor does it appear to have been taken into account by CSC in making their decision of no further action. Furthermore there should have been consideration given to the earlier decision by CART in March 2011 that Bryony should be supported by YCS. Even with this now in place the situation was deteriorating which should have led to a single assessment.

The response to the first referral was to continue with the CAF and for school to continue to provide support however Bryony was not attending school at this time and was classed as a school-refuser.

Although Bryony had been out of school for almost two months High School 1 were still leading the CAF. When consent was withdrawn for Bryony to attend YCS it was decided between YCS and High School 1 that High School 1 should make a referral which they did in May. Bryony was continuing to go missing from home and to engage in other risk taking behaviours at this time.

At this stage CSC should have called a professionals meeting to discuss the case in a multi-agency context. There is no rationale given for rejecting the third referral.

There is no evidence that agencies involved in the CAF (i.e. High School 1 and YCS) considered using escalation as a means of highlighting concerns.

4.3. Key Episode 3 – Bryony placed in foster care in July 2012 and took an overdose of tablets

Following a period of missing from home episodes, concerns regarding CSE and altercations between Bryony and her mother, mother said she could no longer cope with Bryony as she was at risk from her and could not control her behaviour.

A core assessment commenced at the end of July (completed in September) which identified Bryony's risk factors, largely attributing these to her behaviours which are often referred to in the referral as lifestyle choices, these include indications of harmful sexual behaviours, use of drugs and alcohol and missing from home. Bryony was 12 years old at this time.

Following a further incident at home involving aggression towards her mother, a decision was taken to place Bryony in foster care.

In light of Bryony stating that she would harm herself if taken into care there is no evidence of an assessment of the potential impact on Bryony or of any actions that were taken to mitigate risk and support Bryony.

Bryony spent one night in placement. She was then placed with another foster carer and after a further two days in placement took an overdose of paracetamol, which resulted in her being hospitalised. A discharge planning meeting was held in which Bryony's mother withdrew her request/consent for S20, although it is recorded that this was against the advice of social care and health professionals.

4.3.1. Analysis of Practice

The placement of Bryony in foster care was made in response to escalating concerns about Bryony's risk taking behaviour and aggression towards her mother which was a justifiable decision and was taken with mother's full consent.

Professionals did not appear to balance Bryony's wishes and feelings against the planned intervention. There appears to be no clear plan for managing the placement or for reintegrating Bryony once the placement had ended.

There is no evidence that Bryony's response to the placement was considered in future planning, although a referral was made for further CAMHS interventions.

Bryony's propensity for self-harm was beginning to emerge as a significant factor however this does not appear to influence professional judgment in managing this and future 'crises'.[15]

4.4. Key Episode 4 – In January 2013 Bryony placed in foster care with FF1 in North Wales

Following a CIN meeting in early January it was agreed that Bryony be placed with FF1. Bryony's mother was in agreement with the placement and, although Bryony was said to be traumatised by the decision, the placement was deemed by all parties to be in her best interests.

It was felt that the location of the placement would be beneficial to Bryony as it was out of area in a rural setting which Bryony would find it difficult to abscond from. This was considered a protective factor, although this was not the only reason that FF1 was selected, it appears that there were no placements available locally for Bryony.

Bryony was accompanied to the placement by the Catch 22 worker and the YOS worker and was said to be traumatised by the experience. She was visited by both workers in late January and they noted that she appeared to have settled very well into the placement. This was good practice.

4.4.1. Analysis of Practice

This event is significant in that all parties, including Bryony's mother, were in agreement with the placement. The rationale for the placement appears to have been based on Bryony's continuing risks and vulnerabilities and mother's continuing inability to exercise parental control, in addition to the risks she presented to mother.

It is not clear what preparation was made with Bryony and how/whether her wishes and feelings were taken into consideration. It would have been good practice to arrange for Bryony to meet the carers prior to placement.[16]

[15] BAAF Adoption and Fostering Academy: Ten Top Tips for devising a care plan (2015) E. Amende and L. Patterson

[16] http://smileadoptionandfostering.co.uk/

Bryony's mother agreed to the S20 based on the understanding that this would be a temporary arrangement of between 6-12 weeks during which time rehabilitative work would be undertaken to return Bryony home to the care of her mother. Bryony's mother says she would not have agreed to the placement had she known that it could be extended without her consent.

4.5 Key Episode 5 – Following the LAC review the Care Plan is changed for Bryony to remain in the care of FF1 indefinitely – April 2013

The first LAC review took place in February 2013 shortly after Bryony was placed with FF1. The Care Plan at that time was that the placement should last for around 3 months to enable rehabilitative work to take place between Bryony and her mother to facilitate Bryony's return home.

A second LAC review took place in April 2013. Bryony was reported to be doing well in her placement, the difficult behaviours she had exhibited at home had ceased and she was settling well into the placement. Bryony reported that she was happy, although she was missing her mother. Plans were being made for Bryony to start at a local high school. No problems were reported by FF1 and it was judged by the IRO that the placement was meeting Bryony's needs, despite Bryony's educational needs not being met.

The IRO had to undertake the review in two parts because the assessment had not been completed. The Social Work team had presented a plan based on a core assessment however the core assessment had not been written up or provided to Bryony's mother. The IRO said that it was crucial that the assessment was available for scrutiny and discussion with mother.

Mother was unhappy about the plan and felt that she was not sufficiently involved or consulted about decisions that affected Bryony. The view of the Social Worker and Social Work manager was that Bryony's mother was uncooperative and trying to destabilise the placement.

Following this LAC review discussions were held in relation to the length of the placement and a decision was taken that the placement should be extended for 'as long as is necessary', although there is no clarity about what this means. Bryony's mother says that she was not party to these discussions and that it was some time later that she was told that the plan had changed and that the plan was that Bryony would remain in the placement in the long term. The rationale for this was the view of CSC that the work needed to rehabilitate the relationship between Bryony and her mother could not be achieved, (there is no explanation of why); that Bryony was stable in the placement and that she was not reverting to previous behaviours, this was in some part attributed to the location of the foster placement; the IRO reported that the view was that if Bryony was returned home she would go straight back to her previous behaviours.

4.5.1. Analysis of Practice

Due to the lack of a clear and agreed care plan the IRO had insufficient information on which to base her approval, the requested assessment had not been completed, nor had the core assessment been written up.

However, it was the view of the IRO that the placement was of benefit to Bryony (and to her mother) although mother had expressed her unhappiness with the way the placement was being managed and felt that she was being excluded from important decisions about Bryony's life.

The wishes of Bryony in relation to extending the placement (with a view to permanence) do not appear to have been taken into consideration.

There is no evidence of rehabilitative work having taken place or any efforts to undertake such work to reunify Bryony and her mother as was the stated intention at the start of the placement.

4.6. Key Episode 6 – SW1 spoke to Bryony regarding a disclosure of rape – June 2013

In May 2013 Bryony attended the wedding of a family member of FF1. In a conversation with a member of the family Bryony made a disclosure that she had been raped in the past. The family member passed this information to FF1M who spoke to a CSC manager in CWAC. The manager noted the concern and arranged for SW1 to visit Bryony to discuss the disclosure. SW1 visited Bryony in June to discuss the disclosure.

SW1 spoke to Bryony alone, she asked Bryony whether she knew why SW1 was there and what she wanted to talk to her about. Bryony said that she did know why the visit was taking place and that she was not happy about the visit and that the conversation had been disclosed. Bryony said that the nephew had misinterpreted what she had told him.

Bryony became angry and said that she did not want to talk about it anymore. She had seen CAMHS the day before and had told them that she did not want to discuss her past, she said she didn't want to talk about things that would give her nightmares. SW1 noted that Bryony became very withdrawn and would only respond by nodding or shaking her head. She noted that Bryony did not want to discuss it further and did not want to make a complaint about the incident.

4.6.1. Analysis of Practice

SW1 saw Bryony alone to discuss the allegation which is expected practice. She noted that Bryony was angry and upset about the conversation and that Bryony did not want to talk about it. SW1 offered Bryony the opportunity to talk about the alleged incident at any time in the future. After this there was no further action from Children's Social Care. There was no attempt to investigate Bryony's allegations further. This disclosure warranted a S47 strategy discussion with police given the nature of allegation.

4.7. Key Practice Episode 7 – Local Authority Application for a Care Order – September 2013

In September 2013, following a Legal Planning Meeting, SW2 drew up a statement to Court in support of an application for a care order. It was decided by CSC that Bryony's mother would not be informed or consulted in relation to this.

A statement was written by SW2 which outlined the reasons for the local authority's decision. This was heavily focused on the view that Bryony's mother was unable to exercise parental control over her; that relations between Bryony and her mother were difficult and that Bryony's mother had attempted to 'de-stabilise' the foster care placement and was not willing to co-operate with the care plan.

The Court granted an interim care order. The Guardian did not make any objection to the decision, nor was it contested by Bryony's mother.

4.7.1. Analysis of Practice

There was a clear and documented decision not to inform Bryony's that the local authority intended to initiate care proceedings prior to Bryony's mother being issued with the necessary court papers. This resulted in Bryony's mother being unable to express her views in relation to the proposal or to discuss any alternative means of securing Bryony's care needs.

Bryony's mother felt that decisions had been taken 'behind closed doors' that were not in her daughter's best interests.

Bryony was not informed of the local authority to initiate care proceedings and was unware of the decision by the Court until she was informed by SW2 at a meeting in October at the placement. FF1F was present at this meeting and said that Bryony became upset and angry when she was told about the decision. She spoke to her mother on the phone shortly afterwards.

FF1F felt that this was a turning point in the placement and from that time Bryony became unsettled and withdrew from FF1 and from the placement.

4.8 Key Episode 8: LAC Review October 2013

This review was markedly different to the two previous LAC reviews. The plan by this point was to continue with the placement with FF1. The IRO observed changes in Bryony and FF1M that troubled her. She noted that FF1M had changed his appearance, he had dyed his hair and was wearing 'younger' clothes. The IRO felt that FF1M was markedly different in appearance and when asked he said that Bryony had given him a makeover. (NFASW1 said that he did not feel there had been significant changes in FF1M's appearance although he had dyed his hair, but had quickly dyed it back to the original colour).

Bryony appeared to be particularly distressed at the meeting, she was tearful and said that she did not want to remain in the placement and that she wanted to go home to her mother. Bryony kept saying to the IRO 'you don't understand', the IRO asked Bryony to tell her what was wrong, she felt that Bryony was thinking 'you don't get it'.

The IRO had concerns and spoke to her manager, there had been no disclosures however the IRO noted Bryony's distress. The IRO was uncomfortable with what she felt was an unusual dynamic between Bryony and FF1M. The IRO Manager indicated that this was then discussed with the NFA but it appears that no further action was taken.

Bryony's mother continued to express her unhappiness with the plan, SW2 had taken over the case in July and the relationship between SW2 and mother was not positive. Mother had put in a complaint about SW2 as she felt she was not being consulted about the plan and that decisions were being taken about Bryony's long term future that she was not involved in.

The LAC review noted that Bryony had begun to withdraw from the placement and that the relationship between her and FF1 was breaking down. It notes that Bryony's wishes and feelings about the placement have, in the past, been variable and that she has recognised the potential risk of returning to previous behaviours if she returns to her mother, but that she is conflicted because she wants to return home.

4.8.1. Analysis of Practice

The Local Authority had submitted an application to Court for a care order in September which had been granted. The content of the application was strongly focused on the opinion of SW2 and their manager that Bryony's mother was attempting to de-stabilise the foster placement. The application shows a lack of objectivity and makes no reference to Bryony's wishes and feelings or evidence to underpin how mother was seeking to destabilise the placement.

The Team Manager had met with Bryony's mother in August to agree extended contact arrangements, however this decision was 'overturned' at a closed meeting in September without consultation with Bryony's mother.

There is no evidence that Bryony's mother was consulted about the application to court. The relationship between Bryony's mother and SW2 appears to be negative and potentially to have influenced decision making.

Bryony was clearly displaying distress at the meeting, there was some discussion with her about this and an attempt by the IRO to understand the nature of the distress. Reference was made to having support from CAMHS if this was needed by Bryony, however Bryony had recently been seen by CAMHS who had assessed that she would not benefit from the service, and Bryony had said that she did not feel that she needed CAMHS interventions.

The response to the IRO's concerns about FF1M's presentation and the relationship between him and Bryony was not pursued any further although the IRO had sufficient concerns about FF1M's behaviour to raise this with her manager. The IRO spoke to Bryony alone however Bryony would not disclose the reason for her distress.

4.9. Key Episode 9 - Allegations made by Bryony in relation to FF1M and subsequent enquiries – January 2014

At a contact visit in early January Bryony had told her mother that FF1M had facilitated her having a tattoo on her back whilst they were on holiday in America in March 2013 and that he 'fancied her'. Mother reported this to the police who contacted CSC via the Emergency Duty Team. The Manager in CSC spoke to SW3 about the allegation and asked her to go out to see Bryony to discuss it.

At this time SW3 had not met Bryony, nor had she met FF1 although she had spoken to FF1M about the placement when she first took over the case (a few days previously). During that conversation she had been told that the placement was not going well, FF1M had told SW3 that Bryony did not want to go to a medical or CAMHS appointment. SW3 said she found FF1M's tone to be aggressive but did not form an opinion about this. She had tried to speak to him about this previously and had spoken to FF1F who said she would need to speak to her husband, SW3 found this somewhat unusual as both were foster carers for Bryony.

On arriving at High School 2 where the meeting was taking place SW3 found Bryony to be upset and aggressive, she was very upset that the disclosure had been shared as she had asked her mother not to tell anyone. SW3's first impression of Bryony was that she was a very striking girl who looked older than her age (she was 13 at this time). She also observed the extent of Bryony's anger, distress and unhappiness. SW3 explained why she was visiting and reassured Bryony that she would go away if that is what she wanted, but that she did need to confirm with Bryony that she had the tattoo, Bryony confirmed this.

The meeting was a difficult one but SW3 was understanding of Bryony's situation and allowed her time to come to terms with what had happened.

Following the meeting SW3 contacted all family members and left Bryony at school. Bryony walked out of school, she contacted her mother to ask her to come and get her, mother did this but also informed SW3 that this was happening, she said she was taking Bryony to her maternal grandparent's home. SW3 went there to meet them and stayed until the evening. SW3 had been ringing round to find a placement and found one in North Wales (FF2). Bryony was taken there by her mother.

A strategy meeting took place between CWAC CSC and Cheshire police at which it was agreed to contact North Wales Police and Conwy Social Services to arrange a Part 1V (LADO) meeting.

SW3 spoke openly to mother about her perceived lack of cooperation with CSC to date and that she was seen as being difficult to work with. SW3 said that she wanted to work with Bryony and her mother; this was the beginning of a positive working relationship.

In January Bryony was invited to give an 'Achieving Best Evidence (ABE)' interview with police regarding her allegations. SW3 attended the interview with her. Bryony provided

detailed information about the tattoo parlour in America and all the events that took place on the day.

Three LADO meetings took place during January and February to consider the allegations made by Bryony. At the first LADO meeting the allegations were discussed by the meeting and it was decided that further information was necessary, including information from the ABE and that interviews should be conducted with Child FF1, Child Z and FF1F in relation to the accounts Bryony had given.

The second meeting of the LADO considered information from police who stated that it was not their intention to pursue a criminal investigation based on the information provided by Bryony at the ABE. The NFA views expressed in the meeting appear to cast doubt on the validity of Bryony's disclosures and suggested that they should be treated with caution. There are inconsistencies in the minutes of the meeting thereby making it difficult for the review to form a judgement on its objectivity, however, there is a statement from the NFA that two previous allegations had been 'strategised', further enquiries made on behalf of the review found this not to be the case.

At the third meeting it was concluded that Bryony's allegations were 'unsubstantiated'. A letter was sent to FF1 in March informing them of the outcome of the LADO investigations and that they would remain on the register as foster carers.

4.9.1 Analysis of Practice

North Wales police responded appropriately to the S47 and spoke with Bryony and the witnesses she had identified, albeit neither FF1F nor Child FF1 could be considered independent. No corroboration to the allegations was established from these interviews and as such the decision to 'no further action' is understandable. However, further lines of enquiry could have been progressed given the detailed ABE account provided by Bryony.

FF1M was interviewed and he denied any inappropriate behaviour with Bryony, but did say he gave her 'lower leg and foot massages' at her request. This was mentioned by Bryony in her ABE but not probed by the interviewer.

The LADO process was followed correctly however decision making appeared to rely heavily on the police ABE and their decision not to pursue the tattoo allegations any further.

The position taken by NFA in relation to the validity of Bryony's allegations appear to be at odds with safeguarding guidance in that it appears heavily weighted towards FF1.

4.10 Key Episode 10 – Bryony's placement with FF2 – January 2014

Following the allegations made in relation to FF1M Bryony was moved to another placement in North Wales in January 2014. FF2F recalled that Bryony was at first very reticent and a little withdrawn, wearing the hood of her jacket up. FF2F had been told by FF2SW2 about the allegations made against FF1M and that the family should be very careful about leaving Bryony alone with FF2M because she may make allegations against him.

Within a day of the placement FF2F saw that Bryony had an infestation of head-lice. She found them all over Bryony's pillow and on items in the bathroom. She was shocked at the extent of the infestation, noting that Bryony had sores on her scalp and dermatitis as a result of it. FF2F said she was horrified that this had not been dealt with previously. She discussed the best way to deal with it with Bryony and her mother, and they worked together to overcome the problem, with Bryony's mother coming to FF2's home to clean and comb Bryony's hair in addition to treatment by FF2F. FF2F described this as bonding time for her and Bryony and her mother.

Within a few weeks of being in placement Bryony began to relax and 'blossom'. She and FF2 established a very positive and close relationship, although FF2F acknowledged that Bryony had many fears and anxieties that she would not discuss with anyone.

It was clear to FF2F that Bryony wanted to be at home with her mother, although she did have concerns about the threats and risks that she may face if she returned to the local area. SW3 was involved in the placement and was working closely with CAFCASS and with Bryony's mother to effect the necessary changes in their relationship to enable Bryony to return home.

4.10.1 Analysis of Practice

SW3 supported Bryony into her new placement and worked closely with FF2 and Bryony's mother.

There is no evidence of written documentation in relation to a change in the care plan following the new placement.

Bryony's annual Review Health Assessment was completed within six weeks of the new placement and was within expected timeframes.

4.11. Key Episode 11 - Bryony's took a second overdose - September 2014

In September Bryony attended High School 3 on the first day of term. The following day she was hospitalised having taken what was described by clinicians as a 'significant' overdose. She had taken paracetamol, Co-codamol and Diazepam tablets. Bryony was assessed in A&E and remained in hospital for medical care and assessment by CAMHS following which she was discharged to the care of her mother. She was discharged home with a CAMHS follow up appointment in September which Bryony attended. It was assessed that her mood was low and deteriorating, Bryony was prescribed Fluoxetine by CAMHS and given a follow up appointment.

4.11.1 Analysis of Practice

This was Bryony's second intentional overdose and an indication that she was distressed in relation to attending school and reinforcement of her propensity to self-harm. This should have prompted a professionals meeting and further consideration of what additional

information or multi-agency actions might be required at this time. It is not clear why such a meeting was not called by either COCH, CAMHS or the supervising Social Worker.[17]

4.12. Key Episode 12 – Child Z' made a disclosure re allegations against FF1M - September 2014

In September the Social Worker of Child Z, who was now placed in a different local authority placement in England, reported that Child Z had made a disclosure about FF1M's inappropriate behaviour towards Bryony whilst they were both placed with him during 2013. This disclosure resulted in a further LADO Part IV investigation and was found to be substantiated. This resulted in FF1 being deregistered as foster carers.

The NFA arranged a meeting with FF1 to discuss the outcome of the Part IV meeting and to offer appropriate guidance to FF1 in relation to de-registration.

4.12.1 Analysis of Practice

The correct procedures appear to have been followed in relation to the new information available pertaining to the allegation.

These were managed by the Local Authority in Conwy. Communication with CWAC Social Care is not clear from the records.

The information provided by Child Z should have been investigated further by North Wales police to clarify exactly what they had seen and the nature of the touching to which they referred. The LADO changed their decision to 'substantiated' on the balance of probability following a vote by all parties in attendance. North Wales Police did not think the allegation was substantiated by Child Z's disclosure and NFA abstained from voting.

4.13 Key Episode 13 – CSC make a decision to allow Bryony to go on holiday with her father - January 2015

Bryony had recently had more contact with her father (from around October 2014) and SW3 was aware that they had been talking about going on holiday together. This had been discussed with mother who did not object to the proposal to SW3. As Bryony was a Looked after Child permission was required from the local authority for her to leave the country.

Bryony's father spoke to SW3 and asked permission to take her on holiday. SW3 said that she would have to speak to her manager about this, which she did. There appears to have been a discussion about potential risks, but this did not include a full or documented risk assessment. The decision was taken that Bryony should be allowed to go on holiday abroad with her father.

[17] https://www.nice.org.uk/guidance/qs34

4.13.1 Analysis of Practice

SW3 received the request from Bryony's father in January. She felt that it would be good for Bryony to strengthen her relationship with her father, however, she recognised that the decision to allow him to take her away on holiday required discussion with a senior manager. SW3 had spoken to Bryony's mother about the holiday and mother did not express concerns, SW3 reported that mother was generally supportive of the proposal. It was SW3's view that, given Bryony's age, she could have made the decision to go on holiday without permission from the local authority.

Following consultation with her manager, SW3 was asked to undertake a risk assessment in relation to the proposed holiday. Risk assessments procedures are in place however there is no written record of a full assessment having been completed. This is particularly significant given father's known history of domestic abuse (with Bryony's mother and his recent partner) and his known history of alcohol misuse.

SW3 indicated that she felt that Bryony would have 'gone on holiday anyway, without the consent of the Local Authority'. This could not have happened as Bryony was on a care order and the Local Authority could have withheld her passport should this have been deemed necessary in order to safeguard Bryony. Management oversight of the decision does not appear to have been based on a robust risk assessment.

4.14 Research Questions

4.14.1 Is there evidence of timely and robust risk assessment that underpins decision-making?

During the period under review Bryony was at risk from self-harming behaviours; possible CSE, harmful sexual behaviour with peers, harm from offending and substance misuse and ongoing emotional and psychological harm that would be likely to impact her development and future life. Her violent and aggressive behaviour towards her mother also presented adult safeguarding risks.

The risk of self-harm was assessed by CAMHS, although on each occasion that CAMHS assessed it was stated that Bryony did not report suicidal ideation; this appears to conflict with Bryony's actions as she purposely took overdoses on three occasions (one of which resulted in her death), and also presented to A&E having taken an unknown substance that made her unwell.[18]

The response from single agencies in relation to risk assessment was variable. YOS and Catch 22 were both alert to Bryony's risks of offending, substance misuse and possible CSE and responded appropriately, although Bryony's reluctance to talk to them about her experiences meant that interventions did not serve to reduce risk to Bryony.

[18] http://www.iriss.org.uk/resources/understanding-suicide-and-self-harm-amongst-children-care-and-care-leavers

The multi-agency effort in relation to identification and management of risks appeared to be obscured by a lack of clarity about how to manage these risks and by a series of 'crises' that drove multi agency working.

There was no multi-agency risk/vulnerability[19] assessment of Bryony or her mother or, perhaps most importantly of them as a family.

4.14.2. Is the voice of the child evident and does it inform practice and outcomes?

There is evidence that agencies did try to understand Bryony's wants and needs. There are built-in procedures (e.g. within LAC reviews) to ask for the Child's views. However the panel could find no evidence of a consistent or coordinated multi-agency approach to taking Bryony's wishes and feelings into consideration when planning single or multi-agency interventions.

Listening and building relationships with young people such as Bryony can be challenging for professionals but is a vital component of establishing trust and ensuring that the young person has influence over what happens to them.[20]

The Catch 22, YCS and YOS connected well with Bryony and it appears that she responded to workers in these agencies. The CSC response was less interactive, although processes to consult with Bryony were put in place, particularly when SW3 took over the case in January 2014.

There are specific examples where Bryony's wishes and feelings do not appear to have influenced decision making i.e. the decision to place Bryony in foster care in July 2012, the decision not to offer Bryony her first choice of school when she returned to the local area from FF2. The rationale for these decisions is unclear to the Review Team, however the Review Team accepts that agencies may, on occasion, need to make decisions that do not correspond with the wishes of the child. It is important in these instances to record the rationale for the decisions not to act on the Child's wishes and feelings and to talk to the child about the reasons for their decisions.

4.14.3 Were responses by agencies undertaken in a timely fashion when safeguarding concerns were apparent? *(Response to incidents)*

For the most part agency responses appear to have been timely when safeguarding concerns were apparent, however there is one significant instance where a delay in response was apparent.

[19] Guidance contained in the CWAC Risk/Vulnerability Matrix
[20] http://www.communitycare.co.uk/2010/09/17/gaining-the-trust-of-troubled-teenagers/

There is evidence of a lack of escalation in relation to the referrals to CART in early 2012 with the response from the CAF being to send in a second referral from High School 1 one month later. When this was rejected no further action was taken by High School 1.

4.14.4 Did safeguarding processes, including recording systems support information sharing and decision making in this case? *(Agency to agency systems; tools to support professional judgment)*

Record keeping throughout the case is of a variable quality. The review found examples of information not being shared in a timely manner particularly in relation to sharing information across geographic areas, this is not specific to particular agencies.

Sharing information between Adult Services and Children's Services was problematic, the review learned that, although both services use the Liquid Logic system, they cannot access each other's records. This creates an unnecessary and unhelpful blockage in the sharing of assessments, risk management and care plans as well as other important information upon which case decisions are made. Practitioners said that they would find it helpful to be able to access case information on a 'read only' basis to enable them to note any safeguarding flags or information on risk management (e.g. drug or alcohol problems, mental health problems, violent and disruptive behaviours).

The review would not discourage professionals from sharing information verbally or in meetings or indeed holding case management discussions however this should be supported by accessible information systems.

Some important discussion and decisions were made verbally on the telephone, whilst this is not unacceptable practice, the need to record these discussions and decisions in case notes cannot be overlooked.

In compiling the integrated chronology the review received partial or inaccurate information on some important aspects of the case that required follow-up by the review team. This includes information gathered in relation to specific events (e.g. the incident that took place involving the Flintshire Social Worker). This has been noted in the findings as an area for improvement.

4.14.5 How well did agencies communicate with each other to share and seek information from other agencies? *(Agency to agency systems; tools to support professional judgment) – See Finding*

Communication and information sharing during the period under review was inconsistent, both within and between agencies. The sharing of information within and across geographic boundaries was also inconsistent and difficult to track.

The Review has found that improvements are needed in relation to joint working between CSC and ASC. In this case the safeguarding systems for children and adults did not align, indeed the two services worked largely in isolation from each other, each having a focus on either the adult or the child – rather than seeing the needs of the family as a whole. The Adult Social Worker found it difficult to access support and information from Children's

Social Care, with electronic record systems being inaccessible between the two services. There was no mechanism or requirement for shared planning for the family, leading to the needs of Bryony and those of her mother resulting in conflict between the services.

The sharing of information between CWAC Children's Services and Conwy Children's Services (and with the National Fostering Agency) is difficult to track on occasion. – Clearer and more transparent reporting, quality assurance and governance arrangements are needed.

Sharing of school health information between SN1 and SN2 did not take place effectively, there was misunderstanding about where (and if) Bryony was attending school that led to a delay in information provided by SN1 when Bryony entered placement in January 2013 being communicated to the School Nursing Service in North Wales. Effectively this meant that no school health agency was aware of Bryony's whereabouts between January and June 2013. Prompt notification of placements by CWAC and appropriate information sharing when a child starts to be looked after or changes placement are crucial in assisting health organisations to share accurate information in a timely manner. [21]

Other safeguarding processes such as the use of S20 Accommodation and the acquisition of a care order by the Local Authority were used in this case. There is a question as to the judgment to use S20 on a longer term basis without any significant efforts at rehabilitation; the rationale for seeking a care order is well documented however it is questionable whether this was a balanced assessment and judgment given a lack of consultation with Bryony's mother and no evidence of significant effort to rehabilitate the family.

4.14.6 Is there a clear rationale for changes to the care plan in April 2013?

The absence of a written care plan during the first four months of Bryony's placement with FF1 caused difficulties for the IRO and for mother. The LAC Reviews that took place in February and April 2012 indicate that the initial plan was for Bryony to stay in placement for around six weeks to stabilise her behaviour and to work towards rehabilitation to enable Bryony to return home.

There is no evidence that any rehabilitative work took place during this period. The decisions regarding the changes to the care plan are unclear and therefore appear to be without rationale.

4.14.7 There are significant gaps in education during the period under review – how was the child supported to achieve and what role did the virtual school play in this?

21

Decision making in relation to Bryony's educational needs and provision appears uncoordinated and inconsistent lacking a long term focus that would provide stability to Bryony.

The Personal Education Plan (PEP) viewed by the review contained little background information and did not contain a clear statement or plan. The PEP was not updated at any time during the period under review.

Bryony's education was discussed at CAF and CIN meetings and decisions were made in relation to applications for home schooling based on medical needs, which was granted, and for which provision was put in place in September, as was Bryony's attendance at Provision 1. However, once Bryony moved to placement in North Wales the review has seen no evidence of proactive work from CWAC to secure a school place for Bryony. There is no explanation of the delay in securing a place for Bryony at High School 2.

In planning for return to the local area in April/May 2014 discussions were held with the LAC Education Coordinator regarding Bryony's needs. Bryony had expressed a preference not to return to a school in the local area and had given a first choice of school outside of the area. This request was not met although there is no indication of why this was the case.

Bryony was placed at High School 3 who consulted to make the best arrangements for Bryony. A decision was made that Bryony should begin year 10 again because she had lost so much schooling. The intention was that no one in the school would be informed that Bryony was in fact a year 11 student. The likelihood of being able to keep this information from becoming known by other pupils seems slight and may have contributed to Bryony's discomfort at starting at High School 3 in September 2014.

4.14.8 How did parental disability impact on agency responses? How was this supported?

Bryony was identified as a young carer and referred to the local YCS. Bryony clearly indicated to services, including CAMHS, YOS, Catch 22, her GP and YCS that she felt isolated, frustrated, angry and worried about her mother's disability and her role as a young carer. Bryony had heard her father say that she was responsible for her mother's disability which must have caused her considerable distress at the time and in her adolescence.

From a practical perspective, Bryony's caring responsibilities limited her social interaction on occasion, although this did not seem to manifest as an issue for Bryony until she reached adolescence.

The YCS were working with Bryony to understand her feelings about being a young carer and sharing her experiences, thoughts and feelings with other young people and with a skilled support worker. Unfortunately, when YCS made a referral to CSC mother withdrew her consent for Bryony to attend the service.

The review notes that parental consent for involvement in services for young carers should not be a barrier to access or engagement.

The Adult Social Worker saw Bryony as a perpetrator of violence and aggression towards her mother and did not consider Bryony's risks and vulnerabilities. She acknowledged that she

could have done more to assist Bryony but found Bryony's presentation to be a barrier to positive engagement with her. This is poor practice. ASC should ensure that all staff receive sufficient training, support and supervision to ensure that negative perception and bias do not impact on effective practice.

4.14.9 Is the CAMHS response to adolescents who are experiencing behavioural difficulties, and who do not have a diagnosis of mental illness, robust and effective?

CAMHS in Cheshire West was one of the first agencies involved with Bryony following a referral by her GP in 2011. At that time the service assessed Bryony and found her to be emotionally distressed.

Throughout their ongoing contact with Bryony she was never assessed as having a mental illness. Her self-harming behaviours were known to the service. Suicidal ideation was not indicated in risk assessments that were completed.

CAMHS in North Wales saw Bryony on two occasions, both times FF1M was present. Bryony discussed her emotional distress and her desire to overcome her fears and anxieties, but said that she did not feel that engagement with CAMHS would help with this.

When Bryony returned to CWAC from North Wales she was again seen by CAMHS who prescribed fluoxetine to regulate Bryony's mood.

It is the view of the review team that CAMHS in CWAC made efforts to engage with Bryony despite her reluctance to be involved with them. They also provided home visits and attended meetings to discuss Bryony's needs and made efforts to respond to crises. However, the interventions offered appeared to lack creativity i.e. Bryony could have been offered an alternative to talking therapies given it was known to them that she enjoyed poetry and drawing.

The two appointments with CAMHS North Wales may have benefited from taking place without the foster carer and social worker being present.

4.14.10 Do professionals across and within agencies have the necessary skills to objectively assess adolescent risk taking behaviours?

There are examples of good quality risk assessment and risk management from YOS and Catch 22 in relation to Bryony's offending behaviour and risks of exposure to CSE.

The response from CSC was variable in relation to risk behaviours, there was an emphasis on reducing risk by removing Bryony from risk situations (e.g. placement in a rural area) and a focus on parental control, there is little evidence of the long term effectiveness of this approach.

Bryony's risks of self-harm do not appear to have been robustly managed by single or multi-agencies.

4.14.11 Did professionals demonstrate sufficient understanding of the interface between risk and vulnerability?

Bryony's risks and vulnerabilities are documented throughout this report (and throughout the case records). However, the professional mind-set appears to be oriented towards risk rather than vulnerability.

The CWAC risk and vulnerability matrix does not appear to have been used by professionals working with Bryony and her family.

4.14.12 Has the SCR identified issues of conduct or disciplinary nature and are there systems to manage this?

The SCR has not identified any issues of a conduct or disciplinary nature in CWAC. The review raised an issue with Flintshire Social Services in relation to the conduct of the Social Worker who visited the placement with FF1 in March 2012. Flintshire Social Services has conducted a review of the incident and has concluded that there was no professional misconduct.

4.14.13 How did the family dynamic influence professional practice and how was this managed? *(Family and Professional Interaction; Cognitive Influence and Human Bias in Processing Information)*

The relationship between professionals in CSC and Bryony's mother were 'difficult'. Many professionals noted that Bryony's mother was a strong character who had definite views and some, particularly YOS, Catch 22 and Police said that she was co-operative and helpful and proactive in providing information about Bryony's contacts to assist their investigations.

It is documented that SW1 and SW2 found it difficult to work with Bryony's mother, and that SW2 and her manager held the view that Bryony's mother was focused on de-stabilising the placement with FF1.

Until SW3 took over the case in January 2014 there is no evidence that a formal parenting assessment had been completed (although Bryony's mother had engaged with Family Support Work and Multi-Systemic Therapy). The basis for judgment in relation to mother's parenting capability and capacity is therefore subject to question as it appears to be based on subjective factors rather than evidence-based practice.

4.14.14 Has the review identified examples of good practice?

The Catch 22 and YOS workers established strong professional relationships with Bryony and made considerable efforts to engage her. They both demonstrated an intrinsic understanding of Bryony's difficulty in engaging with services and in 'opening up'. Both tried to shape their services to meet Bryony's needs and both used creative methods to engage Bryony, for example allowing Bryony to use her creative talents in contact sessions, on one occasion they sat quietly with Bryony whilst she drew and were satisfied that this was therapeutic and helpful to Bryony.

Both workers remained in contact with Bryony after their services had formally closed the case; this appeared to give Bryony confidence and reassurance that professionals were trying to work in her interests and that her voice was being heard.

4.15 Summary Analysis

The key practice episodes set out above illustrate a number of missed opportunities to put early help in place when Bryony began to experience physical and psychological symptoms of distress. Professionals did not fully explore or assess the underlying reasons for Bryony's early signs and symptoms that may have been associated with her early experiences of witnessing domestic abuse.[22]

Bryony's experience of witnessing domestic abuse and her role as a young carer[23] were recognised but attempts to understand the impact that this had upon Bryony and how this impacted her behaviour were not fully understood or explored.

Despite being referred to CAMHS in CWAC and in North Wales, neither service had a significant impact upon Bryony's behaviours or identified the underlying causes of Bryony's anxieties. Bryony was reluctant to engage with CAMHS in either location; she told professionals in CAMHS and in other agencies that she did not want the service and did not see how she could benefit. West Cheshire CAMHS offered talking therapies to Bryony and later prescribed anti-depressant medication. Bryony's mother reflected that art therapy was mentioned as an option (which she feels would have benefited Bryony) but that this was never put into place. NB: CAMHS have no record of this intervention being offered and said that it would not have been available as there were no practitioners in the service at that time who would have been able to provide this intervention.

Throughout the case there is evidence that Bryony's voice was not sought on matters that concerned her current and future wellbeing, when Bryony did make her wishes and feelings known there are examples of her not being listened to. It is acknowledged by the review that there are opportunities built into procedures and practice to seek the voice of the Child. However it is also known that Bryony was reluctant to engage in some services or to talk about her past experiences and what troubled her. A more creative approach to seeking, hearing and acting upon the child's wishes and feelings would have been beneficial in this case.

The review as a whole has found it difficult to reach conclusions about the impact of events experienced by Bryony, however the review believes that multi-agency working and the application of professional knowledge and expertise was directed more towards incident management than understanding and responding to the underlying causes of Bryony's distress, anger and frustration.

Services such as YOS, Young Carers and Catch 22 made strong connections with Bryony, as did the Educational Social Worker who worked with her during 2012. Despite these strong

[22] Stanley N (2011) Children Experiencing Domestic Violence: A Research Review. Dartington: research in practice

[23] Children's Society: Hidden from View: The Experiences of Young Carers in England

links Bryony did not directly discuss her fears. She did however display her distress through harmful social and sexual behaviours and through self-harming. The Review concludes that the response to the underlying causes of these behaviours was never fully explored by professionals in a co-ordinated way, resulting in a lack of success from the interventions that were put in place.

There was a lack of family focus to the work undertaken by CSC and A SC in particular. The two agencies did not meaningfully share any aspect of their respective roles with Bryony and her mother. There was no joint plan to try to rehabilitate the relationship or to jointly support Bryony and her mother in managing their difficulties. This is significant learning from this review and, whilst this style of review does not usually make recommendations, the review team would urge the Authority to strengthen work in this area.[24]

In large part agency responses to the case lacked focus on the whole family (specifically on the problematic relationship between Bryony and her mother), in understanding the impact upon Bryony in her role as a young carer and in planning interventions. This lack of family focus was particularly marked in relation to communication and joint working between CSC and ASC. This illustrates systemic issues in relation to working with families with complex needs who fall outside of the familiar 'profile' presented to services i.e. Bryony came from a middle class background with an articulate and aspirational parent, although there were some family features in relation to family breakdown, domestic abuse and adolescent behavioural issues.

The review identifies weaknesses in the way some aspects of risk assessment with Bryony were undertaken. It is the view of the Review Team that there was a lack of consideration of alternative strategies to help Bryony by understanding what was driving her risk and vulnerability[25] when she presented with some very challenging and distressing behaviour; this occurred primarily at home with her mother but also in the community.

There was insufficient understanding about how to best organise help that went back to Bryony's early adolescence. Bryony witnessed domestic abuse as a young child and displayed indicators of a child who had been impacted by this experience.[26] [27]

Bryony demonstrated many of the indicators of being at risk of CSE[28] this, coupled with her role as a young carer for a disabled parent and the daily care needs of her mother appear to have been factors that influenced professional decision making in relation to Bryony's mother's ability to safeguard her and consequently appear to have obscured exploration of the underlying issues leading to Bryony's behaviour.

[24] Following a recent LSCB Board meeting there have been steps to initiate a meeting between senior managers in Children's and Adult's Social Care to begin this work.
[25] CWAC Risk and Vulnerability Matrix
[26] http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/domestic-abuse/signs-symptoms-effects/
[27] Stanley N (2011) Children Experiencing domestic violence: a research review. Totnes, Devon : Research in Practice
[28] http://www.barnardos.org.uk/what_we_do/our_work/sexual_exploitation/cse-professionals

For the most part professionals and agencies involved in this Review tried to work together to safeguard Bryony and her mother and there was some good practice in this case. However responses and interventions appear to have been largely driven by incidents and there is evidence of a lack of objectivity in delineating between Bryony's harmful behaviours towards her mother and her own risks and vulnerabilities.

The use of S20 as a means of safeguarding Bryony and the subsequent granting of a Care Order to the Local Authority served to remove Bryony from known risk factors, but may have increased her sense of frustration and isolation. There is no information to suggest that Bryony or her mother were consulted or had any influence in the decision to move from a temporary to a permanent foster care arrangement. This coupled with an apparent lack of any meaningful work to rehabilitate the relationship and reunify Bryony and her mother may have served to deepen Bryony's isolation.

Bryony spent many months out of education, both in England and in North Wales. The absence of a coherent plan to respond to Bryony's complex needs, to understand her fears in relation to perceived and actual risks from peers and to ensure that Bryony was not left without a school placement at what must have been a particularly vulnerable time in her life (when she was first placed in foster care with FF1) is clear throughout the case. The review team have seen little evidence of effective working by the Virtual School system in this case.

In summary professional practice in the case varied across and within agencies and individual practitioners, with some examples of good and expected practice. However, there were several missed opportunities to consider Bryony's safeguarding needs.

CHAPTER 5

5.1 FINDINGS

The findings in this case are drawn from analysis of key practice episodes, responses to the research questions and wider learning drawn from case records and conversations. They are shown below in no specific order of priority.

Each finding is followed by a number SMART recommendations to the Board which were arrived at following discussion of key questions raised by the review. The recommendations will form the basis of a multi-agency action plan which will be overseen by the LSCB. The findings are grouped by theme with each finding highlighting the 'Learning Together[29]' systems categorisation.

Finding 1 - Balancing Professional Focus in relation to risk and vulnerability

(Cognitive human bias in processing information; tools to support professional judgment)

Bryony's risks and vulnerabilities are well documented throughout the case across and within agencies. There were points at which the mind-set of some professionals was skewed towards risk (both to and from Bryony), resulting in Bryony being seen by some professionals as a perpetrator, rather than as a vulnerable child.

Recommendations:

The Board has a well-developed protocol in relation to Risk and Vulnerability. The Board should satisfy itself that all professionals are working to the protocol.

The Board should initiate a focused piece of work that brings risk assessment, risk management and safeguarding practice together across Children's and Adult's Social Care (this work has begun).

The Board should undertake a review of responses to the needs of Young Carer's that particularly addresses risks and vulnerabilities.

The Board should ensure that current policy and practice in relation to managing allegations of sexual abuse is robust and implement any necessary changes.

The Board should review training for all professionals in relation to the links between self-harm and suicide in young people.

[29] http://www.scie.org.uk/publications/ataglance/ataglance01.asp

Finding 2 – Lack of Whole Family Focus (Think Family)

(Professional/family interaction)

There was a lack of focus on working with the whole family. The complexity of the dynamic between Bryony and her mother was difficult for some professionals to understand and respond to. Although family support was provided to support Bryony and her mother at difficult times, there was little or no ongoing work to rehabilitate the relationship once Bryony entered foster care. Parenting interventions appeared to exclude Bryony (e.g. multi-systemic therapy and a parenting course, which Bryony's mother felt was basic and did not address the complexities of the relationship).

Bryony's maternal grandparents were supportive and had Bryony's trust, however there appeared to be little attempt to include them in any family focused work.

Professionals did not take a consistent approach to involving Bryony's father in decision making although he retained parental responsibility for her. The review acknowledges that Bryony and her mother did not always want Father's involvement and that this is a challenging scenario, however wherever possible professionals should endeavour to involve both parents in planning and decision making.

Recommendations:

See Finding 1 : The Board should initiate a focused piece of work that brings risk assessment, risk management and safeguarding practice together across Children's and Adult's Social Care (this work has begun).

The Board should conduct a wider consultation involving all Board partners to benchmark current policy and practice in relation to working across the boundaries of Adults and Children's Service.

The Board should issue guidance on best practice when this work has been completed.

All agencies should consider and implement training needs in relation to future joint working.

Finding 3 – Working Across Geographic Boundaries

Bryony and her mother were involved with many agencies between 2011 and 2015, their involvement crossed agency and geographic boundaries. The complexity of multi-agency involvement across geographic boundaries and the governance required to oversee these complex working arrangements (including the use of independent sector agencies and private foster carers) was not evident in this case.

Recommendations:

The Board should work with bordering authorities to clarify and, where necessary, strengthen governance and joint working arrangements particularly in relation to out of area foster placements and educational provision for looked after children.

The Board should quality assure information sharing systems between authorities and establish standards to ensure that recording and sharing information is of a consistent quality and fit for purpose.

The Board should write to all agencies in CWAC and collaborate with neighbouring authorities to remind them of their duties and responsibilities in relation to participating in serious case reviews.

Finding 4 – (tools to support professional judgment and decision making; management and agency to agency systems)

Bryony's voice was not consistently sought or heard in this case; there are many examples of decisions being taken about her life on which she was not consulted.

Recommendations

The Board should put in place a specific piece of work to ensure that all professionals understand the importance of seeking and listening to the child. This should include focus on what the child says (voice) and what the child does (behaviours).

This work should focus on all domains of working with children, including the work of adult services. It should ensure that guidance in relation to the application of statutory powers requiring an urgent decision should also include the views of the child.

Finding 5 - (family and professional interaction; tools to support professional judgment and decision making; responses to incidents and crises)

The family dynamic, social status and professional relationships with Bryony's mother were key factors in the way professionals worked with and responded to Bryony and her mother. The interaction between some professionals and Bryony's mother appears to have influenced professional decision making and obscured objective analysis of the best way to safeguard Bryony and her mother.

Recommendation:

The Board should use the learning from this review to provide enhanced support to professionals to work with the specific challenges highlighted by this case. This support should cover peer challenge and support in relation to working with families.

Finding 6 - (management and agency to agency systems) – Linked to Finding 2

Some aspects of single and multi-agency communication and information sharing require improvement.

Recommendations:

The Board should agree and implement mechanisms to quality assure information and communication systems and processes to ensure that they do not mitigate against safeguarding? This should include quality assuring the system for notification of placements both within and out of area.

The Board should test the quality of the sharing of health information, both across the Health economy and with wider partnership agencies.

5.2 Wider Learning

In addition to the key findings the review has identified wider learning for agencies involved in the review. Whilst systems reviews do not make multi or single agency recommendations, the review team believe it is important to comment on single agency learning in this section; these learning points will be reflected in the multi-agency action plan to be compiled and overseen by the LSCB.

Quality Assuring Information Provided to Serious Case Reviews

The review team found the quality of information supplied to the review to be variable and at times inconsistent and/or conflicting.

Systems reviews use professional and other conversations to gain insight into the case and triangulate information via agency records, policies, quality standards and guidance. The review would remind all agencies involved of the importance of accurate and timely record keeping, compliance with guidance in relation to securing records where a serious case review is taking place and providing all necessary and relevant information to serious case reviews in a timely manner.

Where there is conflicting information in relation to accounts of important events (see page 29) this should be further investigated outside of the serious case review by the agencies concerned to ensure the robustness of future safeguarding.

Safe Storage of Medicines

Bryony's mother was prescribed various drugs for her medical condition. On one occasion she was told to keep these in the boot of her car when she made professionals aware of Bryony's propensity for self-harm. This is inappropriate advice and is not in line with guidance in relation to safe storage. All professionals need to be aware of current guidance in relation to safe storage of medicines and to ensure that this is provided to patients.

Responding to incidents of ingestion of drugs

Bryony presented to Accident and Emergency on one occasion having ingested a 'white powder'. There was no attempt to identify the substance via toxicology tests to establish the nature of the substance and thereby identify the potential medical risks to Bryony. Practitioners should note the importance of identifying substances in the treatment of a patient presenting with over-dose and ensure that future clinical practice is robust.

Use of LSCB Tools and Guidance

There are two specific examples of where LSCB tools and guidance would have benefited professionals working with Bryony and her family but do not appear to have been used i.e. the resolution pathway and escalation policy and the risk and vulnerability matrix. Increasing practitioner understanding and use of these tools would be of benefit.