Executive Summary

Management Case Review

Ealing Safeguarding Adults Board

The following case was raised on the 15th August 2016 and was discussed at a multi-agency meeting on the 16th August 2016. It was agreed by Sheila Lock, Independent Chair of the Safeguarding Adults Board and the Safeguarding Children's Board, with agreement from Stephen Day, Director of Adult Services and Chris Hogan, the Interim Director of Children and Families on the 8th September 2016.

The Serious Case Review Panel discussed and agreed that the case did not meet the criteria for a Serious Case Review or a Safeguarding Adult Review but would offer scrutiny, challenge and learning so a Management Case Review (MCR) was agreed. An independent consultant was commissioned to undertake the review on the 6th October 2016. The report has been put into the Ealing learning review framework, it supplements individual agency reports.

The report will be shared with the other local authorities and with the family members who will be invited to meet with the chair of the Safeguarding Adults Board. In producing this report the Safeguarding Adults Board has been in contact with boards from other local authorities with responsibility for the victim. Authority 1 supplied information regarding the victim which has been used in the preparation of this report.

The conclusion and recommendations in this Executive Summary are from a wider review that took place for this case.

A Management Case Review in the
London Borough of Ealing

Learning Lessons Review

This Review has been produced to provide practitioners and managers with the key learning from the case of IH.
This case has been considered and discussed at the
Ealing Safeguarding Adults Board and the Performance, Audit and Review Subgroup.

In this case Ealing was not required to conduct a review as the case did not meet the criteria. However, it decided to undertake a review as both the individuals involved were known to services and as a Board we wanted to understand more about the events leading up to the serious incident.

Incident

On 15.08.16 IH a British-born 18-year-old male inflicted several stab wounds on a resident at 'Unit 3' in Hillingdon at which they and others lived. Sadly, the victim LW died. It was reported that this event followed an altercation between the two individuals in the days preceding the murder. This incident was not reported, resulting in relevant agencies being unaware of it.

IH was charged with murder. In April 2017, he pleaded guilty to manslaughter and was sentenced to a 'Hospital Order' under section .37 of the Mental Health Act 1983 with a section .41 Restriction Order, i.e. indefinite detention with the possibility of community supervision.

Conclusion

This case illustrates the complexity of needs presented by some young people and their families. Professionals are faced with supporting such individuals and at the same time, managing risks presented to and by them. It is worth noting that IH presented to many as a likeable, vulnerable young man with complex needs whose level of co-operation reduced as his mental health deteriorated. Getting a 'grip' on the case was rendered more difficult by the episodic minimisation by family of the risks he posed.

There exists no direct evidence that receipt of mental health services and prescribed medication would have prevented the stabbing. It has to be recognised that IH was not always compliant and that his family fluctuated between concern and minimisation of concern.

It is worth noting that in the previous weeks leading up to the incident IH was involved with the criminal justice system where his distress and agitation was attributed to the pending charges. This involvement included a Mental Health Assessment which was due to be held on the 16th August 2016, whilst this was being completed IH was unable to return to his Probation Hostel so other accommodation was required.

It is clear that a huge amount of effort was expended over time by staff in Children's Social Care, and both YJS services in their work with an extremely challenging IH and his family.

There was in general a high level of inter-agency collaboration and information exchange. Fundamental differences of perspectives between mental health and social care staff appear though to have remained unresolved e.g. IH's discharge from hospital (close to his 18th birthday) was regarded by the external professional group as premature and increasing the pressure on a mother who was clearly unable to adequately meet her son's needs. It served to increase the number of intrinsically unhelpful transitions.

A further and more self-contained systemic weakness is apparent in the commissioning of care placements and poor quality of notifications / feedback from those selected. This is compounded by the availability of suitable placements for those with complex needs – and this is a national challenge

The very comprehensive report provided by Children's Social Care raises the possibility that IH's likeability and vulnerability and fluctuation in cooperation may have served to diminish the concerns that justifiably attach to a disturbed young man of uncertain mental health and cognitive ability who often carried, and records confirm, had shown willing to use a blade(knife?).

It is undoubtedly the case that IH's conduct was and continued to be beyond the control of any of the social or health-related community agencies with which he had involvement. Had better risk assessments been developed and updated regularly, the extent to which they were insufficiency mitigated might have been better recognised.

The recommendation below supplement those contained in the individual agency reviews.

What Learning is there from this case and what needs to be different?

This case and the reviews highlight a number of key issues of learning, some are broad and national in their relevance; some pan-London and local:

What can we learn nationally and across the London region?

- An insufficiency of strategic planning across London boroughs for the most needy/ risky of such young people
- Insufficient resources for those approaching adulthood and needing tier 3/4 psychiatric care, including effective planning and availability of commissioned tier 4 beds
- The regulation of supported accommodation providing for vulnerable individuals raises the issue of planning permission for such establishments, qualifications and experience of providers, commissioning expectations and analysis of risks associated with multiple occupancy by those with competing needs
- De-commissioning of placements in consequence of concerns known to one local authority should trigger a consideration of wider safeguarding implications in other local authorities- in this case the decision of authority 2 to stop using the placement should have been notified to other local authorities including Ealing to allow that knowledge to inform decision making
- In the context of extremely limited choice it is hard to ensure that places are selected and commissioned in good quality provision, the absence of inspection of such establishments makes quality hard to access.

What can we learn locally?

- The need for clarity about a term such as 'red zone:' (a simple flag to indicate risk or a trigger for escalation / additional action to seek to mitigate risks?)
- An inefficient and ineffective hospital discharge process with poor transitional arrangements and very little evidence of 'assertive outreach'
- Supported lodgings and semi-independent accommodation is not regulated by any of the regulatory bodies- meaning that accommodation for some of the most vulnerable is not overseen to ensure it is of a high quality.

In moving forward, there are some specific assurances and actions that need to be taken in relation to the learning points above.

EALING SAFEGUARDING BOARDS (ADULTS & CHILDREN)

The board needs to assure itself that the learning from all of the individual agency reviews that contributed to this process are implemented. Some of these recommendations are repeated below for ease.

1. The board should ensure each agency complete the action plan arising from the individual agency reviews in the necessary timescales and should receive an assurance report to this effect
2. Refresh Ealing's Local Practice Guidance on 'Safeguarding Children Missing from Care, Home and Education' with a view to increasing levels of awareness in the context of gang affiliation, sexual exploitation and radicalisation.
3. Set up learning events to involve staff from Ealing Council's Children and Adult services and West London Mental Health Trust to explore the range of issues identified in the report submitted by Children's Social Care.
4. The chair should raise the issues of national concern with the DfE and DoH and make other London chairs aware of the report and the issues raised
5. The chair should raise the issues regarding tier 3/ 4 provision and the impact of a national shortage in meeting the needs of complex individuals
6. The Board should oversee a task and finish group to consider improved transition pathways for young people with mental health issues into adult mental health services.

EALING CHILDREN'S SOCIAL CARE

1. Ensure professionals in the borough are aware of the Vulnerable Adolescents Panel (VAP) and confirm its purpose and process for its use and to raise understanding of the value in effective planning with the most challenging young people.
2. Review and strengthen current arrangements for the assessment and monitoring of the use and performance of semi-independent accommodation providers working with other London Authorities.
3. Develop joint Adults and Children commissioning of local placements that can manage multiple / complex needs pre-and post-18 with a view to minimizing placement changes.
4. The agency must complete actions in their IMR and assure the SAB it has done so by the end of March 2018

EALING YOUTH JUSTICE SERVICE

1. Procedures for listing 'breaches' at Crown Court should be clarified and a procedure introduced that describes a clear required response if there is a delay.
2. The agency must complete actions in their IMR and assure the SAB it has done so by the end of March 2018

WEST LONDON MENTAL HEALTH NHS TRUST

1. The Trust needs a clear risk management plan in relation to individuals who miss medication.
2. The agency must complete actions in their IMR and assure the SAB it has done so by the end of March 2018

Glossary

Abbreviation	Definition and Organisational Leads
A&E	Accident and Emergency Department, Local Healthcare Trust
Authority 1	Islington Borough Council
Authority 2	Brent Borough Council
CPA	Child Protection Adviser, Local Authority
CAMHS	Child & Adolescent Mental Health Service, West London Mental Health Trust
CLA	Children Looked After Team, Local Authority
CMHT	Community Mental Health Team, West London Mental Health Trust
EIS	Early Intervention in Psychosis Service, West London Mental Health Trust
ECIRS	Ealing Children Integrated Response Service, Local Authority
FIP	Family Intervention Project, Local Authority
ILS	Independent Living Scheme
ISSP	Intensive Supervision & Surveillance Programme, Youth Justice Service, Local Authority
LSCB	Local Safeguarding Children Board, Independently Chaired
PSR	Pre-sentence report
YRO	Youth Referral Order
SAFE	Supportive Action for Families in Ealing, Local Authority
SYV	Serious Youth Violence
VAP	Vulnerable Adolescents Panel, Chaired by the Local Authority
YPA	Young Persons Adviser, Youth Justice Service, Local Authority
YRO	Youth Rehabilitation Order, monitored by the Local Authority, Youth Justice Service