



Somerset Safeguarding Children Board & Safeguarding Adults Board

Somerset Learning Review into Deaths of Vulnerable Young Adults

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1 INTRODUCTION

Context

- 1.1 In recent years there has been a growing understanding of the vulnerability for adolescents as a result of early neglect and/or abuse, and the subsequent links with high risk activities, such as alcohol and substance misuse and some criminal activities. Such early life experiences are a feature of the lives of many children who are Looked After¹ by the local authority or of adults who were previously Looked After.
- 1.2 The recognition of the impact of adolescent vulnerability has been reflected in the increasing numbers of Serious Case Reviews being undertaken on older children, with the association being made between such early childhood experiences and teenage suicides and accidental deaths.
- 1.3 Until 2010 the government commissioned regular reports of the learning from serious case reviews undertaken nationally. Brandon et al² in 2008 reported on the increasing number of such reviews involving children aged over 16 years of age and that this represented a greater acknowledgement amongst safeguarding organisations *‘that older children may be beyond the reach of existing services or that their vulnerability is not recognised or taken sufficiently seriously by the multi-agency groupings.Reviews also raised the issue of young people between the ages of 16 and 18 years who fall between child and adult services’*.
- 1.4 In the next Brandon et al report³, the link between adolescent suicide and children in the care of the local authority was noted, with 20 of the serious case reviews studied involving children who committed suicide; of these 7 had previously been Looked After by the local authority.
- 1.5 All deaths of children are reported and considered by the Child Death Review Panel, with serious case reviews being undertaken on those that meet the criteria⁴. Consequently each death of a Child Looked After is identified.
- 1.6 The previous legal status of adults who commit suicide or die early is not known; such details are not identified or collected in local or national statistics. It is likely though

¹ The term ‘Looked after Child’ or ‘Child Looked After [CLA]’ is the term used for a child looked after by the local authority, either through a legal order (Care Order) or through as voluntary agreement with the parents. A young person can be Looked After until they reach the age of 18 years old. [See also footnote 5 for Leaving Care services]

² *Analysing child deaths and serious injury through abuse and neglect: what can we learn?* Brandon et al, DCSF 2008

³ *Understanding Serious Case Reviews and their impact*, Brandon et al, DCSF, 2009

⁴ Serious case reviews are undertaken by local safeguarding children boards (LSCBs) for every case where abuse or neglect is known, or suspected, and either a child dies or a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child

that earlier vulnerabilities will continue to impact on young people as they reach adulthood.

Aims of this study

- 1.7 Through the good links between the Somerset Leaving Care Service⁵ and care leavers, staff became aware of the deaths of several children who had at some stage in their lives been looked after. Further enquiries established that between May 2007 and August 2012, 13 young people who were formerly in the care of Somerset County Council had died unexpectedly. They were aged between 18 – 27 when they died and had entered the care system at varying ages, although the majority (9 of the 13) first became looked after as teenagers (age 13 or over).
- 1.8 Somerset's Local Safeguarding Children Board [LSCB] and Safeguarding Adult Board [SAB] were already concerned about the vulnerability of older adolescents and how to provide ongoing support into adulthood. The need to explore how to improve services for vulnerable care leavers in their transition into adulthood was heightened on hearing about these early and unexpected deaths.
- 1.9 It is important to note that the Board is not aware of any national, regional or local figures with which to compare the picture in Somerset. It therefore does not know whether the incidence of unexpected deaths of young people previously Looked After in Somerset is out of the ordinary. However, Somerset's Local Safeguarding Children Board (LSCB) wanted to explore further to see if there were any themes that could identify ways of improving services for care leavers as they move into adulthood.
- 1.10 In response to this information the LSCB and the SAB decided to jointly commission a study of the experiences of these young adults, so as to learn more about how services can best support care leavers in their transition into independent adulthood. The aim is to better shape the future organisation and delivery of services to this vulnerable group of people.

The report structure

- 1.11 Section 2 describes the methodology used for this research; including what worked well and what caused limitations to the data collected.
- 1.12 Section 3 considers what information is available about the prevalence of early deaths of young adults nationally and locally, as well as the early deaths of ex-care leavers.

⁵ Local authorities have a legal duty to support young people making the transition from care to adulthood. There are leaving care services in all English local. Any young person under 21 (or 24 if in education or training) who ceases to be looked after or accommodated after the age of 16 is eligible for Leaving Care services. In Somerset this service commences at age 18 years.

- 1.13 Section 4 provides the findings from consideration of the experiences and circumstances of the 13 young people. The findings follow the structure that the Social Care Institute for Excellence [SCIE] uses in the Learning Together methodology⁶. This is explained in 4.1 and 4.2. Consistent with this approach is the use of ‘considerations’ for future action by the LSCB and SAB, as opposed to ‘recommendations’. This enables the Boards to consider how best to make the desired service changes relative to their aims and responsibilities.
- 1.14 Additionally, consistent with the Learning Together systems approach to learning, the findings do not limit themselves to what is currently possible within existing national legal and policy imperatives, but points to what would be of benefit to ex- care leavers.
- 1.15 Section 5 covers the conclusions arising from both the statistical data in section 3 and the findings on section 4.
- 1.16 The appendices provide further methodological information and the results of the desk research to pull together the views of young people who have contributed to various past consultation exercises.

⁶ <http://www.scie.org.uk/children/learningtogether/>

2 METHODOLOGY

Systems approach

- 2.1 This study has used the principles of a systems approach to use what was known about the experiences of the 13 young people to inform discussions about what makes it more or less likely that children and young people will receive the kind of help and support they need, at the time that they need it, so as to make changes that improve the services for Children Looked After.
- 2.2 Dr Sheila Fish of the Social Care Institute for Excellence provided initial support in planning the approach taken based on the Learning Together model of case reviews.

Participation

- 2.3 This report has been written by the lead researchers:
 - Lucy Macready, Service Manager Community Safety and lead researcher for this project from adult services, Somerset County Council
 - Carolyn Drew, Independent Reviewing Officer Manager and lead researcher for this project from children's services, Somerset County Council
 - Edi Carmi, Lead researcher: an independent safeguarding consultant and SCIE Associate, accredited in the SCIE Learning Together systems review methodology and experienced in various 'learning from practice' projects
- 2.4 The lead researchers worked closely with:
 - A multi-agency senior management steering group to agree the terms of reference and oversee the project, including the chairs of both the LSCB and the SAB
 - A multi-agency management group to work closely with the lead researchers
 - The project co-ordinator [the LSCB Safeguarding Service Manager]
- 2.5 See appendix 1 for further details of these groups.

Staff involvement

- 2.6 Some practitioners involved with the 13 young people were approached by their agency's member of the management group, as described in 2.14.
- 2.7 Additionally further practitioners were invited to attend one day events, as described in Stage four below (see 2.15-2.17) and the internal lead researchers subsequently held individual conversations with those key staff unable to attend the one day events.

Family involvement

- 2.8 It was agreed that the involvement of young people and families would be a second stage of the project, when considering how to make the service improvements indicated by the findings detailed in section 4 of the report.

Involvement of care leavers

- 2.9 Consideration was given to how best to involve care leavers, given that there have been several recent exercises that have sought their views. Three members of the managers group reviewed the findings from various consultation exercises that have occurred and concluded that it would be preferable to use what had been provided previously and then approach care leavers again as part of follow up to this research. This information is provided in Appendix 2.

Scope of project

- 2.10 The 13 young people had died over a period of 5 years and ranged in age from 18 to 27 years old. It was agreed that to learn about current practice the most relevant periods would be the last few years of each person's contact with services. Earlier experiences would be less able to provide relevant information about current early intervention practice and looked after children services. We did though request that the background context be supplied for each individual, so later practice could be understood within the knowledge of earlier events and service provision. Therefore, although not the focus of the research, early childhood was considered as a background context, when information was available.

A staged approach

- 2.11 In order to learn about the strengths and weaknesses of current and past provision of services to Children Looked After we undertook a staged approach which moved from the experiences of the individual young people to consider what these accounts told us of the general working of the multi-agency services which provide a range of help and support to Children Looked After and Care Leavers.

Stage One: Children's social care

- 2.12 Children's social care (CSC) commissioned an independent consultant to research the services provided to each of the 13 young people, completing individual chronologies and commentary on the services provided, as well as identifying the staff and agencies involved for each young person. This was undertaken through an examination of agency records, both electronic and paper files.
- 2.13 The author of these reports met with the project co-ordinator and lead researchers to identify the relevant period under review for each young person and the agencies that had been involved during that period and earlier in their lives.

Stage Two: Individual agency reports

2.14 The agencies identified in stage one completed the same exercise for each young person for whom they provided services. This was undertaken by the members of the multi-agency management group, largely from records, but in some instances practitioners and/or managers were asked for information, when records could not be located or to supplement the available documentation.

Stage Three: Bringing the information together and identifying practice themes and patterns

2.15 The management group (see 2.4 above) met with the project co-ordinator and the 3 lead researchers over four days to receive information on the project and SCIE's Learning Together methodology and to share information about each young person. Together the group identified the themes emerging about each young person and the services they received. Some of these themes indicated underlying patterns of strengths and vulnerabilities in the way the agencies support care leavers and the group identified which of these were of the highest priority in terms of the outcomes for Care Leavers.

Stage Four: Obtaining a qualitative perspective - an in depth study of two individual experiences

2.16 To deepen the understanding of the impact of such underlying patterns, the next stage of the research focused on the services provided to 2 of the young people. The 2 individuals were selected by the managers group as between them, their experiences were representative of those of the whole group and appeared to provide in depth learning about the underlying strengths and vulnerabilities within the multi-agency safeguarding system.

2.17 The practitioners involved with each young person were asked to attend a practitioner's day, to meet with the lead researchers and some of the management group. This was to enable us to understand the practitioners' perceptions at the time when they were working with the young people, the options available at the time and the rationale for actions and decisions taken.

2.18 The experience of these two days was the confirmation and elaboration of the themes that had emerged from the 13 cases and the underlying patterns that were (and remain) in operation within the multi-agency safeguarding system.

Stage five: literature review

2.19 The lead researchers undertook a literature review. The aim of this was to explore any other publications about the early deaths of care leavers. In practice the learning from the documents was in terms of what contributes in general to good or poor outcomes for care leavers, as opposed to early deaths. Where relevant, this research is included in the findings in section 4.

Stage six: understanding the statistics available on early deaths among care leavers

2.20 When an adult dies, there are no statistics collected in relation to childhood experiences and so there is no data available on the incidence of early deaths among care leavers. Somerset Public Health contributed to this research with the provision of statistical data about deaths of young adults, both locally and nationally (see section 3).

Stage seven: formulating the findings

2.21 The last stage of the research was to put together the learning from the whole exercise into systemic findings about the way we work with young people whilst they are Looked After, when they are Leaving Care and when they have left Care. These have been prioritised and explained in section 4.

What worked well?

- 2.22 This has been a good collaborative process between the Adult and Children Safeguarding Boards, both committed to the need to improve the services and support for Children Looked After and care leavers into their adult lives.
- 2.23 The agencies demonstrated their commitment to this work and participants in the management group devoted a great deal of time and effort in undertaking the individual agency reports on the 13 young people and attending the meetings.
- 2.24 The process of bringing senior representatives together was also deemed to be a valuable opportunity for managers to learn about the broad spectrum of inter-related agencies and services.
- 2.25 The police undertook a great deal of research so as to provide a comprehensive history of any contact with each young person.
- 2.26 Education overcame the challenges of limited written records by speaking to staff at the schools who knew the young people. In this case, the use of peer to peer interface was valuable. It was unlikely that the lead researchers for example, would have been as successful in gathering the quality and depth of information that was obtained by education colleagues.

- 2.27 The involvement of practitioners through their contributions to the individual agency reports, the practitioner days and the individual interviews with key staff worked well in providing qualitative data about the individual young people's experiences. It was also noticeable that the group setting triggered discussions and learning that could not be achieved through a one-on-one interview method. (See also 2.46)
- 2.28 Despite the intensive resources required for this research in terms of staff time and capacity, representatives from all agencies involved retained a steady commitment to the process.
- 2.29 All those involved in the study were affected by hearing about the lives of the young people, the challenges they had faced in their lives from an early age and the efforts they and others had made to help them.

Learning impact as part of the process

- 2.30 Due to the collaborative nature of this research, changes began to be implemented during the course of the project. The following paragraphs provide three examples of this. :

The Independent Reviewing Service

- 2.31 The Independent Reviewing Service is reflecting on the early findings in reference to 'the constellation of difficulties' and transition planning for those approaching care leaving age.

Somerset Domestic Abuse Services

- 2.32 In some instances the way in which domestic abuse featured in the young people's experiences highlighted that the roles of victim and perpetrator are sometimes interchangeable. This had led the internal researchers to take steps to explore how this can be linked into current commissioning for services to victims and perpetrators of domestic abuse.

Somerset Drugs and Alcohol Partnership

- 2.33 The new specification for drug and alcohol services for young people and adults tendered in 2013 incorporated learning from the review. In particular this guided the commissioning approach taken which resulted in:
- The integration of the adults/young people drug and alcohol misuse system so there is a single system and pathway for all people seeking help and support to deal with drug and/or alcohol misuse
 - The active recognition that there are some people that need additional support for a range of reasons to successfully engage in services to achieve a positive outcome, particularly young people and those in transitions such as leaving care

- Learning from service users own views that they would prefer a consistent worker in their journey and for minimal re-assessment when accessing different interventions
- The commissioned service introducing an assertive outreach approach to engaging with young people especially those in transitions, and enhancement of the information/case management system to ensure that CLA status is a mandatory field and that particular attention is given to life history of those people under 25 years entering services.

2.34 The findings complement the 2012 Ofsted report and together have resulted in an intensive programme of workforce development targeted at leaving care staff and those workers in a number of agencies who work with CLA/leaving care young people. This aims to support them to better identify and respond to drug and alcohol use earlier. This work is on-going to develop the knowledge and skills of the leaving care staff team to respond effectively and appropriately to substance use, understanding what they can do, who else to work with and how.

Limitations to the research

2.35 There were limitations in the research, due to data from some agencies [from records and/or practitioners] being less comprehensive or unavailable. However, it is not thought that this would have made a substantial difference to the overall findings.

2.36 The decision not to involve any family members is likely to have had some impact on Finding 1, but will be part of further work to be undertaken in the follow up to this project.

GP records

2.37 Early in the process the steering group delayed the study for 2 months in order to provide sufficient time to access GP records. It was considered that these would be particularly important given that some of the young adults had ceased to have contact with any services in recent years and the GP may have been the only source of information on these adults.

2.38 However, despite major efforts these were largely not possible to access for a variety of reasons including:

- Difficulty identifying the individual GP
- The length of time it takes to access records that have been archived following death
- GPs declined to share the information due to confidentiality issues in respect of surviving family members
- Some young people did not access GP services in latter years

2.39 The result of this omission has restricted the information available in latter years, after the young person ceased to have contact with the Leaving Care service

CAMHS records

2.40 The Child & Adolescent Mental Health service [CAMHS] did not provide written information to the research, partly due to a lack of contact in the periods under review. However there had been contextual information available which was partly obtained via CAMHS involvement in the research group and the provision of verbal information at meetings. However, the absence of consistent written material was a weakness given the significance of the mental health concerns for several of the young adults concerned.

Youth Offending Team [YOT]

2.41 The Somerset Youth Offending Team (YOT) participated fully in the research despite the fact that documentation to evidence their involvement with the young people was lacking. This was due to the fact that The Youth Justice Board requires all Youth Offending Teams to delete records of a young person once they reach 18 years of age. Nevertheless, some copies of Youth Offending Team documents remained held within Children Social Care files. Moreover members of the YOT participated in both management and practitioner groups to provide valuable input from their knowledge of the young people.

Avon and Somerset Probation

- 2.42 Avon and Somerset Probation were not able to play sufficient part in this research. This partly was a result of a delayed approach to them, but the reasons for the lack of participation in the workshops and lack of written information are not clear.
- 2.43 Together with the lack of YOT records, this research has not accessed the considerable interventions by the criminal justice system with the young adults.

Workshop participation

- 2.44 In some cases, practitioners identified by reviewers as potentially valuable to the individual cases felt unable to participate. As a voluntary exercise, researchers were reliant upon good will.
- 2.45 The lead researchers spent a significant amount of time outside of the multi-agency review setting, tracking and speaking to practitioners on a one-on-one basis to obtain further information.
- 2.46 This led to researchers undertaking very sensitive conversations with staff and service providers; it was noticeable that within the group setting the emotions appeared to be managed much better, albeit still difficult for practitioners at times. This may have been due to the support they provided each other within that setting.

3 PREVALANCE OF EARLY DEATHS IN YOUNG ADULTS

Introduction

- 3.1 The early deaths of 13 ex-care leavers over a 5 year period is a major concern. What is not clear is to what extent this is or is not unusual in terms of the population of young adults and of ex-care leavers.
- 3.2 This section examines what available statistics can tell us about the death rates of young adults to establish the significance of what appears to be a very high rate of such early deaths.

International data

- 3.3 Worldwide, 26 million young people ages between 10 and 24 years die each year. The World Health Organisation believes that nearly two-thirds of these deaths are linked back to behaviours and conditions that begin at a young age such as smoking, early sexual activity and violence (WHO 2011) ⁷.

Prevalence of deaths of young adults nationally and locally

- 3.4 In order to explore the prevalence of deaths of young people the researchers obtained information from Somerset Public Health, which is shown in table 1 below.
- 3.5 This shows that the death rate for young adults aged 18 to 24 in England and Wales was higher for Somerset than for the national average. The national rate is 34 per 100,000 of the population of that age in 2012 [1781 in total] as opposed to an average death rate of 49 per 100,000 population in Somerset [2006 to 2012]. This data indicates that Somerset has a higher death rate for this age group overall.
- 3.6 This higher death rate of young adults is partly associated with the incidence of traffic accidents; the rate of these in 2012 was more than double in Somerset to the national picture (15 per 100,000 in contrast to the national rate of 6 per 100,000).
- 3.7 However, the death rate from the causes especially associated with the deaths of the young people in this study are no higher for Somerset than the national picture, with suicide and injury of undetermined intent similar in Somerset to that in England and Wales. This similarity is also to be found in the published ONS tables for the same cause for those aged 15 to 34 in 2012.

⁷ <http://www.who.int/mediacentre/factsheets/fsthreefourfive/en/index.html> 011113

Table 1: Underlying Cause of Death and rates – a National Picture

ICD10 code	Cause	Estimate of Deaths in England and Wales of those aged 18-24 in 2012*	Deaths in Somerset of those aged 18-24 2006-2012	Estimate of Death rate per 100,000 per year in England and Wales of those aged 18-24 in 2012	Death rate per 100,000 per year in Somerset of those aged 18-24 2006-2012
V01-V99	Transport accidents	299 17%	40 31%	6	15
X60-X84, Y10-Y34 exc Y33.9	Intentional self-harm or injury following event of undetermined intent	396 22%	19 15%	8	7
C00-D48	Neoplasms	423 24%	16 13%	8	6
G00-G99	Diseases of nervous system (includes epilepsy)	295 17%	9 7%	6	3
X40-X49	Accidental poisoning by and exposure to noxious substances (includes exposure to narcotics and alcohol)	122 7%	8 6%	2	3
W00-X59 less X40-X49	Remaining Other external causes of accidental injury	97 5%	6 5%	2	2
	Other	150 8%	30 23%	3	11
A00-R99, U00-Y89	All deaths	1781	128	34	49

*Published data is for 15-24 year olds: number estimated based on national deaths by single year of age shows that half of the deaths aged 15-19 occur in the 18-19 year old cohort (provided by Somerset Public Health, Somerset County Council 2013)

Local care leaver deaths

- 3.8 It is not known how many young adults care leavers died during this period, either in Somerset or nationally, as these statistics are not collected. Indeed at the time of death the individual's background may not be known. The 13 deaths identified by the Leaving Care Service are those that were known through informal networks.
- 3.9 What is clear is that this number, which may be an underestimate, demonstrates a higher death rate than that experienced by the local population of that age group. Table 2 shows the number of people aged 18-24 dying in Somerset is just over 18 per year (over the time period 2006-2012) and this varies from 12 in 2011 to 27 in 2008. Somerset Public Health, Somerset County Council 2013 have calculated that this is a rate of 39 per 100,000 population per year and that if you apply that rate to those leaving care locally you would expect about 0.2 deaths in the first year and just about 1 in the first 5 years after leaving care.

Table 2: Deaths of Somerset residents aged 18-24 during 2006-2012

SEX	2006	2007	2008	2009	2010	2011	2012	Total
Males	15	9	19	13	15	8	12	91
Females	5	7	8	3	5	4	5	37
Total	20	16	27	16	20	12	17	128

Data provided by Somerset Public Health, Somerset County Council 2013

- 3.10 Table 3 below shows the age distribution of the 13 young adult care leavers known to have died in Somerset between 2007 –2012, as well as the gender breakdown. This shows that over half were aged 21 and over, which indicates the continuing vulnerability of ex-care leavers over time.

Table 3: Research Cohort: Age v Gender

Age at death and gender									Total
Age at death	18	19	20	21	22	23	25	27	
Male	1		2	1	1		1		6 (46%)
Female		1	2	1	1	1		1	7 (54%)
Total	1	1	4	2	2	1	1	1	13 (100%)

- 3.11 Table 4 demonstrates that in Somerset there are many more male than female deaths in this age group: for the whole time period about 70% of these deaths are for males. Table 5 provides the gender split of Children Looked After in Somerset, which shows a picture of males being consistently over half the Children Looked After population.
- 3.12 However, in contrast to the rest of the population, table 3 above shows that in this cohort of 13 there were slightly more females to males, suggesting the possibility of greater vulnerability within the population of female ex Children Looked After and a higher risk of an early death.

Table 4: Deaths of Somerset residents aged 18-24 during 2006-2012

SEX	Deaths	Population aged 18-24 (summed for all years) from ONS population estimates	Death rate per 100,000 population per year
Males	91	136,630	67
Females	37	189,573	20
Total	128	326,203	39

Data provided by Somerset Public Health, Somerset County Council 2013

Table 5: Children Looked After Gender Split in Somerset 2008 – 2013

	Gender	2008-09	2009-10	2010-11	2011-12	2012-13	Current
Somerset	Male	54%	57%	56%	53%	53%	55%
	Female	46%	43%	44%	47%	47%	45%
England	Male	55%	56%	56%	55%	55%	n/a
	Female	45%	44%	44%	45%	45%	n/a

Data taken from the last 5 years of the annual SSDA903 return submitted to the DfE

Cause of Death

- 3.13 It is difficult to be accurate about the cause of death or the motivation prior to the death mainly because there was no one method for obtaining the information. Death certificates were not available to the research team for all cases and other means included media searches and via the Child Death Review Manager at Somerset County Council, who contacted Coroner's officers. In addition, it was noted that the health records and the police records did not correspond in a number of cases; accounts differed and were open to individual interpretation.
- 3.14 Substance use featured in 8 of the 13 (62%) final accounts of the individual. Of the remaining 5, 3 are female deaths defined as suicide or death following a suicide attempt.
- 3.15 Paracetamol is the most commonly used non-prescription drug for self poisoning and this was used by one of the 13 young adults in Somerset. Fatal self poisoning is commonly coded as suicide or accidental death (in the absence of clear intent) but some hospital databases do not distinguish between overdoses following recreational use of substances and deliberate self harm (Cambridge, Wood & Bateman). This would amplify the problem of determining whether a death was accidental or deliberate.

Summary

- 3.16 There are no national or local statistics of the incidence or the causes of early deaths amongst care leavers, as biographical details are not collected about the deaths of adults.
- 3.17 International data collected by the WHO suggests that the majority of early deaths are associated with behaviours and conditions that begin at a young age such as smoking, early sexual activity and violence. It would not then be unexpected for there to be a higher rate of such deaths for ex-care leavers due to the stressful childhood experiences prior to and during their Looked After periods.
- 3.18 Somerset has a higher early death rate for the age range 18-24 years old than the England and Wales average for the period 2006-2012; however this is largely explained by the larger number of deaths caused by traffic accidents.
- 3.19 From this sample of such known deaths the following conclusions are indicated, albeit tentatively due to the small numbers being considered:
- Ex-care leavers are likely to be statistically over-represented in the numbers of early deaths
 - The fact that over half of this cohort were aged 21 and over indicates the continuing vulnerability of ex-care leavers over time
 - Females ex-care leavers may be at a higher risk of an early death and as such less resilient than their male counterparts

4 THE FINDINGS

- 4.1 The SCIE Learning Together⁸ systems approach uses what has been learnt about an individual young person to provide a ‘window on the system’⁹ into how well the local multi-agency safeguarding systems are operating. It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase risk to the reliability with which we can expect professionals to achieve good quality work.
- 4.2 In this research we will use what we have learnt about the service provision to all 13 young people to provide the window on the system. The deeper examination of the experiences of two of the young people has provided qualitative detail, so as to enrich our understanding of the underlying patterns in the way we work together.
- 4.3 Our task is to identify those patterns that are relevant to the experiences of these young people and the priority to assign each. In order to establish if the patterns are underlying systemic patterns we need to be able to answer the following questions¹⁰ :
 - I. How the issue manifests in this particular study?
 - II. In what way it is underlying – not a quirk of the particular individuals involved?
 - III. How general a problem this is perceived to be locally, or its prevalence nationally?
 - IV. The implications for the reliability of the multi-agency child protection system?
 - V. How the issue is usefully framed for the LSCB and SAB to consider relative to their aims and responsibilities?
- 4.4 Findings 1, 2, 3, 4 and 5 provide the learning arising from consideration of the experiences of the 13 young people.
- 4.5 This is followed by ‘Additional Learning’ from the review process, and this provides further considerations for the Boards.

FINDING 1: ‘PULL’ OF BIRTH FAMILY

The way we engage and work with Children Looked After and their birth families does not sufficiently recognise the role the family may play in the young person’s adult life; consequently renewing relationships can be complex and for some lead to greater stress.

- 4.6 For many Care Leavers the ‘pull of the birth family’ is extremely strong. Both the young person and their family need support so that this renewed relationship can be as positive an experience as is possible. In commenting on the learning about suicides that have become serious case reviews, Brandon et al comment

⁸ SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Dr Sheila Fish, Dr Eileen Munro and Sue Bairstow (October 2008)

⁹ See Vincent CA. Analysis of clinical incidents: a window on the system not a search for root causes. Qual Saf Health Care 2004;13:242-3

¹⁰ These questions are those in the ‘anatomy of a finding’ developed by SCIE, as an analysis tool

*'Young people in care often feel compelled to go back home even if it means more rejection. Once back home, young people and their families need a high level, intensive support not a low level service.'*¹¹

How the issue manifests in this particular study?

- 4.7 One of the patterns amongst the 13 young adults was the need they had for their birth families, especially *after* leaving care, regardless of the level of contact that had been in place whilst they were Looked After or the reasons for them being Looked After in the first place.. One person was living with her/his family at the time of death, another was staying with them and others had returned for short periods.
- 4.8 Where there had been ongoing supportive contact with the birth family this 'return to family' could be positive, but for others where contact had been a less helpful experience or where contact had ceased, the reunification process was more complicated. This was most striking for two of the young adults who had settled into stable, relatively successful independent lifestyles (employment and further education) but following re-establishing more frequent contact with parents with long established drug use the young person's deaths involved self poisoning.
- 4.9 One of these young adults had a very successful foster placement and continued to have the support of her/ his carers. Nevertheless, the pull back to the birth family was very strong and despite all her/his apparent stability this contact led to bouts of drinking with the birth father and substance misuse with the mother.
- 4.10 For another young person, one of the practitioners involved recounted that there had been attempts to cease contact during care proceedings, but this was not successful. Subsequently irregular contact occurred that increased when the individual left care. The parent was found later to have supplied the young adult with drugs.

In what way it is an underlying issue – not a quirk of the particular individuals involved this time?

- 4.11 Young people in care in Somerset all have a qualified social worker and their cases are reviewed by the Independent Reviewing Officer [IRO] service until they are 18. The Leaving Care Service, which contains no social work qualified staff, become involved when they are planning to leave or have left foster or residential care.
- 4.12 It was the view of the management group that the focus of work when children become Looked After is supporting them with the separation from family and in some instances with termination of contact. During their adolescence the focus of support is around future planning, as opposed to re-visiting the traumas in the young people's history. This possibly coincides with the wishes of many young people in receipt of this service, who like other teenagers look forward to becoming independent.

¹¹ Neglect and serious case reviews, Marian Brandon, Sue Bailey, Pippa Belderson and Birgit Larsson University of East Anglia/NSPCC, January 2013

- 4.13 In common with all children, Children Looked After have strong emotions about their parents and families, whether or not they have been in regular contact. For some there will be many unresolved emotions and myths about their families and why they came to be Looked After.
- 4.14 It is likely that to be able to look forward to a successful future, throughout the period children are Looked After individuals will need varying help and support to understand their own history and come to terms with their past.
- 4.15 It is arguable that all children need intermittently to be able to process what has happened in their life, and those that are Looked After would have a greater not lesser need. This needs to be done before transfer to the Leaving Care Service and then consolidated by Leaving Care staff.

How general a problem is this locally or data about its prevalence nationally

- 4.16 Both the management group and the practitioners involved in the workshops confirmed that there is a strong pattern of care leavers returning to their families. Sometimes to live for periods, and other times just to visit.
- 4.17 Research findings show that this is a general finding, for example the final report of the Right2BCared4 Pilots¹²
'As young people reach adulthood they may want to reconnect with birth family and many may return to live with family when they leave care. For some young people these relationships will be beneficial and supportive, however, for others they may be damaging (Biehal et al., 1995; Dixon and Stein, 2005; Stein, 2004; Wade, 2008). It is important that social workers and leaving care workers are proactive in exploring family relationships when pathway planning in order to manage young people's expectations and prepare them for renewed or increased contact.'
- 4.18 This is supported by the Who Cares Trust¹³ on their web-site pages on leaving care: this suggests that it is inevitable that relationships with parents will be rekindled in some way or another and planning must reflect this.

What are the implications for the reliability of the multi-agency safeguarding system?

- 4.19 The likely 'pull' of the birth family for most Care Leavers has to be understood throughout the Looked After period. The significance of the birth family will vary for each individual and be different at different ages and stages of their lives. However, there is a universal need for young people to have information throughout their care history, so as to realistically manage their expectations.

¹²Evaluation of the Right2BCared4 Pilots: Final report, Emily R. Munro*, Clare Lushey*, Harriet Ward* and National Care Advisory Service (DfE 2011)

¹³<http://www.thewhocarestrust.org.uk/pages/leaving-care-what-happens-post-16.html>

- 4.20 Social workers need to understand the likely ‘pull’ of the family sometime in the future, and that this cannot wait until the leaving care phase, when the young person will be planning for the future, rather than the past. However, even after the young person has left care, it is important to explore family relationships again, as well as the sense the young person makes of her/his past.
- 4.21 Bearing in mind that these young people might not be as resilient to deal with the emotional impact family contact might bring, agencies should develop plans with each young person to provide support in connecting with families and if needed, with their subsequent relationship.
- 4.22 Without this planning and support, there is the risk that care leavers return to their birth families with great expectations and risk being engulfed by emotions and behaviours from their childhood, which may [or may not] be associated with why they became Children Looked After in the first place.
- 4.23 Stein (2006)¹⁴ refers to research showing that those care leavers who had moved on had ‘made sense’ of ‘their family relationships’. The research suggests improved planning for young people but it does not consider the parents’ role and possible support mechanisms that they might require. If reunification is as it suggests, inevitable, holistic planning, including the whole family would greatly improve the chances of positive outcomes for both the young person and the parents.

FINDING 1: PULL OF THE BIRTH FAMILY

The way we engage and work with Children Looked After and their birth families does not sufficiently recognise the role the family may play in the young person’s adult life; consequently renewing relationships can be complex and for some lead to greater stress.

Questions for the Safeguarding Boards to consider

- How do we best facilitate Children Looked After to ‘move on’ and make sense of their families and the circumstances which led to their becoming Looked After?
- Does this require an approach throughout their care history involving ‘life story’ work in different ways and at different stages– and if so is there an existing methodology for this?
- How should this be developed for the leaving care service?
- Are the Boards assured that young people know of their right to access their records and are they provided with the requisite support should they do so (as part of making sense of their history)?
- Is there sufficient focus in pathway plans on the birth family and engaging them in the preparation process? Should we seek to engage parents (legal or birth) or other relevant carers in this process?

¹⁴ Young people leaving care , Mike Stein (Child & Family Social Work, Volume 11, Issue 3, pages 273–279, August 2006)

FINDING 2: THE MORE COMPLEX THE NEED THE LESS SUPPORTED THE ACCOMMODATION

Accommodation resources for Children Looked After and care leavers do not sufficiently meet the complex needs of individual children: as a consequence the most vulnerable are least likely to experience placement stability and most likely to find the transition to independence difficult and possibly traumatic.

How the issue manifests in this particular study?

- 4.24 7 of the 13 young people in this study had repeated moves when looked after, reflecting the challenge in finding placements able to meet their needs. The older the individual, the more difficult this became.
- 4.25 The 13 young people moved to independent living between the ages of 16 and 18. One wished to remain at her/his foster carer's home but the lack of financial assistance was a problem in facilitating this arrangement. In all instances there was a requirement and expectation that leaving care was age related with some slight discretion.
- 4.26 10 of the 13 had multiple moves after they moved to independence, with periods of homelessness, living in a car, or 'sofa surfing' with friends. A typical example of this was where one young person's placements were mainly of just one month's duration, with one 6 month period of relative stability and 10 months of supported housing.
- 4.27 10 of the young people were in accommodation judged by the management group as unsuitable to meet their needs in relation to their ability to cope with independent adult life at the time of their deaths.
- 4.28 The management group observed that the more complex the individual's need became, the less specialist and supported the placements became, because most of the more suitable accommodation could not tolerate the challenging behaviour. This was the experience of those young adults with the most complex needs, involving mental health and/or substance misuse problems; challenging and at times violent behaviour and in one instance 'high end autistic' behaviour [CAMHS diagnosis].
- 4.29 It was striking that a few had stable, positive and constructive periods in secure hospital / custodial settings, but on discharge / release there were no suitable accommodation options available.

In what way it is an underlying issue – not a quirk of the particular individuals involved this time?

- 4.30 The Oftsed Inspection in 2012 identified the lack of local accommodation able to tolerate such complex needs. Oftsed provided an urgent recommendation to be implemented within three months to:
- 4.31 ‘develop a clear action plan to secure additional and appropriate high tolerance accommodation for care leavers and ensure that care leavers living in bed and breakfast or in other low support accommodation are well supported and protected.’
- 4.32 Practice in Somerset has changed since this period with greater recognition of the need to delay independent living to 18 [some of the young people in this cohort moved at 16 or 17]. This will be further improved as since April 2014 local authorities are legally obliged to support every young person who wants to stay in foster care until their 21st birthday under the ‘stating put’ amendment to the Children & Families Bill. This does not however apply to residential care and the most vulnerable young people tend to be in residential care.
- 4.33 Despite actual and planned improvements in the transition to independence, it is not clear to what extent young adult’s placements in Somerset are now more suitable for care leavers. The management group knew of major changes being implemented, but practitioners attending workshop days were less positive, encountering less choice than previously and experiencing more difficulty placing young people with high needs, due to the loss of high tolerance accommodation resources. It was acknowledged that this may be a transitional problem.

How general a problem is this locally or data about its prevalence nationally

- 4.34 The damaging effect of frequent placement changes has long been identified as being detrimental for children’s emotional development and this has been incorporated into performance targets for local authorities.
- 4.35 The Joseph Rowntree Foundation [JRF] Young People in Transition research programme shows, during the last 20 years, patterns of transition into adulthood have changed due to decline in youth employment, extension of youth training and education and a reduction in entitlements to universal welfare benefits for young people. These changes resulted in more dependency on families for emotional, financial and practical support, often into their early twenties. Yet, Children Looked After are expected to cope independently at a far younger age than young people living with their families. (Stein JRF 2005)¹⁵ .

¹⁵ Resilience and young people leaving care: overcoming the odds, Mike Stein, Joseph Rowntree Foundation 2005

4.36 Stein points out that for young people leaving care transition is shorter and more hazardous. Also that:

'psychological research suggests that most young people cope with the major changes in their lives, during their journey to adulthood, by dealing with them over a period of time, resolving one issue, then moving onto another. The theory has been tested by empirical research carried out in New Zealand, Scotland and the United States, which demonstrated that those who have to cope with the greatest number of life changes in less time had far poorer outcomes, including less educational qualifications and lower self-esteem (Coleman and Hendry, 1999¹⁶). Yet the accelerated and compressed transitions of care leavers deny them the psychological opportunity to focus, to deal with changes over time (Stein JRF 2005).¹⁷

4.37 Moreover most young people are able to leave their family home when it is right for them, not at an arbitrary age. They are also able to return if things do not work out or their circumstances change. Children Looked After do not have that safety net, unless they are able to return to their families. As discussed in finding one that is not always a positive experience and for some care leavers it is not a possibility at all.

What are the implications for the reliability of the multi-agency safeguarding system?

4.38 Research tells us that:

- Young people are most likely to have a settled experience post sixteen if they have a stable care history and
- Outcomes for care leavers are affected by a lack of stability in accommodation after leaving care:

'Having a stable home life appeared to be a particularly important factor in differentiating outcomes for young people who had an unsettled care history. Young people with unsettled care histories who moved frequently after care were less likely to be able to remain engaged with their economic activity.' (Allen, JRF 2003)¹⁸

4.39 This suggests that unless young people are placed in an environment able to provide them with security and stability whilst they are Looked After and when they leave care, they have less probability of developing the resilience to succeed in adult life.

¹⁶ The Nature of Adolescence, Coleman and Hendry, 1999

¹⁷ Resilience and young people leaving care: overcoming the odds, Mike Stein, Joseph Rowntree Foundation 2005

¹⁸ Into the mainstream, Allen, Joseph Rowntree Foundation, 2003

FINDING 2: THE MORE COMPLEX THE NEED THE LESS SUPPORTED THE ACCOMMODATION

Accommodation resources for Children Looked After and care leavers do not sufficiently meet the complex needs of individual children: as a consequence the most vulnerable are least likely to experience placement stability and most likely to find the transition to independence difficult and possibly traumatic.

Questions for the Safeguarding Boards to consider

- Is the LSCB confident that care leavers are now having a slower transition?
- Although changes are being made to the provision of accommodation for Children Looked After and care leavers, is the LSCB confident that the new arrangements will be able to meet the needs of those young people with complex needs, especially those in residential care provision as opposed to foster care?
- Some young people will not wish to remain in care placements post 18 years of age: are the Boards confident that the new commissioning arrangements provide sufficient support to these young people?
- How can the corporate parent provide ongoing support options to those who have left care beyond the age of twenty one in the same way that families do?
- Does the placement strategy for young people link to the provision for adults?
- Is the placement strategy equitable across Somerset?
- Are the boards assured that the education, health and care plans will be adequate in addressing the needs of individuals into adult provision?

FINDING 3: CONSTELLATIONS OF NEEDS LEADS TO GAPS IN SERVICE

Young adults who have left care tend to receive reactive services which do not necessarily recognise or meet their needs as vulnerable people; this was particularly striking for those with a 'constellation' of needs especially mental health and substance misuse problems

4.40 The biographical details of the 13 young adults demonstrate that 6 were aged 21 or over at the time of death, with the eldest being 27. Some had shown themselves to be settled. This suggests the ongoing vulnerability of Looked After Children, well into adulthood and the need for them to continue to receive services and support which recognises such needs.

How the issue manifests in this particular study?

Constellation of needs

4.41 It was striking that 8 of the young people had a constellation of needs or dual diagnosis [mental health and substance misuse] and tended to fall through the gaps between the services. They were deemed not eligible for any individual services, despite having several areas of difficulties and consequently a high overall level of need.

- 4.42 Whilst from social care records it did not appear that drugs and alcohol was a significant feature for most of the young people, once multi-agency information was obtained it was established that 12 of the young people used drugs and/or alcohol, and the remaining one had a history of overdosing without detail of the substance used.
- 4.43 9 of the 13 received mental health services during their life and a further one had an assessment of need but did not receive a service. We have not been able to ascertain whether mental health services were involved with the remaining 3.
- 4.44 Self harm appears as a key feature for a significant number of the young people: 9 out of 13. The form of self harm varied from cutting, overdosing of over the counter or illegal substances and some severe self injury. Of these young people, the causes of death often involved a degree of self harm variously recorded as suicide or as accidental injury.
- 4.45 In all but one case, the young people behaved in ways that often brought them in contact with the Police. Most were prosecuted at some point and 6 had received custodial sentences in their lives.

Impact of services provided

- 4.46 Once the young people ceased to receive Leaving Care Services, any support that was offered tended to operate individually, without evidence of joint planning and co-ordination. The focus becomes as an adult on eligibility for individual service as opposed to overall vulnerability. Examples cited included:
- A member of housing staff recalled contacting other services, wanting to discuss and problem share, so as to be able to work together to devise the most appropriate plan for hard to place young adults; however, the response related to the eligibility of the young person for a service. In the absence of the young person qualifying for the individual service, it was difficult to obtain the skills and knowledge of social workers, therapists or substance misuse staff to work together to consider how housing could best meet the young person's needs.
 - One young person only entered the system at age 16, and there was no multi-agency assessment of her/his needs, as would have occurred at a younger admission age.
 - Adult social care was not involved with any of this cohort; when there was a referral for one young adult, s/he did not meet the criteria for adult services [Learning Disability]
 - One young person with a dual diagnosis of mental health difficulties and drug and alcohol problems was risk assessed separately by each service and declined access to support until the other need had been resolved

- 4.47 A further complicating feature was the lack of full knowledge within adult service providers of the young person's history and her /his vulnerability. There is no statutory requirement for agencies to disclose information about previous Children Looked After status and any associated history. Services consequently may only have this information if the young person chooses to disclose it her/himself. It was considered that the vulnerability of some of the young people in this cohort might have been identified more clearly if this history had been known.
- 4.48 In some instances the transitional arrangements between children and adult service providers contributed to the young person's vulnerability not being identified. This was a particular issue in substance misuse services due at the time to shortcomings in the commissioning process which led to adult substance misuse services not having the records of the children's service. This should no longer be a problem.
- 4.49 CAMHS in one case terminated services 7 months before a young person's 18th birthday, without any clarity about transitional arrangements or follow up by adult mental health services. Partly this was due to the individual's lack of engagement.
- 4.50 Lack of engagement with services was common with this cohort, but without a co-ordinated response or follow-up to take into account the young adult's vulnerability, such non engagement led to the service being terminated, as opposed to alerting staff to potential concerns.
- 4.51 The lack of engagement and the lack of co-ordinated assessment and planning for young people led to the lack of holistic understanding of the individual's needs and the extent of her/his vulnerability.
- 4.52 Such holistic assessment and provision of services was provided for those young people who received custodial sentences or were in secure accommodation. However, upon release the services do not continue and/or the individual ceases to accept such help.
- 4.53 One young person was subject to criminal proceedings and the court ordered for an assessment to determine whether the individual was able to plead. It was only at that point a diagnosis was made of a conduct disorder *and* a borderline learning disability, with the individual having an intellectual ability in the third percentile i.e. out of 100 people 97 would be more intelligent. Despite this assessment and diagnosis, s/he was not deemed eligible for either adult mental health or learning disability services.

In what way it is an underlying issue – not a quirk of the particular individuals involved this time?

- 4.54 The Children Looked After system provides a structure through the Independent Reviewing Officer [IRO] that lends itself to consideration of the child's needs in a holistic manner, which is able to address multi-agency planning and co-ordination. This continues until the young person is aged 18 years old and enters the Leaving Care Service, when the IRO ceases to be involved.
- 4.55 During the leaving care years, the focus changes from care planning to pathway plans and there are attempts to provide multi-agency co-ordinated planning via the Pathways2Planning strategies. It is not yet clear to what extent this is beginning to be able to deliver the co-ordinated planning, intervention and support that such vulnerable young people need.
- 4.56 The way that adult services are organised results in a lack of recognition of the impact of the 'constellation of needs' and subsequent vulnerabilities. The failure to meet thresholds in a number of services can leave the young person without the support they need unless they are subject to restriction of liberty via prison or mental health services, when they may be subject to more holistic assessments.

How general a problem is this locally or data about its prevalence nationally

- 4.57 Research findings suggest that Children Looked After and young adults who were previously Looked After may be more likely to have complex multiple needs with involvement in several systems and services.
- 4.58 A recent report from the Association of Directors of Adult Social Services (ADASS) (2013)¹⁹ refers to the notion that Children looked After are more over-represented in the youth justice system: 22% of those aged under 14 years of age were living in care at the time of their arrest.
- 4.59 The report refers to people with multiple needs frequently have difficulties with substance misuse, physical health, housing and relationships and that:
*'Effective responses to tackling multiple needs usually include a lead professional role, such as a link worker, who builds a trusting relationship and supports the individual to get access to the range of services they need. It is essential, however, that such arrangements are supported by robust partnership arrangements – often involving pooled or aligned budgets – able to bring together lead professionals from the different services that people need'*²⁰.

¹⁹ Making the Difference: the role of adult social care services in supporting vulnerable offenders (ADASS) 2013

²⁰ Making the Difference: the role of adult social care services in supporting vulnerable offenders (ADASS) 2013

4.60 In these situations of multiple needs, coherent transition planning can often fail. Nevertheless, evidence suggests that whilst the age group 16 to 24 (those in transition) are most likely to commit a crime, it is also this age group that would turn away from criminal behaviour if they received the most appropriate intervention. (Transition to Adulthood Alliance, 2012)²¹. To do this effectively, ADASS (2013)²² suggests would require a central professional coordination role linked to strong partnerships

What are the implications for the reliability of the multi-agency safeguarding system?

4.61 Research tells us that care leavers are more likely to be vulnerable adults. Bullock and Gaehl²³ in one of the few long term studies of 'children in care' comments that:
'All children in care are at increased likelihood of poor outcomes compared with the general population but it is not possible to determine the extent of their vulnerability without knowing their background characteristics and the risks these pose.' (Bullock and Gaehl 2012)

4.62 This study looks at risks of mortality and concludes that
'While it is difficult to be authoritative, there is evidence that the risk of mortality is increased by early illness and disability, abuse and neglect and anti-social life styles.' (Bullock and Gaehl 2012)

4.63 Such life experiences are more commonly found in the Children Looked After population. Hence as adults some are likely to remain vulnerable, or to have vulnerable periods. With disrupted family relationships, these young adults are less likely to have support and more likely to risk being isolated.

4.64 ADASS (2013), in their report in to the role of social services in supporting vulnerable offenders, suggests that there are ways to tackle this issue and in turn, save money in the public sector. This includes:

- Building partnerships with agencies that also serve those with multiple needs
- Social services to offer more personalised services based on individual need
- Influence strategy to support people with personal need

²¹ , <file:///C:/Users/Edi/Downloads/making-the-difference.pdf> Transition to Adulthood Alliance, 2012

²² Making the Difference: the role of adult social care services in supporting vulnerable offenders (ADASS) 2013

²³ Children in Care: a long-term follow up of criminality and mortality, Roger Bullock & Ella Gaehl Children & Youth services review 2012

FINDING 3: CONSTELLATIONS OF NEEDS LEADS TO GAPS IN SERVICE

Young adults who have left care tend to receive reactive services which do not necessarily recognise or meet their needs as vulnerable people; this was particularly striking for those with a 'constellation' of needs especially mental health and substance misuse problems

Questions for the Safeguarding Boards to consider

- How can adult service providers identify and meet the needs of those with a constellation of problems, but currently unable to access each individual service?
- How to improve the transition process so that it becomes co-ordinated across all agencies and information is consistently retained and transferred to adult providers?
- How can services improve co-ordinated assessment and planning for ex-care leavers?
- How does the 'DNA' policy apply in each service? Does it recognise the vulnerabilities of care leavers, and the need for follow-up, in the same way as it does for children?
- How do we try and get better services for these vulnerable young people? Are the Boards happy in the process for agencies to share information in order to get the best outcomes for the individual (ie. Influencing providers to request information)
- What does it mean to be a corporate parent? Should it mean more than ending responsibilities at a particular age or does there need to be more pro-active contact, planning and co-ordination of services well into adulthood?

FINDING 4: NEED FOR STABLE AND CONSISTENT RELATIONSHIPS

The ways we provide services for Children Looked After does not sufficiently take into account the child's need's for consistent and stable relationships both during their time Looked After and as adults?

4.65 Children Looked After experience the disruption of their own family relationships. For some, this is then compounded by frequent moves of placements and education provision so placing further obstacles in the development of stable and nurturing relationships with adults and with peers.

How the issue manifests in this particular study?

4.66 One of the positive aspects of practice for 4 of the young people was ongoing contact with either a mentor (2 of the young people) or foster carers (2 young people).

4.67 We were told of another young person who had maintained contact with her/his social worker following leaving care, but the social worker died shortly before the young person's own death.

4.68 There is no information about any consistent carer / adult relationship in the lives of the remaining 7 young people.

4.69 From records in children's social care it is possible to establish the number of moves and number of changes of workers involved with each individual from point of first allocation to the last information known.

- 4.70 For the 3 who were involved with children's social care from a young age (three, four and five respectively), the number of staff changes ranged from 16 to 21, and the number of moves 17, 25 and 47. Some of the workers and some of the placements would be repeated as children returned to previous accommodation and social workers, family support workers and leaving care staff.
- 4.71 However, all the remaining young people had many changes of workers (ranging from 6 to 15) and many moves (between 7 in two years to 31 in ten years).
- 4.72 Whilst efforts are made to retain children at their schools whenever possible, so as to maintain links with peers, placement moves often led to changes of schools and the breakdown of existing peer relationships, as well as the damaging effect of disrupted education.
- 4.73 In one instance a young person had been placed in a residential school and had settled well and made very good progress. However, on the move of her/his mother out of Somerset, the financial responsibility for the education was transferred to the new local authority. This resulted in the young person's placement being terminated due to lack of funding and it was considered significant that s/he never settled again in a placement or developed strong relationships with care staff or social workers.

In what way it is an underlying issue – not a quirk of the particular individuals involved this time?

- 4.74 The opportunity for young people to be able to develop consistent relationships with carers and peers requires placement and educational stability, along with key members of staff to remain in post. There are obstacles in providing this due to:
- Placement moves
 - Changes of allocated key workers
 - Professional barriers to discourage ongoing relationships between staff and young people

Placement moves

- 4.75 Finding 2 discusses that the most vulnerable with greatest need for security and consistency are most likely to experience more frequent placement moves due to the challenges in providing an appropriate resource which is able to provide the young person with the security they need to enable them to settle and develop relationships with staff and peers.
- 4.76 When children move placement there are obstacles in being able to maintain relationships as the funding arrangements for homes provide for the care for the residents, not for ex-residents. Maintaining contact by staff might also raise questions about probity (see 2.77 -79 below).

4.77 The maintenance of links between peers are usually left up to the young people themselves after a placement move; the feasibility of this is dependent on the geographical locations of the placements. However, the more complex the child's needs, the more specialist the placement is likely to be and the higher probability that this will be some distance from home and school.

Changes of allocated workers

4.78 Commendably Somerset encourages the development of a relationship between social worker and Children Looked After through a structure which maintains case responsibility with the social worker until the child's 18th birthday, when the responsibility transfers to the Leaving Care team. In some local authorities this occurs at age 16. Moreover there is a transfer process to enable the dual involvement of social worker and Personal Advisor [the case responsible worker in the Leaving Care service], prior to the social worker ending contact. In practice we are told though that this does not always happen.

4.79 It is not clear to what extent the turnover of staff affects those working with Children Looked After in Somerset. Within children's social care the turnover of social workers for the year ending 31.12.13 was 12.70% (based on headcount of staff as provided for the DfE returns).

Professional barriers to discourage ongoing relationships between staff and young people

4.80 In the past a vital lifeline for vulnerable children sometimes occurred when the professional relationship developed into a long term or even lifelong friendship, with Children Looked After retaining links with social workers and residential care staff.

4.81 The question of the probity of such ongoing personal relationships between staff and children when the professional role ceases has led to such practice being discouraged. This view stems from the knowledge of historical abuse of vulnerable children and the need to protect children and young adults.

4.82 The mentoring scheme in Somerset does though provide a facility which would be able to provide a safe framework in which to be able to provide such support and friendship to care leavers.

How general a problem is this locally or data about its prevalence nationally

4.83 The shortage of appropriate resources for the care of challenging adolescents who are Looked After is an issue nationally and results in children being sent around the region and even around the country. More information is needed to the extent or not which such moves culminate in a stable placement and enable the development of consistent relationships. The evidence from this cohort of 13 young people is that it did not.

What are the implications for the reliability of the multi-agency safeguarding system?

- 4.84 For children growing up within their own families the existence of consistent relationships with parents, siblings and other family members is taken for granted, along with the development of stable peer relationships during childhood and adolescence. For some children who are Looked After this is not the case.
- 4.85 Brandon et al, in a 2013 report on serious case reviews comments that:
*'Older children carry the legacy of their experiences of neglect and rejection with them. As a consequence, threats to their own life can come from their own high-risk behaviour or from suicide. Adolescents need to maintain, or be helped to build, safe, healthy relationships with their peers and with caring adults.'*²⁴
- 4.86 The ongoing vulnerability demonstrated by this group of 13 young adults demonstrates that this need for healthy relationships with peers and caring adults continues into adulthood, even more than for young adults in the general population.

FINDING 4: NEED FOR STABLE AND CONSISTENT RELATIONSHIPS

The ways we provide services for Children Looked After does not sufficiently take into account the child's need's for consistent and stable relationships both during their time Looked After and as adults?

Questions for the boards to consider

- To what extent does each agency prioritise the need for consistent relationships between Children Looked After / care leavers/ ex-care leavers and staff in plans made for Children Looked After
- To what extent does each agency prioritise the need for consistent relationships between Children Looked After / care leavers/ ex-care leavers and staff in consideration of work force planning, professional career structures and the movement of staff due to organisational reconfigurations?
- Are there routine strategies in place to provide for continuing relationships when children move, such as to enable (and if required fund) ongoing contacts with staff and peers from previous placements
- How widespread is the role of mentor and are staff aware of the possibility of maintaining links with a child through this scheme when case responsibility moves?

²⁴ Neglect and serious case reviews, Marian Brandon, Sue Bailey, Pippa Belderson and Birgit Larsson University of East Anglia/NSPCC, January 2013

FINDING 5: NEED FOR EARLY INTERVENTION

There are opportunities for earlier and more effective intervention which could support children in their families and also better identify those where earlier intervention is required; schools are in a pivotal position to facilitating such identification and support

How the issue manifests in this particular study?

- 4.87 The focus of this study was on the leaving care period for these 13 young people; however, it was clear that most (albeit not all) experienced troubled childhoods from an early age although this did not necessarily involve a long history of being Looked After by the local authority.
- 4.88 9 of the 13 young adults first became looked after aged 13 or over. Of the 4 with earlier care experiences one had been in care continuously from the age of 3. The other three returned home or to family placements, returning to care at ages of 10 in one case, and at 15 in the remaining two cases.
- 4.89 All 13 children suffered varying degrees of early childhood trauma, including for most, elements of abuse and/or neglect. 6 experienced domestic abuse in their childhoods.
- 4.90 The contribution of information from schools in this study demonstrated, that although not in educational records, staff at school had earlier information about family problems and in some instances were providing the child / young person with support. In one case though, whilst the primary school had identified potential learning difficulties, once the pupil transferred to secondary school such concerns were lost and not diagnosed until the young person was assessed as part of criminal court processes.

In what way it is an underlying issue – not a quirk of the particular individuals involved this time?

- 4.91 In her review of child protection, Munro²⁵ states that:
‘Early help is better for children: it minimises the period of adverse experiences and improves outcomes for children’
- 4.92 This refers to both early preventative services to support children and families, and pro-active intervention to prevent children suffering significant harm. Such early intervention is different to the types of service provision that were evident for some of these young people.

How general a problem is this locally or data about its prevalence nationally

²⁵ The Munro Review of Child Protection: Final Report – A child-centred system, DfE May 2011

4.93 It is not known to what extent there have been changes locally or nationally in the availability of early support and identification of the need for intervention.

What are the implications for the reliability of the multi-agency safeguarding system?

4.94 Research tells us the likely impact of early trauma if not dealt with appropriately may interrelate with future stressors to lead to a lifecycle of crime and crisis (Revolving Door Agency 'Towards a shared future')²⁶.

4.95 Moreover, young people with higher needs appear to have a higher risk of suicide according to the National Suicide Prevention Strategy for England (Department of Health, 2012)²⁷.

4.96 While it is difficult to be authoritative, research indicates that the risk of mortality is increased by early illness and disability, abuse and neglect and anti-social life styles (2012 Bullock & Gaehl)²⁸.

FINDING 5: NEED FOR EARLY INTERVENTION

There are opportunities for earlier and more effective intervention which could support children in their families and also better identify those where earlier intervention is required

Questions for the boards to consider

- Is the LSCB confident that the changes made to early support and intervention in Somerset will be more likely to both better support children within their families and to take decisive action to intervene effectively to protect children
- Is the LSCB satisfied that the improvements that have been made have resulted in a greater stability for children, decreasing the movements between home, other family and care placements?
- Is the LSCB confident that the pivotal role of schools is fully exploited in the early support and intervention strategy, and that this is fully integrated into a holistic approach involving other agencies as appropriate
- Do secondary schools continue the work of the primary schools in early identification and provision of support? If not, is this work being undertaken elsewhere in the multi-agency safeguarding system?

²⁶ <http://www.revolving-doors.org.uk/documents/towards-a-shared-future/>

²⁷ Preventing suicide in England A cross-government outcomes strategy to save lives, DoH 2012)

²⁸ Children in Care: a long-term follow up of criminality and mortality, Roger Bullock & Ella Gaehl Children & Youth services review 2012

ADDITIONAL LEARNING EMERGING FROM THE RESEARCH PROCESS ITSELF

4.97 The limitations to the research described in section 2 have highlighted challenges to the Boards arising from:

- Lack of agency or practitioner commitment to learning exercises which are not part of statutory responsibilities
- Limitations to data available from YOT due to national policies on retention of records

4.98 Lack of agency commitment to the research was demonstrated by the obstacles faced in obtaining comprehensive information from GPs, Child & Adolescent Mental Health Service and Probation. The reasons behind this varied between agencies and were not fully evident to the lead researchers. However, the Boards should consider how to maximise learning and improvement exercises with these agencies in the future.

4.99 The current retention of records within the Youth Offending Team requires the destruction of all records when a young person reaches the age of 18 years old. The Boards should consider whether the unavailability of these records for learning and improvement processes warrants challenging this national policy.

5 CONCLUSIONS

- 5.1 There are no national or local statistics of the incidence or the causes of early deaths amongst care leavers, as biographical details are not collected about the deaths of adults.
- 5.2 International data collected by the World Health Organisation suggests that the majority of early deaths are associated with behaviours and conditions that begin at a young age such as smoking, early sexual activity and violence. It would not be unexpected for there to be a higher rate of such deaths for ex-care leavers due to stressful childhood experiences leading to being Looked After, as well as experiences when Looked After.
- 5.3 For the period 2006-2012, Somerset has a higher early death rate than the England and Wales average, for those aged 18-24 years old; however this is largely explained by the larger number of deaths caused by traffic accidents.
- 5.4 From the statistical data provided in section 3 the following conclusions are indicated, albeit tentatively due to the small numbers being considered:
 - Ex-care leavers are likely to be statistically over-represented in the numbers of early deaths
 - The fact that over half of this cohort were aged 21 and over indicates the continuing vulnerability of ex-care leavers over time
 - Females ex-care leavers may be at a higher risk of an early death and as such less resilient than their male counterparts (see 3.11.and 3.12)
- 5.5 Through a focus on the circumstances of the 13 ex-care leavers who have died unexpectedly we have learnt mainly about the care and leaving care experiences which were less likely to have led to resilient young adults. With the exception of 2 individuals with stable foster carer placements, the remainder were in residential care and experienced disrupted placements and relationships.
- 5.6 Allen's conclusions in 2003 hold good for what we have observed in this study:
*'Young people who enjoyed a relatively stable looked after experience were more likely to be settled post-16. Important factors that affected their care experience included the age they entered care, the reasons that brought them there, and the number and type of placements they experienced. Care history affected young people's ability to build and maintain significant relationships, their schooling, and their attitudes and self-esteem'*²⁹

²⁹ Into the mainstream Care leavers entering work, education and training, Allen JRF 2003

- 5.7 The fact that 9 of the 13 in the Somerset study became Looked After as teenagers may well be significant in their subsequent unsettled life experiences, as by this stage most had already suffered a troubled childhood, which was further compounded by relatively unstable care history for some with frequent placement moves and changes of key staff.
- 5.8 Also significant is the dual diagnosis or constellation of problems experienced by some of these young adults, which meant that whilst not necessarily meeting the thresholds for any individual service, the combined impact of their needs and vulnerabilities was not identified. This was further compounded by the lack of effective multi-agency work once the young person leaves care, and the lack of an identified lead professional when Leaving Care service ceases to be involved.
- 5.9 Whilst the changes introduced nationally in 2014 are allowing a longer transition to independence for young people in foster care, this will not help those in residential care or those who do not wish to remain in their placements beyond the age of 18 years old.
- 5.10 In the past the options for supported housing for such young people was limited in effectiveness and led to frequent moves; it is vital that the new commissioning process results in a range of suitable provisions.
- 5.11 The proposed national changes do not address the lifelong need for a family and parenting that Looked After Children require, in the same way as their peers growing up in their own birth families. In some cases the birth family again becomes the main source of support for the individual. The likelihood of the strengthening of family bonds in adulthood has to be recognised throughout the child's care experience and supported by appropriate work with both child and family. For others, if this is not an option or not desirable, how do we address the need for ongoing support? Do we need to develop systems in the UK that enable the corporate parent to continue to provide this beyond the scope of the leaving care service?

GLOSSARY OF TERMS AND ABBREVIATIONS

Term / abbreviation	
CAMHS	Child & Adolescent Mental Health Service
CLA	Children Looked After The term used for a child looked after by the local authority, either through a legal order (Care Order) or through as voluntary agreement
CSC	Children's social care
DNA	Do Not Attend
IRO	Independent Reviewing Officer
LSCB	Local Safeguarding Children Board
SAB	Safeguarding Adult Board
SCIE	Social Care Institute for Excellence
WHO	World Health Organisation
YOT	Youth Offending Team

APPENDIX 1: STEERING GROUP, MANAGEMENT GROUP AND LEAD RESEARCHERS

Steering group

5.12 A multi-agency steering group was formed to agree the terms of reference and oversee the project. The membership of this was:

- Sally Halls, Local Safeguarding Children’s Board chair
- Clare Steele, Safeguarding Adults Board Chair & Lead Commissioner for Adults and Health, Somerset County Council
- Kate Lee, Senior Educational Psychologist
- Trish Lyons, Children’s Services Manager, Leaving Care
- Cath Knowles, Operations Director, Children and Families, Somerset County Council
- Jerry Milton, Strategic Housing Representative - Sedgemoor District Council
- Amanda Payne, Somerset Drugs and Alcohol Partnership
- Ann Wolton, Consultant Psychiatrist, Somerset Partnership
- Vikki Hearn , P2I (Pathways to Independence) Coordinator, Taunton Deane Borough Council
- Sheila Fish, Social Care Institute for Excellence (SCIE) Head of Learning Together

5.13 Also in attendance at steering group meetings were:

- Matthew Turner, Local Safeguarding Children’s Board Coordinator and Coordinator for this Project
- Lucy Macready ,Service Manager Community Safety and lead researcher for this project from adult services, Somerset County Council
- Carolyn Drew, Independent Reviewing Officer Manager and lead researcher for this project from children’s services, Somerset County Council
- Edi Carmi, Lead researcher: an independent safeguarding consultant and SCIE Associate, accredited in the SCIE Learning Together systems review methodology and experienced in various ‘learning from practice’ projects

Multi-agency managers research group

5.14 The three lead researchers and project co-ordinator mentioned in 2.4 worked closely with a multi-agency managers group who were involved in all the stages of the work described below. The membership of this group reflected the involved agencies and was as follows:

- Named nurse, Yeovil District Hospital Acute Trust
- Service Manager safeguarding Adults, Somerset County Council
- Service manager, Leaving Care Service, Somerset County Council
- Mental Health ,Somerset partnership – (Pauline)

- Educational Psychologist, Somerset County Council
- Service Manager, Education Attendance, Somerset County Council
- Co-ordinator, Somerset Drug & Alcohol Partnership
- Manager, Youth Offending Team
- Assistant Headteacher, Stanchester Academy School
- Service Manager for Child and Adolescent Mental Health Services, Somerset Partnership NHS Foundation Trust
- Avon and Somerset Constabulary Representative
- Named doctor, Somerset Partnership
- P2I (Pathways to Independence) coordinator, Taunton Deane Borough Council

APPENDIX 2: SUMMARY OF VIEWS AND EXPERIENCES GIVEN BY YOUNG PEOPLE INVOLVED WITH LEAVING CARE SERVICE FROM EXISTING CONSULTATION DOCUMENTS

From the consultation documents with leaving care young people (locally and nationally) reviewed, a number of common themes have arisen that mirror many of the emerging Somerset thematic review themes.

These have been grouped under a series of headings and include some specific quotes from the documents where the voice of the young person says it all.

It is our feeling that YP have already told us a lot over the years and it would be preferable to demonstrate that we are using this within this piece of work to show that their feedback has mirrored the emerging themes and we approach them a fresh when we want to explore the next steps of the conclusions.

About Agencies / Services

- From a YP perspective agencies are not clear about what they offer or could offer to YP and/or cannot communicate the offer clearly enough to a YP
- YP additionally experience agencies lack of knowledge about what is or what else is available in a local area
- YP experience poor communication / information sharing between agencies
- There is also a general issue of time/availability of trusted adults in particular:
 - Need for there to be staff to talk to in accommodation settings
 - Have time to talk to leaving care worker
 - Capacity to return to carers for help & advice
 - Need for consistency of supportive adults in a YP life which recognises the importance of relationships with staff and the responsiveness of staff
- YP feel that as care leavers they have a role to play in the training of staff / adults
- There is a need to consider the language agencies use and think about what it might actually mean (the impact on the use of some words) for YP
- There is a need for a common language between agencies when working with YP so everyone uses the same language.

Systems issues

- Different systems to understand and negotiate – being in care to leaving care to 18+ services where there is less flexibility.
- Transition should be considered as important as entering care
- Readiness to leave 'care' and what this means / how experienced by YP
- Access to and engagement with preparation to leave care and be 'independent' and make general use of other services. ... *"not prepared but supported"* – YP comment from HMO exit interview³⁰
- Jordan (2008) quotes national research from 2007 – which stresses the importance of the successful transition of care experienced by young people to adulthood. She in a separate

³⁰ Leaving Care HMO Exit Interview from 35 Taunton Road, Somerset County Council 2012/13

piece of work quotes Stein 2004, 2005 which highlights the *importance of support programmes to prepare YP not only in a practical sense for the demands of independent living but also the ability to cope with the emotional difficulties of independent living* such as loneliness and isolation.³¹

- YP as care leavers report they are not used to feeling settled – back to preparation for what being independent can mean; they have raised issues about emotional safety / sabotage when things are going well.
- Variability in usefulness and involvement of young people in pathway planning
- Needs assessment and Pathway Plans need to be shared with others

About the skills for independent living

- Feedback frequently reflects how ‘leaving care’ feels / is experienced by YP:
 - Leaving care at 16 years old and feeling ‘in at the deep end’
 - A sense of loneliness and isolation
 - Readiness to leave care and what this might mean for the YP and how they experience it
- Range of life skills issues identified:
 - Need for problem solving skills
 - Workbook useful but may create conflict if there is non-engagement from most complex young people
 - Need for a common language between young people and adults
 - Young people need to keep ownership of workbook
 - Need for nurture for those with complex needs
 - The term ‘independence’ may be unhelpful – need to consider the language used and the meaning(s) attached to it
 - Young people need a ‘tool box’ to prepare them
 - Need for more in-depth dialogue between adults and care leavers and between adults/agencies before they have the dialogue with care leavers.
 - Need for peer mentoring

Accommodation

- Ability to trial accommodation would be helpful – young people need to be able to make informed choices about leaving care
- Do not always feel safe, questions about the security measures e.g. CCTV use, but also in some accommodation safety and security has been good
- Problems with other residents – including drug & alcohol use, peer relationships, *“If you live with people with problems, it makes it hard for you to get on with your own life...”*³²
- Multiple accommodation moves for a variety of reasons but what does that mean for the YP
- Differences in experiences in different areas of Somerset - not an equal service user experience.
- Positives and negatives of care leavers being accommodated together

Care leavers together

³¹ Jordan, N (October 2008 – February 2009) *How could integrated services for Care Leavers be further developed to help young people make a successful transition from the care system to independence?*, Somerset County Council, PLR Project Reference No: PLR0809-002

³² Jordan, N (28 February 2008) *How can Somerset Children’s Social Care Leaving Care Service (SCLS) improve the transition of young people leaving the care system to adulthood across the 5 Every Child Matters Outcomes?*, Somerset County Council, PLR Project Reference No:065.

- Positive activity days would be good
- Newsletter to share info. would be good
- Drop-in centres & area forums – secure social environment, potential as place to meet other agencies/services
- Attendance at groups useful

Education training and employment

- YP report future plans not coming to fruition
- Care leavers do have ambitions & care leavers receive good advice from Leaving Care workers, however this does not always translate into jobs / college admission/attendance as many remain as NEETs.

Discrimination – real or perceived

- Experiencing discrimination by others due to having been in care or a care leaver
- Being a care leaver has implications for job applications and views of others

Kate Lee
Trish Lyons
Amanda Payne
August 2013

Documents reviewed

1. Jordan, N (28 February 2008) *How can Somerset Children's Social Care Leaving Care Service (SCLS) improve the transition of young people leaving the care system to adulthood across the 5 Every Child Matters Outcomes?* Somerset County Council, PLR Project Reference No: 065.
2. Jordan, N (October 2008 – February 2009) *How could integrated services for Care Leavers be further developed to help young people make a successful transition from the care system to independence?* Somerset County Council, PLR Project Reference No: PLR0809-002
3. Somerset County Council 2012/13 internal report on responses to Leaving Care HMO Exit Interview from 35 Taunton Road
4. Somerset County Council 2012/13 internal report on responses to Leaving Care HMO Exit Interview from 65 Galmington
5. Somerset County Council 2012/13 internal report on responses to Leaving Care HMO Exit Interview from Burtons Orchard
6. Somerset County Council (Draft May 2013) Exit Interviews with Care Leavers 2012/13 (internal report)
7. Somerset County Council (September 2011) Exit Interviews with Care Leavers 2010/11, (internal report)