



MANAGING TRANSITIONS

FROM

SECURE SETTINGS

S.A.N.

MANAGING TRANSITIONS FROM SECURE CHILDREN'S HOMES

This document has drawn together examples from Secure Children's Homes detailing poor practice in managing the transition of children from secure care back into the community. Sadly the examples are just some of the many drawn from the experiences of secure homes and they speak for themselves I believe. Unfortunately there are many more out there!

I decided to draw together the document as a response to both the Care Matters: Time to Deliver document from the D.C.S.F. and because of the continued undervaluing of the work of Secure Children's Homes. Too often we are blamed for practice we have no responsibility for or control over.

Care Matters outlines what must be done in order to achieve better outcomes for those children who are looked after. Children in secure homes, no matter what their legal status, are looked after but too often they are left behind and forgotten. Yet in most cases their needs are precisely the same as those living in the community and in many ways more complex precisely because they have been placed in secure care. Children living in secure homes must not be forgotten in the response to Care Matters.

Secure care is part of the continuum of care that can be offered to children and it is essential that it is seen as such, not some kind of adjunct into which children are shunted into a siding. If we have learnt anything from all the inquiries into residential care over the years, it surely must be that on an 'out of sight, out of mind' approach is not acceptable.

Secure Children's Homes provide a high quality, multi disciplinary approach to working with some of the most difficult and damaged children. This understandably is not a cheap option. However, all too often, as can be seen from the examples outlined, there is a distinct lack of exit planning for the return of children to the community.

Secure care provides a real opportunity for direct work meeting the needs of the child, yet on too many occasions this is undermined by what is to be offered when the child leaves. Whether this be suitable accommodation, appropriate education, family contact or structured support to enable the child to make, what is understandably, the challenging transition of being 'locked up' to being back into the community.

Yet when the frailties of these plans are exposed by the difficulties the child faces the 'blame' is placed upon secure children's homes. However, whilst we can ask for good exit plans, and we do, we have no responsibilities for doing so. We can demand and try to influence the exit plans, and we do that, ultimately this role lies with the placing authority, Social Workers and the Youth Offending Team.

The purpose of this document therefore is to highlight the impact of poor exit planning on children who in fact need the highest quality plans. It is an area where the Secure Accommodation Network (S.A.N.) feels there is an urgent need for more regulation or at the very least clear guidance on what is required when children leave secure care.

S.A.N. represents Secure Children's Homes in England and Wales. Its primary aim is to develop the practice in secure care to ensure that highest standards of care possible can be provided for the children placed there. These children, who have their liberty restricted, should be given the support they require to help their return to the community. Unfortunately the examples quoted show that a lot more work is required to achieve this.

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Examples of practice issues from Secure Children's Homes. Collected by the Secure Accommodation Network (S.A.N.) to illustrate the current problems they are experiencing

East Moor

Empirical data may be more useful than anecdotal evidence. In preparing for my SAN presentation at Chelmsford I looked at 100 consecutive DTO discharges (young people who completed their sentences here, not including mid-placement transfer or release on appeal.

1. One in seven YPs had no accommodation exit plan in place by the final review. All but 1 got last minute accommodation fixed up before their discharge, of varying degrees of appropriateness. The exception was a looked after Nottingham lad who had been here for four months and was collected by a stranger volunteer to be taken to sit in Children's resources for several hours while they found a vacant bed.
2. A third of YPs still had no education plan in place by the final review! Of the other 2/3, as you know many of these are with YOT schemes or a couple of hours home tutor per week. As parents we have a statutory responsibility to send our kids to school. If we don't then we can be sent to prison. LAs have a statutory responsibility to provide full-time education. They fail abysmally to meet this requirement but nothing ever happens. Where is the governance and accountability?
3. Bear in mind that we have a full time Resettlement Officer who spends his time chasing YOTs and Social Workers to make constructive plans. Were it not for him the figures would be much worse!
4. I broke the sample down into Looked After -v- Non-Looked After kids and looked at accommodation exit plans. (Remember, these were DTOs so they are proper Looked After kids, not those technically Looked After by virtue of Sec. 23). By definition these kids must arrive with a Care Plan but at the IPM only one in five had any discharge accommodation planned. I needn't elaborate to you . . . out of sight, out of mind . . . worry about it when they are out. By the Final Review one in five Looked After kids still had no accommodation sorted! What a damning indictment of our care system. Kids are not looked after because they are disadvantaged, but disadvantaged because they are looked after!

Example

Dear X,

Re: N.F. (dob. 02/06/93)

N.F. was admitted here on 23rd October last year having been sentenced to an 8-month Detention and Training Order. He is a looked after child, subject to a full Care Order. At his Initial Planning Meeting and at each subsequent Review it was agreed by all parties that it would be wholly inappropriate on his release for N.F. to return to, or anywhere near the Pitsmoor area where he has all his criminal associates and was previously himself dealing drugs. You will appreciate that the professional criminals who run the drugs world are amongst the most ruthless. They do not accommodate defectors or allow for rehabilitation and their techniques of persuasion can be quite brutal.

We were therefore somewhat dismayed when a deputising social worker who knew almost nothing of the case turned up at his Final Review and advised that despite having had four months to explore alternative options, N.F. would nonetheless be placed in precisely this area when discharged on 21st February. We have made a very substantial investment in N.F.'s sentence plan with regards substance misuse and offence-related work. To place him right back into the setting where he previously offended and will come under threats of serious harm if he does not resume his activities is nothing short of an irresponsible mockery of all those who have worked towards his successful rehabilitation! Initial advice from the Howard League legal department is that your authority has not only failed in its statutory responsibility to properly assess N.F.'s needs and make appropriate provision, but will be liable to accusations of gross neglect of its duty to care and protect if he is put into such a manifestly inappropriate placement about which there is multi-agency consensus that it will inevitably expose him to significant risk.

If I do not hear from you by close of business on Friday 15th that plans to return him to this area have been abandoned and a reassurance that a more appropriate placement will be in place by the time of his release I shall request formal intervention by the Howard League.



Atkinson Unit

1. DC was told to report as homeless on leaving the unit so that he could be allocated lodgings. He was 16 and scared of returning to the area where a gang was out to "get him ". 18 month sentence (that was quite an old example.)
2. J.A. left the unit this month being placed in a B&B many miles from her home and with little support. Felt to be at risk in her home area. The unit had involved the Howard League because so little active progress was being made in finding her somewhere to go to. 10 month DTO.

3. MF, aged 15, no surviving family placed in a 6x8 room in lodgings for adults, no proper support, no help to get to the college placement found for him. Ended up in a job cleaning bricks and re-offended because he was desperate to get away from the lodgings and job. 6 Month sentence.
4. Issues for all...lack of creative planning; lack of interest in the welfare of the child and what could reasonably be expected of them. Failure by pressurised SWs to prioritise their needs, feeling that they were old enough to look after themselves. Good luck to both of you.



Red Bank

Here is just one example from secure:

EM - 16 year old female
Dob: 18/12/90
Local Authority: Leeds
Sentence: 85 day recall

Summary of Issues

EM was admitted to the unit and at the time was five months pregnant, re-settlement was a priority agenda item at each review meeting. EM was due to be discharged on the 04/01/06 the plan was that the Resettlement worker would collect EM @ 9.30 and escort her to a housing provider where she would present herself as homeless and hopefully be allocated a hostel placement. The day before EM was due to be discharged the unit received a telephone call informing them that the RAP worker was off sick and would not be collecting EM. Staff contacted the YOT worker who informed the staff that EM was not her responsibility and advised staff to inform EM to make her own way to the Housing Department in Leeds, there was no appointed Social Worker and very little family support at that point in time the staff were waiting for the YOT Manager to telephone to confirm that he wanted us to discharge EM with her train fare to Leeds and the address of the Housing Department. @ 4pm the YOT Manager contacted secure administration to inform the staff that EM would not be allowed into Leeds town centre (which is where the Housing Department is situated) so the situation remained at that time unresolved. I am sure that this only added to EM anxiety during a very unsettling and stressful time. Under no circumstances would any young person be discharged from Red Bank with train fare and directions to a potential placement, I think it would be useful to point out that we have a "duty of care" to all service users and "good practice" in this particular case most definitely should be questioned.



Barton Moss

Transition – a poor example?

JT, a young man aged 17 yrs (dob 16.02.91) was admitted to Barton Moss on 22.07.05, initially on remand then sentenced to custody on 31.03.06 (Sec 228, 3yrs 6 months in custody with extended licence of 3yrs). This followed a life of being 'in care' having been removed from home at the age of 2yrs.

JT was initially placed on one of our admissions units then transferred to the mid-long term unit on 4.01.07. As Head of Home for Ash House I then became responsible for chairing his reviews. Throughout the process the issue of resettlement was discussed but owing to the nature of JT's index offence (sexual assault) the precise location was debated at length. At the point of transfer a referral to Red Bank's open unit had been considered but as the months went on GMap (therapeutic practitioners) provided his social worker with several other options with a view that his behaviour could be managed in an open setting with supervision and continued therapeutic work.

With this in mind his social worker informed a review meeting on 30.11.07 that she had made a referral to Glebe House, a therapeutic community in Cambridgeshire and intended visiting in the following fortnight. The process would then involve staff from Glebe House visiting JT at Barton Moss: social worker agreed to liaise with YOT worker over possible transfer plan. At the same meeting the YOT worker informed the meeting that a forensic assessment was to be organised.

The staff from Glebe House duly visited and by early Feb 08 we were being asked if it was possible to make arrangements to take JT to Cambridgeshire as part of the process before a decision was made. In January it was necessary to inform the police that JT had been involved in an incident in our education suite where he exposed himself to a member of staff.

The police proceedings apart the referral process to Glebe House continued and discussion with the Prison Service ensured that his mobility proposal included the opportunity to visit this prospective new placement.

On the 11th Feb I received a letter from Northumberland, Tyne & Wear NHS Trust informing me that the Northern Forensic Mental Health Service for Young People had been asked to assess JT's viability for admission to the Nationally Commissioned Adolescent Medium Secure Services. The assessment was planned for 14.02.08. Following the assessment staff on the unit were given verbal feedback which indicated the psychiatrists recommendations were likely to be either further Sec 25 Welfare order or a 'sectioning' order to facilitate an in depth assessment. When I returned from leave on the 18th of February I contacted JT's social worker to try and clarify the situation and she was unaware of any plans to pursue that course of action. I proposed she discuss the matter with the YOT worker and asked that one of them then ring back to inform me of the outcome, particularly as plans were in place to visit the placement in Cambridge on the 21st February; if there was no intention of pursuing this plan I felt it was a) a waste of our time and resources given the distance and b) unfair to give the young person false hope. Later that afternoon

JTs YOT worker rang me back and stated 'the written report hasn't been received yet but the psychiatrists are recommending we proceed with the referral to Glebe House; this young man needs to be given a chance and if there are further problems the psychiatrists would become involved at that point'. As a result of this clarification the visit proceeded.

On Wednesday 27th February we assembled for JTs final review and as I was about to proceed with introductions the YOT worker asked if she could just have a quick word with me outside of the meeting room before we began. I was then informed 'it's a bit awkward really because the written confirmation hasn't been received yet but we've had a phone call to say that JT will be sectioned and transferred to Newcastle, and I don't want to discuss it with him until its confirmed'. When I challenged the information which totally contradicted the conversation I'd had in the previous fortnight when I had directly asked if this was a possibility I was told. 'Yes, it's come as a bit of a surprise to everyone.' Although working in the same authority this information had not been shared with JTs social worker prior to the meeting either. I was also able to confirm that JTs dad had not yet been informed. I negotiated with JT that he left the room while the adults had a short professionals meeting before inviting him back to join us. During his absence several points were debated and I was asked not to contact the Prison Service, GMap or the police until the written confirmation had been received. I asked the YOT worker to clarify the 'mechanics' of the move as JT had been subjected to many moves in his life, usually as the result of a crisis or breakdown in placement and I felt quite strongly that after almost two and a half years of being at Barton Moss his move should be planned and as positive an ending as possible. My biggest concern was that he was due to attend the police station the following Wednesday (5th March) and if charged I was unsure how quickly they would seek a court hearing with a view to having him remanded to custody as he was due for release on the 7th – it had already been identified that if further custody was required he would be transferred to Hindley; having had limited experience of mental health legislation I was unsure where the sectioning order would fit. I was given assurances by the YOT worker that he would not just be 'whisked away' at short notice and it was important that he had a planned and positive ending.

I was contacted by one of the psychiatrists from Newcastle on Thursday 27th February regarding the transfer and subsequently received a fax notifying me of the intention to transfer under Sec 47 of the Mental Health Act 1983 to the Roycroft Clinic in Newcastle. I then informed the police, GMap and Prison Service of the change of plan. Later that afternoon I received a telephone call from the YOT worker asking me to contact our local GP and ask him to provide the second opinion required for the process. He initially indicated that as a professional he was not happy being asked to perform this task as he did not know the young man, having only seen him once in Dec 2005 relating to his asthma and did not know if this was in his best interests or not. We then received a further request from the psychiatrist the following day asking that we approach the doctor again but I suggested he contact the GP directly and discuss on a professional basis which he did and the GP subsequently attended the unit and completed the necessary paperwork.

On Tuesday 4th March I accompanied JT to his final session at GMap (part of agreed mobility) and as I returned to the unit received a telephone call from the YOT worker asking if I'd been updated by anyone. I explained I had just returned to the unit and she informed me that JT would be transferring the next day. I opposed that and expressed my anger that this was the plan having been assured the previous week that sufficient notice was given if there was a change to his discharge date of the 7th March. Following negotiation with the hospital she then informed me he would have to transfer on Thursday as there would not be sufficient staffing in place at the hospital on the Friday to accommodate a move then.

Having informed JT that he would now be moving a day early we rescheduled plans for his 'leaving supper' to take place on the Wednesday evening.

Several problems were then encountered on the Thursday including the Ministry of Justice questioning Barton Moss about which 'special hospital' we had approached as they did not consider the Roycroft Clinic to be in this category. Then there was an error found with a date we had provided (genuine mistake of a member of staff trying, to respond to an urgent request of psychiatrist to fill in and fax off a form, not realising the sentence calculation had been updated and consequently noted a wrong discharge date). As the day progressed we were just told the warrant would be issued and JT would be moved. By 4pm I had escorts at the gate waiting as they had been told to attend the unit and be on standby to move the young person as soon as the warrant was received; and assurances that up until 5pm he could still go. The YOT manager phoned to see if the warrant had arrived and informed me that the Ministry of Justice closed at 4.30pm therefore he was contacting the Prison Service to see if they had received the warrant. I subsequently received a fax at 5.15pm authorising transfer and the young man left our building.

I now understand that the rush to move him related to the Sec 47 Warrant – he had to be moved whilst still considered to be 'in custody'. Had it not arrived on the Thursday evening I have been told that JT could then have refused to go as he would be considered 'released'.

Whilst I do not have the medical knowledge to contest the psychiatrists recommendations I will be writing a letter of complaint about the process that has been followed in relation to this discharge. (The therapeutic practitioners employed by GMap are of the opinion that although JT presents some risk his behaviour could have been managed in the therapeutic provision of Glebe House.) From telephone conversation during the last 2 weeks I know the responsibility for making decisions and communication is being disputed by psychiatrists and the YOT team – with each blaming the other for mis-communicating information.

I am saddened that in spite of commitments and protocols in place to encourage a multi agency approach this situation was able to occur.



Lansdowne Unit

1. CF admitted 14.4.06 discharged 6.10.06 Legal status Section 38(i) Interim Care Order.

Throughout his stay with us the young man was adamant that he needed a place that was easy for contact with his mother. He was of Black Caribbean ethnicity and was happy to be flexible but the placement should meet his ethnic needs. His mother lived in Kilburn London and the placement found for him with just a week to go was Spalding Lincolnshire with no black workers or children and a predominantly white locality. CF contacted the office for Children's Rights and pressure was put on the Local Authority to seek an alternative. My staff were left with the intolerable task of keeping up this young man's spirits until at 10.00am on 6th October he had to be persuaded to go to Spalding. He stuck it out for a couple of weeks but had to be moved and eventually ended up in a specialist foster placement near his mum. Surprise, surprise he is now out of trouble, doing well at school and having good regular contact with his mother.

2. JK admitted 7.09.07 discharged 1.11.07 Legal status Section 31 Full Care Order.

JK had been lost into the travelling community where she had been exploited. She bounced back to health both emotionally and physically whilst with us. Her mother now lived in Spain and had Doctor's letters to confirm that she was clean from drugs and was working in Spain. She wanted JK with her as she herself had escaped that particular part of the family and community that dragged her into drugs and 'slavery'. The Local Authority would not even contemplate considering Spain as an option. Instead JK was placed in a Foster Placement which soon broke down and J has disappeared again. My staff had a distressing phone call from her which was garbled and confused but she asked for help. The call could not be traced and we have heard nothing since. The Local Authority say that they know she is safe.



St. Catherines

Case Study 1

Young Person	CK
Legal Status	Section 20
Length of Stay	3 months

C had successful placement-had engaged well but St. Catherine's recommendation was that she transfer to Laboure house on permissive order with a view to facilitating transitional work to new placement. Local Authority however was keen to move C on as quickly as possible. A couple of Open placements had been identified as possible

options-the one chosen was based on cost. A member of staff from St. Catherine's accompanied C to the placement for her first visit on Boxing day 2007. The staff member had some serious concerns regarding the peer group already resident at the establishment-3 teenage boys (bearing in mind the reasons why C had been put in Secure-sexual exploitation). Other concerns regarding levels of supervision were raised. All such issues were discussed with Local Authority. However, C was transferred on the 8th Jan 2008, having had no further visits.

C absconded after 1 night in placement and was missing for over a week before being re-admitted into Secure Accommodation.

Case Study 2

Young Person	MN
Legal Status	Section 31
Length of Stay	6 weeks

M found it easy to cooperate with the boundaries set within Secure-however there were still concerns re her ability to keep herself safe when in any form of Open provision. Therefore it was essential to identify her next placement very early on in order to prepare her to move on successfully. This was stressed to the Local Authority. However, the Local Authority did not identify anywhere-this was not helped by the fact that M did not have consistent Social Worker input-there was a mixture of short-term and Agency personnel used by her Local Authority. Concerns re lack of a contingency plan were raised at M's Secure Accommodation Review. The Independent Panel determined that M still fit criteria, however this was overturned in Court. M was taken by escorts from the Court. St. Catherine's have still not been informed of her forwarding address, despite our enquiries. M is currently missing from care.

Case Study 3

Young Person	DM
Legal Status	Section 31
Length of stay	4.5 months

D had been in Secure on previous occasions and it had been identified that D found it extremely difficult to cope within any kind of supported Open provision. The Local Authority had requested that D move to St. Catherine's Open provision but we felt that we would not be able to keep her safe and suggested a longer transition in order to phase D' s move to an appropriate future placement. The Local Authority did not identify a placement and St. Catherine's were put in a situation where we had to transfer D into our Open setting because the Local Authority & Secure Panel refused to consider our recommendations re longer transition. An alternative placement had not been identified. D had nowhere to go and so St. Catherine's felt morally obliged to offer a place in Orrell House-open provision. The advantage of this was that we

could quickly identify and alert the Local Authority that D was placing herself and others at significant risk-to the point which necessitated a re-admission into Secure. D is still resident within St. Catherine's secure provision, with a view to being referred to St. Andrews.



Lincolnshire Secure Unit

Example 1

Risk Assessment

C is a 16 year old female, who has had a very turbulent life, this is her second time at xx Unit.

C received a Six month D.T.O for breach her offences where violence against a person C has a history of violence.

C has a history of substance misuse she has tried a wide range of substances.

C has a history of self harm she has taken several overdoses and this has put a strain on her liver and other major organs.

C has been placed under section 2 of the Mental Health Act.

Assessed to have a borderline personality disorder.

Significant Life Events

C has had a very turbulent life she has had lots of placements through social services all of which have broke down

Family Circumstances

C has been accommodated as her behaviour was out of control. Her family left to live in Spain which left C feeling abounded family have returned her relationship with mother did improve and she returned to live at home unfortunately this again broke down and C ended up in bed and breakfast accommodation and this also failed. At present C has contact with her father and this is appears to be the focus for release.

Protective Factors

C does engage in Education

Asset state she has a positive relationship with one family member.

C recognises she needs a stable place to live on release to enable her to have a more positive future.

Risk of Self Harm

C has taken several overdoses in the past with large amounts of alcohol this has put a strain on her liver and major organs.

C has cut her arms she was transferred from Medway as her self harm had increased with other young people who were also self harming. C has secreted razor

blades whilst in police custody and cut her arms badly, she also secreted a cord and staff had concerns she would ligature. C was placed on a section 2 but discharged within a week as the psychiatrist assessed her to have a borderline personality disorder.

Assets states that C displays erratic and impulsive behaviour. C appears to be unable to control her emotions and displays violent behaviour.

Assessed with a borderline personality disorder.

C has a history of drug abuse with a wide range of substances.

Commentary

This young person was clearly telling us that she felt unsafe to be released from custody. The LA decided to discharge her to bed and breakfast. Our Psychologist felt this was a very unsafe plan. Using the Howard League after trying in many other ways, her view was represented in court. The court found against the Local Authority and ordered them to place her in secure accommodation.

She was placed in secure accommodation for approx 6 months and then transferred to an open unit. This lasted three months breaking down because of assaults, self harm and suicidal behaviour. A plan was formed to put her in B&B.

A psychiatric assessment was ordered by court but the hospital identified refused admission.

She was again admitted to a secure unit following deterioration in behaviour including hospital admission for alcohol poisoning. Following a further incident she was sectioned and admitted to a different psychiatric hospital. She is now on a S3 Mental health act and finally receiving therapeutic help.

The Howard League are now claiming costs from the Local Authority as they believe it would be unjust to accept Legal aid for this when the LA could have easily avoided this by planning correctly.

Example Two

We had a young girl on a 12 month DTO. KG. She was admitted from an STC because her behaviour was such they could not manage her, she was ligaturing and getting restrained about seven times a day. She had a history of sexual abuse including gang rape. Her LA failed to put a proper plan in place and even on the discharge day did not have a placement. At one point they were looking at care afloat, a narrow barge but we said given that she had previously gone into the sea to try and drown herself this may be too risky.

The final plan was that she would go to crisis care and go camping the next day. This was something she did not want to do. As this girl was driven away from the home, the Howard League informed us that the placement was not confirmed. She did jump in a river at this placement but it seems to have been fairly successful.

This letter was sent to a social worker:

CS has been serving a Detention and Training order (10 months) at Secure Unit, and due to her good behaviour earned early release, this is being put in jeopardy due to having no address at present, for her release date.

C is clearly stating that she does not want to return to the Manchester area, or live with her mum at present. Cs wishes are to return to her previous children's home in Liverpool, whose care staff has supported C by visit's and phone calls throughout her time at xx secure unit. C states the home is willing to have her back and that she is already on role in a local school in the area.

In order for C to be released early, paperwork has to be sent to the youth justice board in London no later than Friday 17.02.06, in order for a tagging system to be installed and her licence conditions to be recorded and signed by all relevant agencies.

No placement was found for this girl and we had to hold her beyond her early release date even though her behaviour was first class, only after intervention by the Howard League was the situation resolved.

Update on KS – further problems in the community involving underage sex, absconding, being drunk and offences of assault. Now back in secure at another unit.



Sutton Place Safe Centre

AC – aged 16, served the custodial part of a DTO in an STC. When breached, placed in Secure Accommodation to complete her sentence. Thus, there was no licence and no support offered to her on release. AC had nowhere to live. Her only appointment on release was with the homelessness team in her area.

SC – A Looked After Child serving a short DTO in Secure Accommodation, had an extremely supportive YOT team who knew him well and were aware of his needs., including substance misuse worker. A very robust and supportive plan put in place for him in his home town in South Yorkshire, Local Authority placed him in Southport.

DK – An immigrant from the Congo. Had been Looked After in one London Borough but placed in another prior to custody. Extremely difficult to plan successfully, as the two Authorities had conflicting opinions as to whose responsibility she was. Howard League to the rescue!



Aldine House

J from Norfolk DTO - prior to admission was on the child protection register and had an allocated s/w, as soon as he was placed with us the s/w input was withdrawn as they stated he no longer needed one as he was no longer at risk and also took him off the child protection register. This obviously had a big impact on our ability to plan his discharge with the YOT because the nature of his offence meant that he couldn't reside in the family home and they have no input into the issue of accommodation for our young people. The ss dept refused to co-operate with our numerous requests to reallocate him a s/w (yot worker thank god for this young person was fab), I ended up having to release a manager on at least 3 occasions to 'gatecrash'/attend the cp mtgs being held for his siblings in Norfolk to argue our point further, they grudgingly did finally appoint one approx 3-4 wks before he was discharged, this worker had no relationship with J and despite attending AH for our review mtgs never stayed to have a 1:1 visit with J. We had social work attendance at 1 mtg in the 7mths J was with us

J had very acute mental health issues in regards to his ability to accept/talk to new people so the fact he never had a chance to build relations with this s/w had a dramatic affect on how successful the discharge plan was. J spent approx 4 wks in his new placement before ending up at East Moor.

DL welfare young person 16 yrs old due to turn 17 from the time of his admission we kept flagging up the issue that may arise because of his age and tired to have the sw dept set up an interim plan that could run alongside of the secure provision should he no longer wish to co-operate with his secure order - they were unwilling to do this, he rapidly seemingly to their surprise turned 17 and he didn't want to comply with his secure order anymore and the courts would not give him a renewal so on a friday evening we were asked to take him to a B&B for the night and his interim placement could take him sat morn and his permanent placement would be ready for him 3 wks later. I declined to take him to the B&B and asked the yp his preference of staying with us with his door un secured, no set bedtime etc and then a member of staff would take him to his placement the next day spend sometime with him to help him settle in etc - the yp picked this option. Upon taking him to the interim placement the yp and staff member were horrified to see the staff in a locked office whilst the young people at the placement were having a water and flour fight in and around the building, the building was covered in graffiti and when a member of staff did exit the office long enough to say hello they merely directed D and the AH member of staff upstairs to where his new bedroom was going to be, on going upstairs they found 2 young people in a compromising position! The member of staff and D were extremely unhappy with the situation and D asked if could return to Aldine - unfortunately this was not possible as his secure order had ended on fri and we shouldn't have kept him on the fri evening - I agreed that we would release staff each day for the remainder of the weekend to occupy him away from the placement as long as possible until we could hold an emergency mtg at the beginning of the week, unfortunately this never occurred a D got arrested along with 3 other young people on the sunday evening following an incident in a local park.



Orchard Lodge

Case Study 1

A.W. aged 16 years on release.

A.W. was on a 3 year custodial sentence for serious offences under Sec 91 CJA. He stayed at Orchard Lodge for 18 months. When he arrived he had a reading age of 8 years, he was misusing illegal drugs, and abusing alcohol.

He had been estranged from his family, and he was approx. 2 stones under weight. Whilst at Orchard Lodge he received regular care from the staff and was provided with a balanced nutritional diet, he returned to his average weight, he received 25 hours educational / school work each week and finally achieved 4 GCSE's.

His reading age increased by 5 years by using the 'Toe by Toe' reading programme. He underwent a substance misuse programme and did work on preventing further offending behaviour.

Clear positive steps had been taken to go towards a positive future. There had been monthly sentencing planning and review meetings and a clear resettlement plan had been agreed.

However on the day of his release the planned accommodation was not available and A.W. had to wait sat in a local authority office for 4 hours before he was placed in a bed and breakfast hotel several miles from his family, no education had been arranged and he had been removed from the school roll.

Within 4 weeks of living in the B+B a.w. had reoffended, no educational placement, he had joined with others from the B+B in using illegal drugs.

Following sentence he was returned to a YOI.

18 months work by a multidisciplinary team was undone within 4 weeks

Case Study 2

D.W. After 2 years at Orchard Lodge he was released back to his community. At Orchard Lodge he had received 25 hours each week educational timetable, 5 hours homework, and 18 hours each week of enrichment. D.W. returned to 2 hours per week 'Home Tuition'. During the remaining time he wandered the streets and began to associate with other young people who were offending and committing anti social behaviour. D.W. was shortly re arrested for being in breach of his license and was returned to custody.

Case Study 3.

R.P was at Orchard Lodge for 6 months.

A clear resettlement plan was put in place on his first day and clear agreements were brokered between Orchard lodge and his local authority.

The Housing Department attending Sentence Planning and review meetings and accommodation was identified and agreed prior to release. Working in partnership with his local PCT and GP was identified and R.P was registered thereby accessing local health care. Work Experience placements had been agreed, and by using video conferencing Links he had spoken to his new company. Electricians.

R.P was excellent at sports and links had been made to local football clubs and training times and match days were organised.

As RP had no immediate family to assist work had been done to ensure access to benefits, advice and a bank account had been created.

There was been no further offending, the work is going well with R.P. attending every day, and he has managed to get into the 1st team of his football club.

This was a clear case a partnership working in action to achieve positive outcomes.



Kyloe House

Example 1 (latest)

A young person MN (female), Section 25, Welfare. Admitted to Kyloe House on 27 September 2007, was due to leave on Thursday 20 March 2008. On Thursday 13 March 2008 no exit placement had been identified. MN broke down in tears on Thursday 13 March 2008 saying she “thought her Social Worker was going to return her to somewhere in Birmingham”. MN was terrified, as Birmingham was where she felt “others could get her, stab her, seek retaliation etc, because that’s how they acted in that area”. She felt that if she was returned to her local area in Birmingham “they would find her”. Both the Residential Child Care Officer and myself who were in the room when MN broke down went off to explore what was going on.

After various phone calls a placement was found for MN. Why could it not have been done much earlier? Any young person about to leave secure in a few days who still did not know where they were going is not maximising their chances of success.

Example 2 (previous)

A young person NY (male), 18 month DTO, through Kyloe House began a part-time work experience at a local agricultural college. NY was to continue at this college on a full-time course to start two days after leaving Kyloe House. NY left us on the Friday and was to start college on the Monday. On the Thursday NY did not know where he was to be living. He was placed with emergency foster parents he had not met and spent the weekend with them. We received a report from a member of staff that “during the weekend NY spent long periods of time cycling around the community on his own”. On the first day of his agricultural college course the foster parents dropped him off at the college. The college has no contact numbers for the

foster parents and were unaware of how NY had spent the weekend. NY also did not have with him the necessary protective work boots for his agricultural course; he was confronted about this by college staff and reacted in a hostile manner. NY left the college area for a short while and college staff had no contact numbers. NY was excluded from his course and despite many meetings could not be re-instated until representations were made from NY's authority and ourselves. Unfortunately by the time the college agreed to take NY back he had been moved back to his local area and was committing offences again. NY was "locked up" again.



Information from VOICE Exit Interviews

VOICE have carried out exit interviews with young people at Sutton Place, Gladstone House and Clayfields. The 2007/08 figures also include Aldine House.

2002/04 (N=88)

- a. Young people who didn't know where they were going = 12%
- b. Young people who needed more information about where they were going = 18%

2005 (N=51)

- a. = 4%
- b. = 8%

2006 (N=53)

- a. = 9%
- b. = 8%

2007 (N=72)

- a. = 8%
- b. = 18%

2008 (N=79)

- a. = 4%
- b. = 8%



Vinney Green

1. T.C, 4 month DTO. T.C, family and social services were happy for him to return home. On his day of release he had an argument with parents and they threw him out. T.C spent a night on the streets. Social worker managed to talk the parents around the following day and within half an hour they had thrown him out again. YOT managed to get T.C a bed at the YMCA and meanwhile phoned social services. Social services said they didn't have any

responsibility for him now and wouldn't help. YOT phoned the Howard League and they put pressure on social services, as T.C was now classed as homeless, to find him accommodation and they found him a foster care placement. T.C settled in really well and it has been successful. YOT discovered that social services had kept some vital information from them and they can now understand why T.C is so mixed up as there are a lot of 'issues' around the family and past disclosures.

2. Z.C, 12 month DTO. Full care order and all his siblings are on the child protection register under neglect. Arrived at Vinney Green July 07. Transfer from Oakhill. I contacted social worker manager to make a complaint about Z.C social worker as we had held since his arrival at the unit, 3 reviews and there had been no representative from social services. This lack of commitment had not gone unnoticed by the other professionals that were involved with Z.C. Z.C finally got a visit on 25th September, following my official complaint and the social worker asked Z.C why he was here and took notes! He also told Z.C that he would be returning to a school once released, it was then that I joined the meeting and informed the social worker that he wouldn't be returning to that particular school as he had been there before and didn't like it. I also informed him that I myself had spoken to the education liaison officer and she told me they wouldn't have him back anyway. Therefore an application had been made for him to attend a pre-16 course at a local college. I also explained that I had been working closely with Connexions and they would track progress and if there were no spaces at the local college they would pursue another training provider in his area. The social worker told myself and Z.C that he had been looking for a placement for Z.C and had managed to find one, which was laughable as the place he had 'found' was where Z.C was accommodated prior to custody!!!! Z.C also put in an official complaint to VOICE re: his corporate parent !
3. N.D 4 month DTO. Full care order and on child protection register as result of exposure to violence in the home. Arrived at Vinney Green 13th September and on 5th Oct she hadn't received any visits/communication from social worker. I made an official complaint and copied VOICE who also took it up. Social worker e mailed me 8th Oct to advise the department had been restructured and she was not N.D's social worker anymore and a new one was to be appointed (bearing in mind N.D would be released on 12th Nov and had no idea where she would be accommodated once released). A new social worker came to her exit review on 30th Oct and told the mtg that they wanted her to go to a residential school upon release but the decision would be made by a panel on 8th Nov (4 days before her release). We received a decision on Friday 9th Nov that they wouldn't pay for her to go to this school and on the following Monday she was released, back to the care home where she had offended and absconded from prior to her arrest. On 23rd Nov she was in court re: breach and was sent to Oakhill.

Social services are letting these very vulnerable kids down very badly.



Claire Lodge

- a) Decisions around when young women should leave: We do have input into this though not always without difficulty. There is confusion within many placing authorities regarding the function of criteria reviews and other planning / strategy meetings which are generally chairs by different parts of the same authority. Criteria review chairs are usually more senior than planning meeting chairs though often know the child less well. They seem unable to confine themselves to the criteria and often seek to “re-plan” for the child. This creates a situation where the child at best has a combination of two plans which may be somewhat contradictory and which leaves those engaged in practical work with the child trying to square the proverbial circle - the result being a diversion of energies from the child, and confusion regarding the practical arrangements. Whilst I cannot evidence it, I suspect criteria chairs are much more about making strategic decisions – i.e. managing an authority's risk, finance, etc. which may or may not be in the best interests of the child.
- b) Practical arrangements: Unless being asked to assist with transport the response gained when attempting to discuss transition planning is one of feeling as though we are poking our nose in. I suspect this is because transitions are still seen by many in the field as a low priority, and in reality few transitions are planned to any real level of detail. Some young women do have pre-placement visits (though are not particularly involved in placement choice), and may have a school to go to (but in many cases do not), and are unlikely to have any continuity in terms of primary / mental health care unless being transferred to a specialist facility providing this. It is not only about where young women go, but also how they come to be placed. It is not unusual for some to have had 15 / 20 changes of permanent address in the 2 years leading to placement. In some cases a place at Clare Lodge is booked without the commissioner knowing what exactly we are, or do. Questions such as:- where do the boys live?, do you have an open unit? how many places are contracted to the YJB? are not uncommon demonstrating little research prior to placement. Similarly, rarely are we asked about continuity of services previously made available to the young woman. Overall therefore the information we gain (education and social care) generally has to be sought rather than being offered.

I am sure you have by now a collection of bad practice stories but my favorite concerns the discharge of a young woman from here by escorts who were told to telephone the placing authority when arriving at the motorway so they could be informed whether to turn left or right.

Given the negativity of the above I do need to say that in some cases planning is excellent – this tends to be the authorities that positively and in some cases regularly use us and know what we do, rather than those with a poor view of secure, or who are looking for a short, sharp, shock. I also think we need to take care not to propose another hoop for placing authorities to jump through if they use secure. It would be better that a written transition plan is produced for all moves of children within the residential care system (accepting there would need to be some provision for emergency / crisis placements – i.e. a requirement to produce a plan within 24 hours).



Swanwick Lodge

Case of a 14 years old girl, served the custodial part of her sentence, ending in November last year, discharged to a children's home of which she had little notice. Four weeks later she was arrested for further crime and appeared before the court asking specifically to be admitted to this establishment. Despite knowing her discharge date and her needs the Children's services could not identify a placement until three days before discharge meaning that the young person had no information and didn't know where she was going to school. The suitability of the placement was paramount as this young person was helping give evidence to the police regarding a number of sexual assaults and had close ties with her family.



Aycliffe

Some information regarding the resettlement of T.D., Bradford.

T.D. was remanded to us with a care order, our experience was one of little to no communication between the Y.O.T. Team and Social Service, there was a number of secure reviews and planning reviews there was no resettlement plan in place at any of the meetings. This resulted in T.D. going to Court and receiving a supervision order, she was released to her home address this subsequently broke down after a very short period.



Clayfields

1. Day of discharge, young man went to Tesco's to buy a T.V. with Jenny as he had no idea where he was going. When the S.W. collected him, we enquired as to his release address, S.W. didn't know but explained he would be making some calls on the way back up the motorway ... least the young person had a t.v!!

2. Young man due to leave us on the Monday, from London was informed on the Friday before that he would be living on a barge, I asked young person if he knew what a barge was, he did not.



Beechfield Secure Unit

1. Fifteen year old male with learning difficulties was informed by phone that the placing authority had identified a placement for him. He was then informed that he would be moving to this placement the next day. The young person received no information on this placement. When he asked the Social Worker if he could visit the placement to see if he liked it, he was informed that as the secure order expired the next day, visiting would not be possible.

The young man became highly distressed and withdrawn. Staff became concerned for his welfare as the young man had a history of self harm and began to verbalise that he would run away.

The unit contacted VOICE on his behalf who went on to supply the young man with legal advice and support.

2. Young male met his new Social Worker on the Friday; the Social Worker then rang various placement advertised in Community Care. One of these placements accepted him and he was moved on the Monday, because his order ran out that day.
3. Young female with a placement identified, visits had taken place, young person keen to move on. The day before her secure order ran out and move to new placement, the placement withdrew their offer and refused to accept her. Young female was then placed back at home with abusers.
4. Fifteen year old female with learning difficulties had been informed by the Chair of her review that she would be leaving in two days. The young lady explained that she did not feel safe with the staff at the new placement as she really did not know them as she had only met them twice. The young lady wanted evidence that they would keep her safe, as she was afraid her father would come after her (Child Protection issue). She was also unsure about living with a young male who she had not met on her visits. Her views and wishes were not taken into consideration, which caused the young lady some distress.

Again the unit contacted VOICE on her behalf who then contacted the placing authority.

Other exit plans from secure are:

- Moved into a Y.M.C.A.
- Placed in a Travel Lodge.

- Having built up positive relationships in current secure placement, the placing authorities move young people to secure units closer to their base of operations, often ignoring the wishes of the young people
- Promises made to young people about external counselling e.g. Bereavement, Rape, not taking place as set out at the exit meeting.



NYAS

Have a number of examples of poor leaving care plans including discharge to a bed and breakfast accommodation with limited support and poor exit planning around education.

Roy Walker
Acting Chair SAN
April 2008