Wiltshire Safeguarding Children Board

SERIOUS CASE REVIEW

Re Child G

Overview Report

10th August 2011

Ron Lock

Contents

1. Introduction

1.1 This Serious Case Review (SCR) relates to the circumstances of a teenage girl (who was under 17 yrs at the time, and will be referred to as Child G in this report) who tragically died in late 2010, after she was found hanged at her home. The verdict from the Coroner's Inquest was that Child G took her own life. Child G was the youngest of a large family.

1.2 Child G had never been subject to formal Child Protection procedures, although professionals who worked with her as a young teenager, primarily from her school and from Youth Services, recognised her vulnerabilities and worked to address these. Child G's behaviours caused concerns and at times she had talked of suicide. These overall concerns led to referrals to the Child and Adolescent Mental Health Service (CAMHS), and possible risks of self harm were also discussed with and referred to Children's Social Care, although they did not ultimately become directly involved with Child G or her family. Although there were professional concerns that Child G may be self harming, often because she said this herself, the Coroner's Inquest found that there was no evidence that any physical self harming had in fact taken place.

1.3 Because of the degree of multi agency involvement with Child G, Wiltshire Local Safeguarding Children Board (LSCB) decided to commission a Serious Case Review as it was considered that there were lessons to be learned regarding how the agencies worked together to safeguard and promote her welfare . The purpose of this Serious Case Review as detailed in Paragraph 8.5 of Working Together to Safeguard Children[1] was to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working to better safeguard and promote the welfare of children.

[1] Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children – Dept of Children, Schools and Families – March 2010

2. Terms of Reference

2.1 Time Period

It was decided that the SCR would cover the period of 1st January 2000 to the date of Child G's death, and that this would include a detailed chronology from 1st September 2005 which was the start of Child G's last year in Primary School. At a later SCR Panel meeting it was agreed that agencies conducting Individual Management Reviews (IMRs) would also include any relevant background information prior to 2000 of any involvement with the family that might prove helpful in any later understanding of Child G's home life and care.

2.2 Agencies required to undertake Individual Management Reviews

- NHS Wiltshire (Wiltshire PCT) – Health – GP
- Child G's Secondary School
- Child G's Junior School
- Child G's Infants School
- Wiltshire Police
- Wiltshire Council – Including Children's Social Care and Targeted Services
- Wiltshire Community health Service
- Royal United Hospital, Bath
- Avon and Wiltshire Partnership/Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (re CAMHS)

2.3 Serious Case Review Panel

Julie Downey - Independent Chair

Julie is an independent safeguarding consultant and has no connection or employment relationship with professional agencies within Wiltshire or with the Wiltshire LSCB. She has previous experience of involvement in Serious Case Reviews in the South West Region.

Panel Members:

- Designated Nurse Child Protection, Wiltshire PCT
- Virtual Head Teacher – Looked after Children and Young People Wiltshire Council
- Head of Service (North and East), Children's Social Care, Wiltshire Council
- Consultant Child and Adolescent Psychiatrist and Clinical Director for Specialist CAMHS, Oxfordshire and Buckinghamshire Mental Health Trust

- Head of Public Protection/ Detective chief Inspector – Public Protection, Wiltshire Police
- Consultant Paediatrician, NHS Bath and North East Somerset

Also in attendance at Panel meetings: -

Ron Lock - Independent Overview Report Author
Ron is an independent safeguarding children consultant and has been the chair or author of a number of Serious Case Reviews in the South of England – he has no formal connection or employment relationship with agencies in Wiltshire or with the Wiltshire LSCB.

In support of the work of the Panel: -

LSCB Development Manager, Wiltshire LSCB
LSCB Business Manager
LSCB Administrator

2.4 Specific Terms of Reference

In addition to the questions listed in Paragraph 8.20 of the relevant guidance[2], this SCR will additionally consider: -

- Did organisations make appropriate and timely assessments of parents and child in line with the South West Child Protection Procedures?
- Did the age, wishes and feelings of the Young Person (Child G) influence the actions of professionals and managers with particular regard to following safeguarding concerns and child protection procedures
- At what point were safeguarding concerns about the young person shared with other agencies? What detail was shared and how effective was this contact in obtaining a timely and appropriate level of service and safeguarding for this young person? Are there actions that could have been taken at identified times to prevent her death?
- To establish the history of agency involvement with Child G and/or her parents in order to understand the young person's welfare, daily life experiences including school, the family involvement, their beliefs, parenting capacity and physical and mental health of the mother, the role of the step father and birth father. Are there issues that were identified and if acted upon could have affected the outcome?
- Were diversity and equality issues, particularly regarding the young persons' disability and religious beliefs in the family appropriately addressed and acted upon?

[2] Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children – Dept of Children, Schools and Families – March 2010

- What examples of good safeguarding practice within agencies are evident for this young person?
- Are there local and national lessons to be learnt or recommended actions to prevent and protect young people from taking their own life?

3. The Child's Experience

3.1 Being the youngest daughter of a large family, and being somewhat younger than her siblings, meant that Child G undoubtedly had a very different family experience and upbringing than her siblings.

3.2 Before Child G had moved into her teens, her siblings had left the home and therefore in many aspects she was then an "only child" living with her mother and stepfather (she had never been cared for by her natural father and her step father had been a parent to her since she was an infant). To what extent Child G's unique position in the family made her feel different, either positively or negatively is difficult to judge, and no assessments were ever undertaken which aided any understanding of how she viewed herself at that time. According to her siblings, it was however apparent that Child G had a unique place in the family as the youngest, and Child G developed a set of different relationships with her siblings, confiding different things to them about her life and worries as an adolescent.

3.3 Within Infants School, Child G was described as "a bright little girl who was thoughtful and insightful" and despite not joining the school for the reception year, was very quickly working at a good level. Child G's school attendance for her last year was 84%, and although of a level lower than expected, there was felt to be no need for Education Welfare support. Nevertheless, greater enquiry may have revealed the reasons for her absences. However, there was no evidence within the school that Child G was unhappy or presenting with any difficulties. In general she seemed to have managed her early school life reasonably well.

3.4 From a health perspective, Child G had no serious illnesses, and although there were some later references to her having different long term conditions, these do not appear to have been formally diagnosed as such.

3.5 At Junior School, once again the school were not aware of any welfare concerns or of any illness that gave rise to concerns about Child G. For her last year at this school, Child G's attendance was 93%, which in fact reflected a general good school attendance throughout. During this last year she was described by her head teacher as "one of the leading lights, organising events and playing a very active part in school life" and generally that she was a "very well-liked and able girl". From these presentations it therefore appeared that Child G had positive school experiences.

3.6 Within her secondary school, Child G was again viewed as a bright and able student academically, and there were no recorded welfare or behavioural concerns during her first two years at the school. Throughout her time there, Child G appeared to have a number of friends and she certainly did not present as isolated, and had an active peer group. However it was from late in 2008 that difficulties began to emerge in terms of behavioural difficulties, and the following year there were concerns about her substance misuse, whether she might be self-harming, and hearing voices. Some threats to kill herself ultimately followed in 2010, and there was clear evidence that Child G was very vulnerable at this time

3.7 Child G had strong views about not wishing to involve her parents (mother and stepfather) in trying to resolve these problems, and she relied heavily on the pastoral team at her school to provide her with practical and emotional support. It was apparent that Child G was strong willed and was very clear in her assertions to different professionals who she came into contact with, regarding issues of confidentiality and with whom they were allowed to share information. Whilst at one time she very much wanted professional support and requested referrals to Substance Misuse services and to the CAMHS, a pattern developed of her changing her mind and becoming difficult to engage in services. Child G also made it clear to her siblings that if she told them anything of her problems or activities, such as substance misuse or the existence of a boyfriend that they were not to tell her parents. They seemed to have kept this commitment. With her boyfriend and a sister Child G also made brief contact with her natural father on her own initiative although her mother and stepfather became aware of that she had made such contact only after her death.

3.8 The lack of family involvement with professionals at times of crises in Child G's life was striking, and in many respects she successfully kept professionals at bay from involving her family.

3.9 In many respects it appeared that as a teenager, Child G was managing her own life and dealing with much of this emotional trauma on her own. Within this however, she had made clear plans for her future career, and plans were reasonably well advanced for her to have a specific work placement to help progress this, and yet it was not long after this that Child G died.

4. The Serious Case Review Process

Contributions to the Serious Case Review from Family Members

4.1 Child G's parents (mother and stepfather) were initially visited by the LSCB Development Manager and the Police Family Liaison Officer in order to explain about the SCR, and they were given written information regarding the SCR process.

4.2 The Overview Report author had telephone conversations with Child G's mother and visited both parents in order to seek their contribution to the SCR. The parents were very forthcoming and keen to participate in the SCR, and their views have been identified and incorporated within the factual and analysis parts of this report. They were informed of the range of agencies who were involved with Child G, and although they did not know detail of these interventions at the time

they were occurring, they were made aware within these conversations that Child G had not wished them to be informed or involved at the time.

4.3 In respect of information from other family members, the Coroner's office gave permission for statements by family members to be viewed.

4.4 In summary, these statements gave each sibling's view about Child G and of her life and care within the family, from their individual perspectives.

4.5 The Individual Management Reviews

4.5.1 **NHS Wiltshire (Wiltshire PCT) – Health – GP**

- The IMR regarding the services of the GP surgery provides useful information and analysis into the role of the surgery with Child G and her family. As a result, the author has recognised some implications for service provision although the resulting recommendations primarily relate to training initiatives.

- Following comment and questions by the SCR Panel, two further drafts of the IMR were completed. Much of the additional information provided was generated as the result of interviews with the main GP who was involved. Whilst this was helpful, the IMR appropriately identified that "relevant information was held by personal knowledge which was not recorded in the medical records".

4.5.2 **The Secondary School**

- This was an informative and detailed IMR which provided helpful analysis of the services provided by the school, and of the challenges and frustrations that the school staff faced in trying to support and advice Child G, particularly those from the Pastoral Support team.

4.5.3 **The Junior School**

- This IMR provided brief information in respect of Child G's presentation at primary school and that as far as they were concerned, no issues or concerns of note were raised by Child G's attendance there. There was no evidence to suggest that areas of concern were missed.

4.5.4 **The Infants School**

- Similar to the Junior School, this IMR provided basic background information about Child G's time at the school, and they considered that no concerns were raised or needed addressing by the school in respect of Child G.

4.5.5 **Wiltshire Police**

- This IMR provided some useful contextual information in respect of Child G's family

4.5.6 **Wiltshire Council - Children's Social Care and Targeted Services**

- This IMR integrated the work of Substance Misuse Team, the Youth Inclusion Project, and there was also minor involvement of Connexions and "Healthy Minds" with Child G. All of these services came under the umbrella of Targeted Services and of the Youth Offending Team (YOT). Although originally separate IMRs were produced for Targeted Services and for Children's Social Care, these were eventually incorporated into a combined IMR under the over arching organisational structure of Wiltshire Council.

- Whilst one benefit of an amalgamated IMR was to provide greater critical analysis of the internal working arrangements, in essence this was not particularly well accomplished, as the two services from Targeted Services and those of Children's Social Care, appeared to operate separately.

- Whilst the report identifies that well intentioned work by Targeted Services was undertaken, in effect they felt that they had been left to deal with a level of risk in respect of Child G which required greater specialism. The IMR identifies the contradictory advice sometimes given by Children's Social Care and of the working relationship with Targeted Services being strained at times, with lack of clarity about referral and threshold processes. There is a comprehensive set of recommendations to address some of the shortfalls in practice recognised.

4.5.7 **Wiltshire Community Health Service**

- There was minimal involvement from this service, and in effect reflected a brief period of intervention by the School Nurse, whom it was considered acted professionally and responsibly in carrying out her duties in respect of Child G.

4.5.8 **Royal United Hospital, Bath**

- There was very limited involvement from the hospital with Child G that warranted detailed analysis

4.5.9 **Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (OBMH)**

- The Child and Adolescent Mental Health Service (CAMHS) was initially provided by the Avon and Wiltshire Partnership (AWP) until 1st April 2010 when OBMH took over. OBMH undertook the Individual Management Review (IMR) that collated the information from its own and AWP provision of the CAMHS service. This gives some useful detail and analysis about CAMHS involvement and provides context about the change of organisational management arrangements at the time of referrals in 2010. Successive drafts of the IMR produced considerable new information at late stages in the SCR process. Although some good pieces of practice were identified, the IMR did not offer explanations about the lack of adherence to the policy regarding failed appointments and incomplete assessments of Child G. However these were addressed within the recommendations.

4.5.10 **Health Overview Report**

- The Health Overview Report usefully brought together the involvement of the GP surgery, CAMHS services and the school nurse. As a result of the overall analysis, this report has made recommendations for the GP service and for CAMHS to act upon, in order to improve their response to vulnerable young people, particularly those who may not reach the threshold for child protection.

4.6 Family Trees.

A number of the above IMRs did not include family trees as part of their contribution to this SCR. In many respects this was because the individual agencies considered that they had insufficient information about the extended family in order to complete a meaningful family Tree or one that they were confident was accurate. To a large extent this reflected Child G's success at requesting professionals to not involve her family, but it would have been a potentially useful exercise for each agency to have drawn up a family tree from their own knowledge, in that this may have reflected inaccuracies or assumptions that were perhaps unhelpfully informing interventions.

4.7 Consideration of concurrent Legal Proceedings

There were no criminal or care proceedings being initiated at the time of this SCR being undertaken. A Coroner's Inquest took place, following the completion of this Overview Report. Liaison with the Coroner was maintained during the SCR process.

4.8 The Serious Case Review process

- The SCR Panel was made up of senior professionals who were relevant to the circumstances of the case, in that there was representation of the main agencies who contributed to the process by the submission of IMRs. Each member of the Panel was independent of the services which were provided to the family and had no direct involvement in any of the operational practice in this case. Targeted Services representation was provided initially for the Panel, but once that member left the organisation, it proved difficult to get the necessary level of independence.

- Whilst the Overview Author was not a formal member of the Panel, he attended each meeting in order to be able to assist the process when required, and to gain the Panel's contribution to the analysis component of the SCR.

- To varying degrees, The majority of the IMR reports required some development and revision, and further versions were produced in response to particular questions and issues being raised by the Panel for the respective authors to consider.

4.9 Publication Arrangements

The publication of the Overview report and Executive Summary on the WSCB website has been substantially delayed for a variety of reasons. Initially, the publication date had to await the outcome of the Coroner's Inquest. Advice was then taken and careful consideration given to the

impact publication of the report may have had on other vulnerable young people. Further liaison with the family has also taken place.

The FACTS

For the period 2000 – September 2010

5.1 In **September 2000,** Child G commenced Infants school – she was just over 5 years old at the time.

5.2 She commenced her Juniorschool in **September 2002**, and at about this time, an Initial Assessment was conducted in relation to Child G's older siblings, and following this a referral was made for the family to receive family support services, although there was no record whether this was taken up or not.

5.3 In **September '06** Child G commenced at her secondary school.

5.4 It was during **September and October '08** that Child G was "on report" at school on three occasions, generally in relation to lateness to lessons and for inappropriate make-up/jewellery.

5.5 In **February 2009** an Assistant Pastoral Support Manager (PS1) met with Child G and was concerned about her behaviour, which in her view was indicative of substance misuse. Child G had a high shrill voice, was very manic and giggling. The pastoral team manager (PS5) had the same concerns, and as a result, the mother was asked to come to the school to discuss the concerns. Although she was initially reluctant to attend, she did eventually do so due to the staff member's insistence. According to the school, a heated meeting followed, with the mother not accepting that Child G may have been using drugs and stating that recent medication prescribed by the GP accounted for the behaviour. It was because of the noise emanating from the meeting that the head teacher joined the meeting. During the meeting Child G was noted as being very distressed.

5.6 In the interview for this SCR, the mother recalled the concerns being expressed by the school in respect of possible drug use by Child G but she reiterated that she believed that her odd behaviours were as a result of recent antibiotic medication, and that the school's concerns were misplaced. Moreover, she considered that her daughter had been mistakenly identified by school staff as presenting with the concerning behaviours.

5.7 **A few days after this incident**, further concerns arose in respect of Child G's behaviour who on this occasion was described by PS1 as being "wobbly on her feet with a glazed expression and her mood varying from laughing loudly and hysterically to gazing vacantly or talking randomly to staff". Once again the mother was contacted when she was told that there was concern for Child G and asked if she could go home and be supervised by someone there. The mother stated that she was working in the north and so could not help but that Child G should go straight home. A member of staff spoke with the mother who again was angry at being contacted and claimed that the behaviour was due to Child G's reaction to medication. Child G then left to go home. Once again the mother's recollection of this incident reflected that of the school's, namely that the demands of her job made it too difficult to respond in the way that the school had requested on

this occasion. The mother also retained the view that the school were incorrect to consider that her daughter was using drugs at that time.

5.8 In **early Summer 2009** PS1 completed a referral form for the local Young People's Substance Misuse Service (part of Targeted Services), following a disclosure by Child G that she was taking drugs and wanted help with this problem. The referral form was clear that Child G did not want any information shared with her parents.

5.9 Following the referral being made, Child G was seen by a Substance Misuse Treatment Worker (Subs Misuse Wkr 1) at the school when an assessment was commenced in respect of her substance misuse. This assessment was completed and issues of mental health were highlighted, including self harm. The case was transferred to another Tier 3 substance misuse treatment worker (Subs Misuse Wkr2) and Child G agreed to a referral being made the Child and Adolescent Mental Health Service (CAMHS)) and initial contact was made by Subs Misuse Wker2 a few days later with Healthy Minds (A tier 2 Mental Health Service provided by the local authority for non urgent referrals)

5.10 In a one to one session with Child G, Subs Misuse Wker2 noted concerns about poly drug use, that Child G claimed she was self harming by cutting, mental health issues, weight loss and possible child protection issues. Subs Misuse Wkr 2 faxed a referral to CAMHS on the following day repeating the concerns although "suicidal thoughts" were added in this referral, and there was also reference to Child G hearing occasional voices.

5.11 CAMHS wrote to Subs Misuse Wker2 to offer an appointment for Child G to take place in about three weeks time in early **August 2009.** This appointment went ahead and Child G attended with Subs Misuse Wkr 2 to meet with a specialist Occupational Therapist from CAMHS. Within the session, it was said that Child G talked openly about her situation and of her worry about feelings of overwhelming anger and control and episodes of "flipping out". She talked of being unable to trust anyone and that she bottled up her feelings. In respect of the counselling service advised by the GP, Child G said that her mother had seen reference to this on the GP's computer screen when she attended an appointment with her mother, and that this had caused a lot of difficulties at home. Although Child G was informed in the session that her information would be confidential and that her parents would not be told, she remained worried about this. She also spoke of having difficulties in socialising.

5.12 In respect of her drug misuse, Child G disclosed current use of cannabis and cocaine and that she was fearful of not being able to manage without the use of cannabis. She spoke of hearing voices telling her to cut herself (although there was no evidence that she ever did self harm). She said that she heard these voices when she was sad, angry or stressed and especially when she was alone.

5.13 The outcome from the CAMHS appointment was that a follow up appointment would be offered, and that letters would be sent to Child G via Subs Misuse Wker2. The GP surgery was informed of CAMHS involvement by letter which included that Child G did not want any involvement from her

family and would disengage with the service if her parents heard about this through the GP. It was also reported in the letter that correspondence was not to go to Child G's home address.

5.14 Child G failed to attend for her follow up appointment at CAMHS - Child G did not meet up with Subs Misuse Wker2 to get a lift to the appointment. The worker then discussed the situation with her manager the same day and with the CAMHS Registrar and Care Coordinator, in terms of any immediate concerns for Child G. Subs Misuse Wker2 telephoned the duty officer for Children's Social Care and according to the worker's records, "discussed the pros and cons of intervention". The duty officer was to speak with her manager and call back which she did on the next day and then told Subs Misuse Wker2 to discuss the situation directly with the Children's Social Care manager.

5.15 In **late Summer 2009,** Child G contacted her Subs Misuse Wker2 via text to apologise for missing her calls but that she wished to discontinue contact with Substance Misuse team. However, a week later Subs Misuse Wker2 set up a meeting with Child G at the school and also spoke with the Children's Social Care Team Manager (SW Team Mgr2) identifying that concerns for Child G had been heightened because she was not engaging in services. The team manager apparently advised that telephone call referrals will not be logged and that referrals would need to be made formally with Child G informed. Subs Misuse Wker2 followed this up with an e-mail to the team manager reiterating her concerns that Child G was at heightened risk. (There is no record of this communication contained in the relevant IMR for Children's Social Care).

5.16 Subs Misuse Wker2 wrote to the GP surgery to explain that Child G had withdrawn from the Substance Misuse service and from CAMHS, and that she was now trying to involve the school nurse. The letter offered for the GP to discuss Child G's circumstances over the phone if she wished although this did not happen.

5.17 Subs Misuse Wker2 then met with Child G a few days later at the school when, although she remained of the view that she did not want to continue to be involved with the Substance Misuse team, she nevertheless agreed to continue to see Subs Misuse Wker2 fortnightly for the next two or three months on an informal basis.

5.18 The Subs Misuse Wker2 spoke to the CAMHS Specialist Occupational Therapist over the telephone and told her that Child G was not willing to engage. The CAMHS position was that they would close the case in respect of Child G, with a proposal (according to the Substance Misuse Team) that the adult mental health services would be contacted, (although it is not clear why). In **September 2009** Child G again met with Subs Misuse Wkr2 at the school as previously arranged.

5.19 **During October 2009** there were some occasions of Child G's disruptive behaviour in school and being rude to staff, with a note of the concerns being sent home. Also at this time there were periods of unauthorised absences. The response to texts from Subs Misuse Wker2 to Child G was for Child G to enquire why there was concern about her and that she had been sick.

5.20 CAMHS wrote to the GP surgery (copied to the Substance Misuse team) to inform them that as Child G had failed to attend the last appointment offered (early September) that the case file had now been closed. Advice was given to re-refer if further input was required from CAMHS.

5.21 In **November 2009** Child G was interviewed by a Connexions Worker following a referral from PS3 of the school pastoral team who was working with Child G. (Connexions were an integral part of the Targeted Services provision). From this contact Child G expressed a preference for a career path and to develop an employee route through university.

5.22 At the next meeting between Child G and Subs Misuse Wker2 at the school, it was noted that Child G was doing well and was assessed as not to be at risk at home or from herself. The Connexions Worker recorded attending a multi agency meeting on the **in December 2009** when it was decided that a referral to the Young Person's Drug Advisory agency be made. (It is not clear what happened to this referral).

5.23 **During December 2009** Child G had some informal contact with Connexions, and was still keen on her career choice but was concerned that some of the help she had received from Targeted Services and CAMHS might impact upon any application that she made. Subs Misuse Wker2 had looked into this matter for Child G and reassured her that no inappropriate information would be released, but that Child G needed to discuss this with the GP (Dr12) who would fill in the appropriate forms with her.

5.24 In **early 2010,** there was another meeting with Subs Misuse Wker2, when Child G's school attendance was noted as good and that her mood was good. It was suggested that there was one more meeting needed, and this was held shortly afterwards, and although Child G presented as well, she said that she had been self-harming and that her home life was not good. There was concern noted for her mental health. Subs Misuse Wker2 discussed her concerns about Child G with her manager and the advice was to make a referral to Children's Social Care as it was considered that Child G was at considerable risk to herself.

5.25 Subs Misuse Wker2 telephoned Children's Social Care to make a referral, a follow up referral letter was also sent. The referral contained information that Child G was using cannabis and pills to block out low feelings, felt unloved and was hearing a voice telling her to "do bad things". Subs Misuse Wker2 stated that although Child G had talked of having tried to kill herself, she referred to cutting. The referral letter gave a synopsis of the meetings with Child G and also confirmed that Child G was adamant that no one contact her family. The duty officer (Duty SW1) advised that a mental health assessment should be undertaken before deciding on further action and advised that CAMHS be contacted for an emergency assessment. The Team Manager YOT e-mailed SW Team Mgr2 on the next day to advise that they (Targeted Services – Substance Misuse Team) were closing the case and that they will advise Child G that Social Care will provide her with support via an assessment if she wished to have one. Also in **early February 2010** a meeting was held at the school when Child G was told that concerns for her had been discussed with Children's Social Care and with CAMHS but that no action would be taken without her consent. Child G was

also told at this meeting that Substance Misuse team would be closing the case. Child G apparently stormed out of the meeting. (The reason for the case closure was that the substance team manager considered that Child G was a risk to herself and that it would be inappropriate for Subs Misuse Wker2 to work with her on her own).

5.26 CAMHS advice in response to the school pastoral team worker (PS3) was that any referral needed to come via the GP. On the next day Child G was in agreement to a referral being made. It was during **early February 2010** that Child G began to arrive late at school because of oversleeping, and there were some concerns for her behaviour in school. At this time, the school recorded that PS3 had telephoned SW Team Mgr2 who had advised that they were unable to accept a referral unless Child G wanted their involvement. On the following day PS3 spoke with the Team Manager YOT who advised that the school "put a child protection strategy in place" with her manager, and to follow guidelines. The IMR for Children's Social Care identifies that similar advice was also separately given to Subs Misuse Wker2 by a different duty officer in **early February 2010** when the need for further intervention was discussed. By **mid February 2010 the** Substance Misuse team had closed the case.

5.27 A meeting was held at the school with Child G early the next month to review her attendance and behaviour concerns, when it was agreed that she would attend school daily, and she gave permission for the school to make an appointment with her GP in order to request another CAMHS referral. . PS3 contacted the Team manager YOT to enquire if a Common Assessment Framework (CAF) had been completed in respect of Child G - it was confirmed that no CAF had been undertaken. On the same day Child G rang her GP surgery and asked for a referral to be made to CAMHS when she was advised to attend the surgery for a discussion as this was a different GP (Dr7) who had not met Child G before. Child G did not take up this offer.

5.28 Following Child G's attendance at the surgery in the **Spring of 2010,** when she saw another GP (Dr1), a referral was made to CAMHS on behalf of her via a letter. The Dr1's letter described Child G as in quite low mood with some disturbed thought patterns "almost bordering on paranoia" but that she was asking for help. Dr1 acknowledged that she found it difficult to assess her. CAMHS offered an appointment a month later.

5.29 In **early April 2010,** there were further concerns regarding Child G's disruptive behaviours in school, although actions were proposed to give her as much support as possible to control these behaviours, noting that her "home life was very complicated" and that Child G herself acknowledged that her academic work was "slipping away from her".

5.30 Child G had a further consultation with Dr1 at the surgery later that month when Child G was feeling anxious but said she was coping and keen to meet with CAMHS. There was no CAMHS record in relation to Child G's attendance at the planned appointment **at the end of April 2010 -** it is understood that this appointment was either cancelled or changed.

5.31 In **early May 2010,** Child G went to the pastoral team centre within the school in an extremely distressed state and talking to the pastoral support manager (PS5) about committing suicide. It

was recorded that Child G was shaking, distant and rambling throughout the conversation, and she admitted that she had smoked cannabis during the day but denied any other drug use. Child G talked about her boyfriend being involved with another girl and that she was apparently pregnant. She was very upset by this and said a number of times that "she did not want to be here anymore". Child G talked about herself, reflecting a poor self image and poor body image. Although Child G talked of wanting to join the army, she said that she hoped she would be killed in action. Child G was offered a meeting with the Relate counsellor but she declined these and left. Nothing further transpired in terms of these suggested interventions.

5.32 All pupils at Child G's school were told **during May 2010** of the "death by suicide" of a female year 9 pupil. It was noted that Child G was very upset and displayed this to the head teacher. Two days later Child G again spoke of not "wanting to be here anymore". **Later that month**, Child G again went to the pastoral team in a distressed state, but refused to say what was causing her distress.

5.33 PS3 contacted CAMHS and spoke with the Clinical Psychologist to ask if the appointment could be brought forward because of Child G's level of distress, in particular her expressed "thoughts of ending her life and writing letters to people". The Clinical Psychologist offered advice over the phone about making a safety plan over the weekend with Child G, and offered an early emergency appointment immediately after the weekend. Child G was later reported to be relieved and grateful for the earlier appointment and she explained her plans for the weekend to PS3 and that she would have support from friends.

5.34 Child G attended the CAMHS appointment and talked of her difficult relationship with her mother and having to look after herself, not liking school but recognising that it kept her occupied. She talked about rarely being happy, but that her drug usage had decreased. Whilst she said that talking was not helpful, she was prepared to see a female worker from CAMHS. Child G said she was concerned about any reaction to her problems at home, but this was not explored further. Although it was noted that this session was not a full assessment of depression or of the family difficulties, there was no indication that Child G had suicidal thoughts. The Consultant Psychiatrist (a male) indicated the need for a follow up in order to complete the assessment but that an urgent follow up appointment was not necessary.

5.35 A letter outlining their discussion was sent to Child G at her home address **on** the same day – Child G apparently gave permission for this to be sent to the home address – a copy letter was also sent to the GP (Dr1). A follow up appointment was made with a female worker from CAMHS.

5.36 A Youth Inclusion Engagement Worker with the Youth Inclusion Project (YIP) had previously been made aware of Child G's circumstances and completed an ONSET[3] Assessment with Child G when a high score was recorded indicating a particularly high risk of offending as well as safeguarding

[3] ONSET – an optional referral and screening tool that is used to refer a young person to prevention programme.

issues. According to the respective IMR, the assessment highlighted concerns in respect of emotional and mental health issues, neighbourhood, substance misuse, family, physical health and perception of self". This worker (the YIP Inclusion Worker) then became the case worker for Child G who had voluntarily agreed to have weekly contact. In **early June 2010** this YIP Inclusion Worker checked if Children's Social Care, Healthy Minds and the Youth Service were involved. The latter two were not and Children's Social Care advised the YIP Inclusion Worker to continue to gain Child G's trust and to contact again if the she felt that the young person was at risk of self harm or if further advice was needed. The YIP Engagement Worker also later made contact with the GP surgery for information but was told that the patient's permission would be needed to share information.

5.37 When the YIP Engagement Worker met with Child G, she said that she wished to take her own life and planned to do so. As a result, the YIP Engagement Worker in conjunction with advice from her manager, asked CAMHS if Child G's appointment in August could be brought forward, giving the reason that Child G was talking openly about suicide. The YIP Engagement Worker felt that Child G was at a serious risk who had said that she wanted to join the Army Bomb Squad so as she could blow herself up. Internal communication within the school noted that Child G was at high risk but that CAMHS did not seem to be treating her as such.

5.38 Child G dislocated her finger in **late June 2010** apparently by "messing about" at school, but an ambulance could not be arranged for her to go to hospital. Child G was very distressed and did not want her mother contacted saying that her mother "would either blame her or the school for not doing their job properly". The school arranged for Child G to be escorted to the hospital. On the next day Child G said that she had told her mother of the incident who was angry.

5.39 At her meeting with the YIP Engagement Worker in **mid July 2010,** Child G was said to be particularly buoyant and looking forward to the CAMHS appointment. A few days later a Common Assessment Framework (CAF) was completed at the school although Child G only agreed for the YIP Engagement Worker to have a copy of it. She also did not agree to the CAF being formally registered. Up to the end of term in the **Summer of 2010** there continued to be a consistent number of complaints within the school in respect of Child G's disruptive and rude behaviour within school – on one of these occasions, Child G was later regretful and took the initiative to apologise.

5.40 Child G failed to attend her CAMHS appointment on the **in July 2010** and despite reminder texts from the YIP Engagement Worker to Child G, she failed to turn up for their planned meeting. Where to send a letter from CAMHS to Child G was queried with the YIP Engagement Worker who said that due to the volatile situation at the home, not to write to her there. The YIP Engagement Worker asked CAMHS not to close the case.

5.41 On advice from the Team Manager YOT, the YIP Engagement Worker made a telephone call to Child G's mother on the **in late July 2010** to enquire after Child G, although the mother queried why she was calling, saying that Child G was simply tired. In interview, the mother recalled this

telephone contact and that she had queried why they were ringing but that no mention was made of any concerns about Child G other than there were concerns that she was tired. The YIP Engagement Worker later contacted CAMHS again to say that Child G was fine but tired and that she still wanted a CAMHS appointment and to arrange this via the YIP Engagement Worker. The YIP Engagement Worker expected CAMHS to contact her back a few days later but this did not happen.

5.42 The CAMHS Nurse Therapist wrote to the GP (Dr1) in **early August 2010** stating their inability to engage Child G and that this was hampered by their inability to contact her directly. A suggestion was made that other services for young people may be more appropriate (and gave details of these) or to re-refer if necessary. The CAMHS Nurse Therapist informed the YIP Engagement Worker of the letter that had discharged Child G back to her GP.

5.43 In **mid August 2010** Child G rang the YIP Engagement Worker to say that she wanted to stop working with her, and the YIP Engagement Worker later confirmed this in a letter to Child G and to the school, GP and Connexions.

5.44 During **2010**, it was understood Child G visited her natural father unexpectedly on her own initiative. She had not met him before. The mother and stepfather confirmed in interview that Child G did visit her natural father, accompanied by her boyfriend and a sister, although they were not aware of this until after her death. Mother and step-father recalled that child G was very angry and upset that she had not received a text from who they thought at the time was her boyfriend but they now understood that Child G was upset about not receiving a text from her natural father.

5.45 In interview for this SCR with the mother, she also recalled that Child G had spoken to her at about this time about the voices she was hearing in her head and that it was distressing her. The mother explained that she tried to reassure her about this.

5.46 The YIP Engagement Worker's letter in early **September 2010** to the GP (Dr1) expressed concerns about Child G's mental health and that she had talked of suicide and how she had extreme highs or lows. The letter went on to say "I would like to know that Child G is getting the support she needs to deal with the voices and feelings she has …. As her doctor I was wondering if you were able to keep an eye on her emotional needs as well as her physical" The letter was marked for Dr1's attention, who was due to return from leave a few days later – (unfortunately by this time that Child G had died.)

5.47 Soon after the new school term resumed, Child G was very positive in her conversations in school and was said to be very excited about and looking forward to her work placement with the Army but was worried about the travel arrangements. The teacher commented how nice Child G's hair looked and she replied that she was going to do it ready for the Army placement.

5.48 On the following day, on return of her mother from shopping in the afternoon, Child G was found hanged in the hallway. The emergency services were called and Child G was certified dead at 15.43 hours.

Analysis

6. The Range of Professional Interventions with Child G and her family

Early Interventions

The period 2000 – Summer 2006 (Child G aged 5 – 11 years of age

6.1 Prior to specific concerns being raised in respect of Child G's behaviours in February 2009, there were no focussed professional interventions in respect of concerns for her welfare, apart from the involvement of the GP regarding her health issues. There were also some examples of specialist appointments being missed for Child G in relation to her painful knee – this was what was sometimes later referred to by Child G as her having arthritis. The lack of attendance at appointments could have been followed up by the surgery, but they were not.

6.2 Potentially the school nurse could have been alerted to provide some further support or assessment of Child G's needs at that time, but this was not undertaken. Interestingly, none of the contributions from Child G's infant and primary schools noted any concerns about Child G's health or of any concerns about her care.

6.3 In respect of the two early interventions by Children's Social Care in respect of the older children, the latter one leading to an Initial Assessment being undertaken, children were seen by the Social Worker at the time and described as appearing "happy and well adjusted, bright and articulate" – this included Child G.

6.4 An outcome from the interventions was a referral for family support services although it was unclear if services were ever provided.

6.5 It was apparent therefore that as Child G was of such a different age to the rest of her siblings, her circumstances were not given appropriate attention by professionals involved in these investigations and initial assessments, preferring to focus on the different circumstances that were being presented in respect of the older teenage children. In this way, Child G's unique and potentially isolating position was to some extent reflected by these early periods of professional intervention.

6.6 The Infant School considered that they had no reasons presented to them to intervene in order to address difficulties or to express concern about the care and well-being of Child G, and in fact their observations were generally positive regarding her contributions within the school. In the infant's school, Child G had 84% attendance in her final year, but the school felt that there was no need to bring in Education Welfare support. Whilst greater exploration of the reasons for absences might have provided useful information or identified any possible concerns, it is recognised that the level of school attendance and the pattern of absences did not trigger the need for formal interventions at that time.

6.7 The Primary School had no records of any welfare concerns nor were they aware of any health concerns. They viewed Child G as a having a positive contribution to the school, and at this time, the school appeared to be an important environment for Child G in which she appeared to thrive, despite not having a record of consistently good attendances.

<u>Senior School – From September 2006</u>

6.8 Apparently, here was no need for any focussed additional support or interventions during her first two and a half years in senior school. However by the time that she reached the age of almost 14 years old, the school's pastoral support team appropriately became involved.

6.9 Members of the pastoral support team from then on (February 2009) began to play a very important part in supporting Child G at the time of her presenting challenging behaviours, substance misuse and self harming. The fact that support from Child G's mother and stepfather to resolve these difficulties was viewed as counter productive and then non-existent, presented increased challenges for the pastoral support team. In general however, their interventions were very child focussed, were committed, and they worked hard to provide the necessary level of emotional and practical support to Child G. Despite being difficult to engage at times, it was apparent that Child G viewed their support and advice in a positive light which was no doubt important to her in managing her difficulties. The school made appropriate referrals to relevant teams within Targeted Services and also attempted to gain the involvement of Children's Social Care and to enlist greater urgency regarding CAMHS involvement when situations demanded it. In respect of mental health concerns, the school did not however make any initial referral to "Healthy Minds", which would have been the correct referral route for Tier 2 adolescent mental health services.

6.10 At the first evidence of Child G potentially misusing drugs, the school understandably and appropriately took the route of immediately involving the parents, via contact with the mother. This occurred on the first two occasions when drug misuse was suspected by the school. On both occasions the school considered that they were met with unhelpful responses from the mother which failed to clarify the extent of any drug misuse or what steps needed to be undertaken to address these concerns.

6.11 There was a strong team culture among the pastoral support workers with group supervision provided by the manager alongside regular contact with the Head Teacher. The nurse in the team

received additional clinical supervision from another source. However, apart from the nurses, (PS1 & PS2) none of the pastoral team had professional qualification relevant for the complex work they undertook with Child G. Despite at one point Child G being described as "probably the most needy child within the school", it was surprising that she did not figure as one of the children for discussion within the internal Safeguarding Triangular Meetings which were held in June and July 202010. This was probably because Child G's circumstances had not been recognised as "child protection", which was no doubt a continuing challenge for the pastoral team workers. The pastoral team workers also reported that the sort of child protection training which they had received primarily focussed upon signs and symptoms of abuse and was insufficient to prepare them for the challenging situations presented by Child G.

6.12 Child G warranted much of their time and concerns, but they found that her circumstances were not deemed sufficiently concerning to enlist robust interventions from statutory agencies. In some way this was not helped by the fact that there was no evidence that the Designated Senior Person for Safeguarding within the school had any involvement in the pastoral care and support offered to Child G. A greater connection should have been made in this regard and at least this would have consistently raised the issue about whether Child G's circumstances had reached the threshold of significant harm.

<u>Substance Misuse Services (as part of Targeted Services)</u>

6.13 The first referral made for specialist support services was when the school pastoral team made a referral to the Targeted Support Service in June 2009 following Child G's disclosure that she was taking drugs and wanted help with her problems. The clear request from Child G to not involve or inform her mother was accepted, and this was made clear in the referral to the Substance Misuse team. Because of the previous unhelpful outcomes of involving the mother as perceived by the school, then agreement to this confidential referral by the pastoral support team was understandable and appropriate in these circumstances. It was apparent that Child G was acting responsibly by disclosing her drug misuse and recognising the need for help.

6.14 It was the Tier 3 Subs Misuse Wker2 who then became involved in providing direct support and advice to Child G, and this continued for a period of eight months. Soon after Subs Misuse Wker2's involvement commenced, it was identified that Child G was at risk of harming her self (although the Coroner's Inquest later proved this not to be the case) and that there were mental health concerns. It was therefore appropriate that a referral was quickly made to CAMHS and at Child G's first appointment, Subs Misuse Wker2 attended with her as support. This was good practice. However, once again the referral route through Healthy Minds was omitted.

6.15 Because of the recognition of the level of risk that Child G was at, and without any support or involvement of the family, Subs Misuse Wker2 continued to endeavour to keep the CAMHS service involved, despite Child G failing follow up appointments. Subs Misuse Wker2 also communicated with Children's Social Care for their possible intervention, but this did not materialise. This occurred when Subs Misuse Wker2 was appropriately concerned (in September

202009) that Child G wished to cease involvement with the Substance Misuse service. This was an example of how difficult to engage Child G was at various times, and it became a pattern that once a service or particular worker began to make inroads into supporting and redressing some of the presenting problems, Child G then wanted to withdraw.

6.16 Whilst it was unclear what the regular fortnightly "informal contact" that was then agreed between Subs Misuse Wker2 in fact meant in practice, it was nevertheless an imaginative way of ensuring that Child G remained in contact with the service. It was therefore an important successful strategy to re-engage Child G in the service, despite her wish to withdraw.

6.17 Interventions from the Substance Misuse team formally ceased in February 2010, and this was based on a decision in consultation with the respective manager, that it was inappropriate for Subs Misuse Wker2 to continue to work with Child G who was continuing to present with self harming intentions. It was considered that for Subs Misuse Wker2 to continue to work alone with Child G was not in her best interests. With unsuccessful attempts to engage CAMHS and to make a referral to Children's Social Care, there was a clear sense that Subs Misuse Wker2 had been left with the primary responsibility for dealing with Child G, when it was considered that other agencies had more expertise to do so.

6.18 Whilst the manager confirmed the areas of concern about Child G with her counterpart manager in Children's Social Care, this did not seem to have sufficiently escalated the concerns in order to get a greater commitment from them to providing interventions. To use the initiative of calling a multi agency meeting to try to engender a multidisciplinary approach to helping Child G was attempted, and in fact a meeting was held at the school but there was no representation from CAMHS or Children's Social Care. In respect of the latter they apparently responded to an invitation by saying that they would only attend if they were working with the named child. The Substance Misuse service potentially found itself in a "Catch 22" situation. However it is recognised that Child G's unwillingness to engage and the lack of family involvement challenged the ability to enlist the help of other agencies.

<u>Child and Adolescent Mental Health Service</u>

6.19 The first referral to CAMHS from the Substance Misuse service at the beginning of their involvement, led to an assessment interview which was able to identify a range of needs following detailed information provided by Child G. This appeared to be a useful initial session which clearly needed follow up appointments. Although such an appointment was arranged for three weeks time, Child G failed to attend, and the support of Subs Misuse Wker2 failed to gain her commitment to the appointment. The GP was informed by letter of the failed appointment, and when Child G failed a further appointment in September 2009, CAMHS again wrote to the GP surgery in November 202009 informing them that as far as CAMHS were concerned, the case would be closed. There is reference in the respective IMR that"five potential further appointment dates were offered" before the decision was made to close the case in November

2009. However there was no corroboratory record that these were firm appointments which Child G failed to attend. This should have been clear in the records.

6.20 It was during this time that Subs Misuse Wker2 was trying to retain CAMHS involvement for Child G, but she was unable to persuade CAMHS not to close the case. The policy at that time in respect of service users who fail to engage with CAMHS was that their case must not be closed due to non attendance at appointments and that if the service user asks to be discharged that a "full review of the circumstances and risks" should be undertaken before discharge. Whilst Child G's insistence that she should not be contacted via her home address created difficulties, there was a communication pathway via Subs Misuse Wker2, and so contact with Child G was not an insurmountable issue. There was no evidence provided in the relevant IMR, or supported by information from Subs Misuse Wker2, that CAMHS undertook any assessment of risk in relation to Child G's non attendance.

6.21 In summary therefore, whilst this first period of CAMHS involvement was short lived, a useful first assessment interview was undertaken, but the failure to achieve any outcome via further appointments, meant that this initial intervention was generally ineffective.

6.22 A month after Subs Misuse Wker2 ceased her involvement with Child G, Child G gave permission for the school to make an appointment for her to again become involved with CAMHS, by initially making an appointment with the GP, which was done. The later GP's referral letter to CAMHS on Child G's behalf, described some concerning behaviours and concerns for her mental health. Whilst access to CAMHS for routine work was via Healthy Minds, an urgent referral would require a different route, and as the GP did not identify that the matter was urgent, Healthy Minds should have been used.

6.23 Nevertheless an appointment was offered by CAMHS a month later. This was either cancelled or Child G failed to attend, which meant that once again an early opportunity to engage Child G was lost. Child G was eventually seen by CAMHS almost three months after the most recent level of concerns had arisen. This appointment was in fact offered (and attended by Child G) after the school pastoral support team appropriately sought an urgent appointment be made at a time of crisis when Child G was distressed and talking of suicide, which CAMHS were able to respond to. If there had been a closer timeframe from the first appointment, there may not have been a need for the considerable amount of agency communication that was required to get this emergency appointment set up.

6.24 Unfortunately, the next appointment which was offered two and a half months later was apparently delayed because Child G had wanted to see a female worker from CAMHS, and there was no available routine appointment available. In the circumstances this was concerning and gave little recognition of Child G's more urgent needs at this time. The follow up appointment was apparently to continue with the assessment that had already commenced, but if this was the case, a much earlier session was needed. Leaving such a long gap before seeing Child G again meant that it would have been difficult to simply continue with the assessment process. The

respective IMR was not able to clarify reasons for the delay in the new appointment with a female practitioner being offered, and that the situation needed to be seen with greater urgency in order to bring the appointment forward. However at the time of the referral in late March 2010, there was a major organisational change in service provision being instigated due to the transfer of management of CAMHS. This process lasted from April 2010 for three months, followed by continued operation under a transition period to the new service delivery model which took place with effect from October 2010. Whilst this significant organisational change had the potential to impact on the quality of service provision, this was not in fact seen as adversely affecting the responses to Child G.

6.25 A similar pattern to the earlier CAMHS involvement occurred, when, although two follow up appointments were offered, these were not attended. CAMHS were again encouraged in June 2010 (by the YIP Engagement Worker on this occasion) to bring Child G's appointment forward, because of a presenting crisis time for Child G at that time. Because an urgent appointment could not be provided, telephone support was offered in the interim period of time. However there was no documented plan or any advice or assessment made to support the YIP Engagement Worker in her dealings with Child G at that time. It was not clear from the IMR whether there was a practical inability for CAMHS to provide an urgent appointment or whether they made their own assessment via their contacts with the school and the YIP Engagement Worker that Child G's situation did not require such an intervention.

6.26 When Child G eventually failed to attend later appointments, once again the case was closed by CAMHS (in August 202010). Similarly to the previous occasion when the case was closed due to Child G's failure to engage, there was no evidence that the relevant policy was followed, which by this time was that after two consecutive appointments were failed, that liaison with the GP, Care Coordinator, or Consultant needed to take place to agree further action. There was no evidence that this took place. A recent review of Serious Case Reviews[4] identified that "A number of cases of older adolescents…demonstrated that CAMHS help needs to be more accessible", which goes on to add that "young people may find it difficult to attend appointments without their parent's help and cooperation" - the latter issue was particularly pertinent in this case. The respective CAMHS IMR identifies that a new model is being introduced which includes the need for a Care Programme Approach assessment and that if this process had been in existence at this time, that Child G should not have been discharged from the service. However from this point onwards, Child G had no further involvement with CAMHS.

<u>Youth Intervention Project (YIP) - (as part of Targeted Services)</u>

6.27 Following Subs Misuse Wker2 ceasing contact with Child G in February 202010, a youth inclusion engagement worker from the YIP became involved in May 2010. This YIP Engagement Worker

[4] Understanding Serious Case Reviews and their Impact – A biennial study of Serious Case Reviews 2005-07 – Brandon et al DFS June 2009

came under the same organisational umbrella as Subs Misuse Wker2, in that both services were provided by the Targeted Support Services (managed by the Youth Offending Team – YOT).

6.28 In a number of ways this YIP Engagement Worker had similar experiences to her substance misuse colleague, in that whilst Child G initially engaged with her, and some useful work was undertaken with her, ultimately Child G rejected their involvement. The period of time of the YIP Engagement Worker's involvement (from May - August 2010) was also categorised by attempts to obtain meaningful involvement from either CAMHS (as identified above) or Children's Social Care. Similarly, this worker was unable to secure such involvement, and like her predecessor felt that she held the main responsibility for the case, which was both complex and demanding, and there was clearly frustration that a more joined approach, with relevant specialisms, had not been achievable.

6.29 One difficulty for the YIP Engagement Worker was that there were no case notes available from Subs Misuse Wker2 for her to refer to and so she was presumably unaware of the type of previous interventions undertaken. Also the YIP Engagement Worker was at a Tier 2 level and it was identified in the respective IMR that this worker would not have received the necessary level of training to be able to deal with high risk cases. In fact the YIP Engagement Worker did not consider herself to be sufficiently trained to hold high risk cases. It was therefore inappropriate for this worker to have been allocated this case, or if there was no alternative, then she should have had additional support and supervision to attempt to address some or the shortfalls in training or experience.

6.30 the decision of the YIP engagement worker and the manager to close the case, followed requests from Child G to disengage with the service, even though there were continuing concerns about her suicidal talk, and it occurred at a time when other agencies, notably CAMHS and Children's Social Care, were unable or unwilling to provide any direct input. Whilst the letter from the YIP Engagement Worker to the GP at this time asking for him/her to "keep an eye on Child G's emotional needs as well as physical" was no doubt intended to make sure that another professional was aware of the concerns, this type of vague communication was not very helpful and unlikely to elicit any new or direct response from the GP surgery to proactively seek Child G's engagement.

<u>The GP Surgery</u>

6.31 In fact the IMR in relation to the GP's surgery suggests that it was difficult to know what sort of action would have been an appropriate response to the letter from the YIP Engagement Worker, with the assumption that if the matter was more urgent, then a telephone call would have been made. In fact the opposite could be said, that the more important the issue, the more appropriate it is to put it in writing. In any event the GP who had the most contact with Child G was on leave at the time of the arrival of the letter and did not respond. Nevertheless, if it was considered that the letter gave insufficient details of concerns or about what actions were needed, it was incumbent on the recipient of the letter (i.e. the GP surgery) to request further

detail and clarification. The letter had made reference to Child G talking of committing suicide, so the concerns were clearly of a serious nature.

6.32 In consideration of the GP Surgery's involvement from the outset with Child G as a younger child, she had a high number of contacts and whilst the GP surgery should no doubt have viewed the care of Child G more holistically, but whether these reflected any patterns of concern to have met the threshold for a referral to Children's Social Care, was debateable.

6.33 Child G raised issues of self harm with the GP (Dr 12 – a female GP) for the first time in April 2009. Advice and information was given to her about a self referral to a teenage counselling service and because the GP was confident that Child G would take this up on her own initiative with help from her sister, the GP did not take any action or consider the need for any referral to Children's Services. Whilst this was clearly a professional judgement to make at the time, and even if the threshold for a child protection referral had not been reached, a follow up appointment for Child G with the surgery or a referral letter to the counselling service could have been the additional action that may have led to Child G accepting the necessary help.

6.34 At the same time the GP was a source of support and advice of a personal nature for Child G (who was then almost 14 years old), as was the school nurse.

6.35 Overall the GP surgery did make some appropriate and helpful interventions, and in particular the detailed referral to CAMHS in March 2010 was helpful in achieving an appointment for Child G at CAMHS at that time. For these latter periods of involvement, Child G primarily had contact with two GPs – both females, and presumably this enabled Child G to feel more comfortable in sharing personal information.

<u>Children's Social Care</u>

6.36 Not all of the information about when Children's Social Care were contacted by other agencies for advice or to make a referral, was clear, in that some of the records between the agencies did not always exactly fit. In fact in some instances there were no corroboratory records within Children's Social Care. The occasions when Children's Social Care were contacted regarding concerns for Child G were in August/Sept 2009, in February 2010 and again in June 2010.

6.37 In response to the first of these communications (from Subs Misuse Wker2), concerns were raised in respect of the heightened level of risk of Child G. It was not apparent that a referral was made at this time but that advice and support was being sought regarding how to deal with Child G. There are no corresponding Social Care records referring to this set of communications and ultimately they did not lead to any action or direct response with the family, by Children's Social Care. Interestingly, at the same time, CAMHS had also advised Subs Misuse Wker2 to contact Children's Social Care, although this had already taken place.

6.38 The next occasion when Children's Social Care became alerted to concerns about Child G was when both Subs Misuse Wker2 and the school separately telephoned them because of renewed

concerns about Child G's mental health and her refusal to engage with CAMHS at that time, but that the Substance Misuse team would be closing the case. The responses from Children's Social Care were to some extent confusing and contradictory. The team manager had responded that they were unable to accept a referral unless Child G wanted their involvement. Whilst to some extent this was an understandable position to take, it did not take account of the potential for significant harm, and it appeared as though there was little consideration of why Child G did not want to engage and whether innovative strategies could be used to address this, and thereby engage her. It also appeared that Children's Social Care made the inappropriate assumption that case closure by the Substance Misuse team reflected a low level of concern.

6.39 At about this time, Children's Social Care gave some differing advice to professionals working with Child G ,when there were sufficient concerns for Children's Social Care to have considered innovative and more robust ways to engage Child G, and potentially to have initiated an Initial Assessment.

6.40 There was a further occasion in June 2010 when YIP Engagement Worker apparently made telephone contact with Children's Social Care who advised to continue to gain Child G's trust and to contact again if necessary regarding self harm concerns. There was no corresponding record by Children's Social Care of this communication.

6.41 There appeared to be some confusion by Children's Social Care regarding the role of the Youth Offending Service (YOS) as the overall umbrella body for Targeted Services. In Social Care's recording of contact with Targeted Services staff, they are referred to as the YOS, and there was potentially some confusion that because Child G had not committed any offences that she did not meet the criteria for intervention by the YOS. It was not YOS who were directly providing the services, but if some confusion existed, this may have affected the degree of significance regarding levels of concern that was accorded to the issues being raised.

<u>Summary re Agency Interventions</u>

6.42 In effect the only consistent services and support provided to Child G as a teenager came from the school, and more particularly the pastoral support team. Whilst the focussed work by Subs Misuse Wker2 and by the YIP Engagement Worker also provided important consistent interventions for the time that they were involved, ultimately their involvement ended in the context of Child G's circumstances becoming more concerning and entrenched alongside limited or reducing initiatives being provided from other agencies. Also Child G may potentially have experienced that all of the endings to these professional relationships were negative experiences, having to deal with more difficulties rather than less, by the time that their involvement ceased. This does not mean that the work of Subs Misuse Wker2 and the YIP Engagement Worker was not committed and insightful – in many respects their work and ability to engage Child G was praiseworthy, but as they recognised, their involvement on their own, (alongside the school support) was insufficient to meet Child G's needs.

7. Assessment Practice

7.1 A number of assessments were commenced in respect of Child G although not all of them were completed. To summarise, these assessments were as follows: -

June 2009 – Assessment in respect of substance misuse

August 2009 - Assessment session with CAMHS

March 2010 – Partial assessment by the GP as part of a CAMHS referral

May 2010 – Assessment session with CAMHS

Late May 2010 – ONSET Assessment by Youth Inclusion Engagement Worker

July 2010 – Common Assessment Framework

Substance Misuse Assessment

7.2 To consider the effectiveness and quality of these assessments as they occurred, the first one in relation to Child G was conducted by Subs Misuse Wker2 at the outset of her involvement with her. The assessment was in fact commenced by another Subs Misuse Wker1 before being handed over to the Wker2 who then became regularly involved with Child G. It was normal practice for only one worker to undertake the assessment but for practical staffing reasons it was not possible to do so in this instance. It did not appear to materially effect the quality of the assessment which was completed within three days of the referral (the agency target is to complete assessments within five days).

7.3 Although this assessment identified a range of concerns in respect of poly drug use, self harm and mental health concerns regarding Child G, there was no subsequent treatment plan. Nevertheless, the information which was obtained from the assessment did appear to help to initiate some appropriate substance misuse interventions to try and support Child G's withdrawal from substance misuse. Ultimately however, the assessment did not give any understanding of how Child G was funding her substance misuse and where she obtained her drugs from.

7.4 Ideally a formal treatment plan should have been developed, as to not do so, negated the value of an assessment to inform future interventions. The need to respond to Child G's various crises was given as one of the main reasons given for the number of sessions it took to complete the assessment and for the lack of any treatment plan. Also, Child G's wish to withdraw from the service meant that there were insufficient sessions to complete the treatment plan. Therefore there were some difficult challenges to overcome in making full use of the assessment. As the assessment also identified mental health concerns, it was appropriate that a referral was made for an assessment at CAMHS although despite the references to suicidal thoughts and self harming, there was no comment about any urgency in respect of the referral. Subs Misuse

Wker2 facilitated the eventual appointment approximately a month later and attended the CAMHS session with Child G.

7.5 In the interview with the mother and stepfather for the SCR, their view was that they had no knowledge that their daughter was using drugs and they considered that they would have noticed if she behaved in any unusual way.

7.6 The substance misuse assessment report identified "possible child protection concerns" although there was no detail and no reference to the need for any action. However, three months later, Subs Misuse Wker2 did make contact with Children's Social Care when concerns were heightened and when Child G wanted to withdraw from the Substance Misuse service. However no formal child protection referral was made at this time or as a result of the assessment. This was potentially a missed opportunity.

Assessments by CAMHS

7.7 Child G attended her first CAMHS assessment session following the referral from Subs Misuse Wker2, and a lot of detailed information was collected as part of the assessment in respect of Child G's drug misuse, family relationships, her mental health, (including reference to hearing voices when she was alone) and her current low mood and difficulty in socialising. The documentation in respect of the assessment was clear and showed that the initial assessment had appropriately commenced and was thorough.

7.8 Useful information was therefore obtained from this assessment session, when it was noted that Child G had "talked openly" about her situation, although it was not apparent that there was any constructive challenge to the information she was sharing at this time. Because Child G failed to attend the two follow up appointments that were offered, CAMHS closed the case. In effect these appointments were to continue in order to complete the assessment, so it was not fully completed. Also, because the information derived from the assessment was not included in the letters to the GP because of Child G's concerns about confidentiality, then the outcome of the assessment session was not formally shared with other professionals. In this way this assessment session was unable to inform future interventions with Child G, and was therefore ineffective.

7.9 The second period of CAMHS involvement in terms of an assessment occurred following the referral from the GP. In the referral letter, the GP made observations from her own assessment of Child G including comments that she was "almost bordering on paranoia" but acknowledging that she found it difficult to assess Child G. Child G was offered an initial "First Steps" appointment by CAMHS which was to consider the young person's need for service prior to a full assessment. (This process has now been discontinued and instead a young person is seen by an appropriate clinician when an initial assessment is completed). This appointment was not attended by Child G, and it was not until there were urgent concerns about her levels of risk, that an emergency appointment was offered in late May 2010. This was two months after the original GP referral.

7.10 Child G was apparently unhappy at having this emergency assessment session with a male practitioner (Consultant Psychiatrist) and it was said that she had to be persuaded to continue with the assessment. A self-assessment questionnaire was completed which indicated her emotional difficulties and family life, in which she described a difficult relationship with her mother and that she generally had to look after herself. Child G also described her drug usage as having reduced from the previous autumn, although what this meant in detail was unclear from the assessment. Overall the Consultant Psychiatrist was unable to rate the self-assessment documentation due to lack of information. However there was no indication from the assessment session that Child G had suicidal thoughts. There was no risk assessment identified within the records when this would be expected as normal practice, and the Consultant Psychiatrist could not recall if he completed this. Even though Child G was reluctant to give full information, a partial risk assessment could have provided useful information for the referrer and for follow up appointments.

7.11 Whilst it was relevant that a female practitioner needed to be identified to complete the assessment, the delay in this being actioned, followed up by the apparent inability of CAMHS to provide a more urgent appointment, meant that alongside Child G's reluctance to engage, the assessment remained incomplete and therefore unable to inform future treatment interventions. There was no Care programme Approach (CPA) as a result of the assessment interviews undertaken when this would have been appropriate practice.

7.12 According to the IMR for Targeted Services, their staff held a view that Child G needed to control her drug use before CAMHS would accept a referral and could become involved. The respective CAMHS IMR does not state that this sort of referral criteria existed, but whether it was accurate or not, it appeared to have been a view or assumption held by Targeted Services as a referring agency. Clearly this should have been clarified, as inter agency communication and decisions about referrals were potentially being based upon untrue assumptions.

7.13 Generally however, CAMHS should have been more responsive during the period June – July 2010 to requests from the YIP Engagement Worker in order to provide a more detailed assessment of her needs, and more importantly, any levels of risk. It was not clear why Child G was not seen earlier to reflect the level of concerns, and whilst it would have been expected that the levels of future likelihood of harm would have been discussed within CAMHS at that time in order to inform their decisions, there was nothing recorded of any such discussion. In this respect, the level of frustrations felt by the school and the other professionals from the Targeted Support Services regarding the response by CAMHS was understandable. Once again the lack of use of the Healthy Minds service was an issue here, as a referral route through them may have enabled them to respond directly themselves, or to have referred on to CAMHS with greater clarity of need.

7.14 The IMR for CAMHS identifies that since this time that there have been significant changes in how their services are delivered and of the response to referrals. There is now an outreach service that is specifically targeted at those young people who do not wish to engage with services.

Youth Inclusion Programme Assessment

7.15 This assessment was identified as an ONSET Assessment which is a framework used within YOT services as an optional tool to be used to refer a young person to a prevention programme. This was seen as appropriate because Child G was to be referred to one of the programme activities (such as canoeing, survival courses, etc) and part of the assessment was to gain information to ensure that Child G was safe to go onto such activities. The assessment tool includes the potential to consider a full range of issues from anti social behaviour to substance misuse, mental health issues and relationships with family and friends.

7.16 Although the YIP Engagement Worker was first made aware of Child G's circumstances in mid February 2010, the ONSET assessment was not completed until late May 2010. It appears that the reason for the gap was that part of the assessment was to gain information from other agencies and that the YIP Engagement Worker was waiting for this information to arrive. Due to these delays the YIP Engagement Worker made direct contact with the school to be reassured that Child G would be suitable to attend one of their courses. A similar request was made to the GP and to CAMHS, with the latter being unable to provide relevant information because they lacked up to date knowledge in respect of Child G. Nevertheless, despite the need to collect and collate relevant information, it still appeared to take an excessive amount of time to complete the assessment. The day to day case records were not easily accessible but could have been used to provide material not only for the ONSET assessment but also to inform the interventions by the new YIP Engagement Worker. For the organisation to have a case management system to centralise information in one place in respect of individual service users, was clearly compromised by the continued practice of hand-writing of case records.

7.17 The relevant IMR identified that this particular assessment revealed that Child G had a high score in respect of a risk of offending behaviour and regarding "safeguarding issues". These safeguarding concerns related to the assessment revealing concerns in respect of emotional and mental health issues, substance misuse, family, physical health and perception of self. No doubt as part of the information obtained from the assessment process as well as the ongoing contact with Child G by the YIP Engagement Worker, attempts were appropriately made to gain earlier interventions from CAMHS than had been arranged. The individual plans agreed as a result of the assessment work undertaken, appropriately led to agreed one to one meetings for Child G with the YIP Engagement Worker in the school.

Common Assessment Framework

7.18 There was just one occasion when a Common Assessment Framework (CAF) was commenced in respect of Child G and this was when a member of the school pastoral team initiated this and completed it with Child G in July 2010. The guidance for a professional regarding the need to undertake a CAF is "when you believe that the child or young person has additional needs that are

not being met and you cannot provide the additional help"[5], and so it can be seen how this fitted with Child G's situation. However, there was also clear guidance that the use of a CAF also required full agreement with the parent or young person. The purpose of completing the CAF in respect of Child G was therefore unclear, as she refused to allow the CAF to be shared with other agencies, other than with the YIP Engagement Worker who was already involved in providing services to Child G. Whilst some information was nevertheless gained from this assessment activity and seemed to get Child G to discuss her situation in a little more depth, it probably added little more to what by this time was already known about Child G. However, it was concerning that she reported that she did not see a future with her in it, although the stated goals in the CAF were for her to "develop a more positive image" and to "gain more self control". Without the committed engagement of another agency, it was difficult to see how these aims were going to be achieved. In this way, Child G again went through an assessment activity without there being any definitive outcome. *(See Recommendation 13.8)*

7.19 As part of the school's continuing role with Child G it was not clear whether consideration was formally given to making a referral to Children's Social Care for an assessment to be carried out. In effect the school did accurately assess the risk situations that Child G was in, without this being part of any formal assessment model. However the lack of a formal assessment model may have been one of the factors which led to the school having limited recording of their on going actions, assessments or decision making in relation to the support they provided for Child G.

<u>Knowledge of Family</u>

7.20 More generally in respect of the range of assessments that were undertaken or were commenced in respect of Child G, none of them connected with each other, even when they were undertaken within the same organisation. An additional consistent feature of these assessments was the lack of input by the family and any detailed or reliable knowledge about Child G's family relationships. There was limited probing of Child G about her relationships at home.

7.21 As part of her contribution to this SCR, the mother recalled Child G was upset and complaining to her, just a few weeks before her death, that she was hearing voices and wanted them to stop. The mother said that she told Child G not to be worried and that like her, she probably had the gift of hearing spirit voices, and that she needed to accept this. The mother had not been aware that her daughter had earlier told some of the professionals that she had been hearing voices. Child G had also told one of her sisters that she was hearing voices. It was concerning that no assessment had been made by professionals to understand whether there was any level of psychosis or depression for Child G, or whether substance misuse had generated experiences of hearing voices.

[5] "What to do if children and young people need additional help – A guide for Wiltshire service providers to completing the CAF and acting as Lead Professional" – Wiltshire and Children and Y9oung People's Trust - March `10

Assessment of and response to child protection concerns

7.22 Whilst some of the assessments undertaken, notably those by Subs Misuse Wkr 2 and the YIP Engagement Worker, included reference to child protection or safeguarding concerns, it was not clear what these concerns specifically referred to. In fact child protection concerns were mentioned in the very first referral to CAMHS via Healthy Minds in July 2009. No clarification was sought or given at these times in respect of the actual detail of such concerns, which reflected inadequate professional communication from both agencies. There was only one occasion when a referral was made to Children's Social Care which was in February 2010 with a combination of concerns by Subs Misuse Wker2 and the school.

7.23 This would suggest that overall, the assessment activity had not identified a sufficient level of concerns to warrant formal referrals to Children's Social Care, apart from the one identified above. During the second CAMHS assessment there was potentially a missed opportunity to gain a greater understanding from Child G about her own life. It does however have to be acknowledged that Child G was reluctant to engage with the male Consultant Psychiatrist during this assessment session.

7.24 From a more general perspective of what was collectively known about Child G, the fact that she was misusing a number of drugs and also that she presented with suicidal thoughts, meant that these were in essence child protection concerns. The key issue however was to what degree such concerns were actively viewed in child protection terms by the professionals involved in providing services to Child G. The definitions of child abuse as contained in the South West Child Protection procedures, in line with many other similar procedures, only identify children and young people who are subject to abusive practices by their parents or carers rather than them placing themselves at risk by their own behaviours. This difficulty was possibly further exacerbated by the issue that the behaviour and role of Child G's parents was not directly connected to any assessment of risks to Child G, primarily because they had not been included within any assessment activity. Substance misuse and self harming are therefore not in themselves formally categorised as part of the formal child protection procedures. For example, references to "substance misuse" in the procedures document refer solely to parental substance misuse.

7.25 Recent research[6] in respect of safeguarding young people has identified that there was a fairly common view among professionals that the child protection process was not the best way to respond to young people suffering significant harm. Some of the key reasons for this was that "the process was seen as being aimed at younger children who were being hurt by someone within the family, and perceived as being less relevant in circumstances were young people were "putting themselves at risk"". Additionally it was considered that such young people did not want to be involved and therefore could not be engaged effectively in the child protection system. This potentially very much reflected how Child G was seen, and the inter agency system was unable to

[6] Safeguarding Young People: Responding to young people aged 11-17 who are maltreated. The Children's Society.

break this notion down and consider Child G's situation in a more inventive or resourceful way in terms of its relationship to child protection processes.

7.26 Nevertheless, it could be argued that in taking the traditional perspective of defining child abuse, consideration could have been given to whether Child G as an adolescent was subject to neglect. A recent focussed literature review[7] highlighted "important differences in that neglect might be conceptualised at different stages of childhood" but that because of limited research, "we know relatively little about the distinctive features of adolescent neglect". It may therefore have been particularly challenging to categorise Child G's circumstances as neglect, but at least the issue could have been considered.

7.27 If any of the assessments had been fully completed or included the family, then they may have helped to better understand the reasons of Child G's substance misuse or whether she was self harming. It was significant that the assessments that were undertaken were unable to give any clear view about the amount of drug abuse by Child G or of the extent of any self-harming behaviours. The lack of this level of assessment detail would have made it difficult to understand the strength of her suicide ideation. *(See Recommendation 13.2)*

7.28 There was limited information in respect of any self harming marks being seen on Child G by a professional, although she often spoke of doing so, and later of voices telling her to cut herself. The mother and stepfather stated that they had never seen any such marks. It was not very clear whether the extent of self harming to professionals at that time and of any direct triggers to doing so, was considered as part of any assessment of Child G. **NB - it needs to be noted that the Coroner' Inquest later found that there was no evidence that Child G ever self harmed.**

7.29 As it was the school who were most consistently involved with Child G as a troubled teenager, and worked extensively to support Child G, it needs to be considered whether there were opportunities for child protection referrals to be made. The IMR in respect of Targeted Services identified that one of their managers questioned the school why they were not following their child protection procedures if they had serious concerns about Child G, and that he outlined to one of the pastoral team members of the appropriate steps to make to undertake a child protection referral. There was no reference to this communication within the respective school IMR.

7.30 Despite the school providing some very supportive interventions with Child G in making judgements about her risk taking behaviours, and making relevant referrals as a result, they failed to adequately record the range of work and internal discussions, and referrals that they made. To what extent this impacted on the school to secure relevant referrals and interventions is unclear. A greater level of detail about the concerns that the school had witnessed may have meant that they would have had greater confidence about making a child protection referral.

[7] Neglected Adolescents – Literature Review – Research Brief April 2009 - DCSF

7.31 To what extent a referral was actually made to Children's Services in February 2010 was somewhat confusing and whether it was the school pastoral team or Subs Misuse Wker2. Both certainly had discussions with Children's Social Care but if formal referrals were actually made then it was incumbent upon Children's Social Care to give a more formal response in respect of their decision. Overall this was poor inter agency communication in respect of a crucial issue regarding whether the threshold for a child protection referral had been reached.

7.32 The contradictory and procedurally inaccurate responses which Children's Social Care gave at this time, only served to complicate rather than clarify whether the child protection threshold for intervention had been reached. Child G's situation should have been viewed as a safeguarding concern and in this way her circumstances should have been the subject of a formal assessment by Children's Social Care.

7.33 There nevertheless appeared to be an expectation by Targeted Services that Children's Social Care would undertake either an Initial or Core Assessment. In fact there were several occasions when the threshold for an Initial Assessment had been met, and yet it was not apparent that any detailed consideration of this as an appropriate action was given by Children's Social Care. The reasons for this was probably a mix of Children's Social Care not being clear whether the concerns being presented warranted a Child Protection or Child in Need response, and the fact that Child G was herself not wishing to engage with Children's Social Care.

7.34 The suicide by another child at Child G's school appeared to have had a particularly upsetting impact on her, in that Child G vehemently accused the head teacher of failing to appreciate the extent of her upset. Child G had recently expressed her own suicidal thoughts although it was not apparent that any professional recognised the potential impact that this suicide by one of her peers could have on Child G's own future actions. It could have been identified as an additional risk factor for Child G, and whether the renewed urgency by the pastoral support team a few days later to gain an earlier more urgent CAMHS referral was in part motivated by this factor, is not known. It was not clear whether the factor of the other girl's suicide was mentioned in the communication with CAMHS – it was certainly not recorded as such. "Research has found that suicidal behaviour can be learnt through imitation. This is especially true for children, adolescents and young adults"[8] In the mother's contribution to this SCR, she stated that the other girl's suicide had affected Child G and led her to think about and talk about her own death. However this was something which the mother learned at a later time rather than at the time it took place.

8. Inter Agency Communication regarding Safeguarding Concerns

8.1 Generally there were good levels of communication between the school (pastoral support team) and the services provided by the Targeted Support Services. There was evidence that they undertook a collaborative approach to working to resolve Child G's difficulties.

[8] "Deliberate self harm in Adolescence" – Fox, C and Hawton, K - 2004

8.2 The GP IMR identified that there were no records which specifically related to risk to Child G, but when she was an adolescent, the surgery was not in fact initially aware of the full range of concerns that other professionals possessed. For example, the CAMHS letter to the GP following Child G's failure to attend follow up appointments in August and September 2009, purposely did not contain any clinical information regarding the CAMHS assessment. This was primarily because of Child G's request that her information be kept confidential and that she was anxious because she claimed that the GP's surgery had inadvertently allowed her mother to see her records. The effect however was that important information about her substance misuse and self harming was not known to the GP surgery at this time. However, in Subs Misuse Wker2's letter to the GP at this time, she had offered to discuss the matter over the phone with the GP. In fact neither professional progressed this, which meant that the GP surgery remained unaware of substance misuse problem at that time. When Child G later saw the GP in March 2010 which led to a referral letter being sent to CAMHS expressing concerns that Child G "was bordering on paranoia", there was no reference to whether drug misuse was discussed in the consultation.

8.3 If there had been a multi agency approach to addressing Child G's failure to attend appointments, particularly those for the CAMHS service, then this may have been of assistance. The GP could potentially have had a key role here in that NICE[9] guidelines state that "health care professionals should make contact with young people with depression who do not follow up appointments. As GPs are the hub of information regarding their patients it would seem valid for the GP to take the lead in undertaking the follow up". Although Child G was not known to be suffering from depression, the guidance remains pertinent. A recent report into the future of GP Practices identified the need for clarity regarding the role of GPs in care pathways, and stated "Even where the main elements of care are to be delivered by other staff, there may be important elements of role and responsibility – for example, to ensure communication, co-ordination and competence"[10]

8.4 In August 2010, the GP once again received notification of CAMHS closing the case in respect of Child G because of lack of engagement, and although this was followed a month later by the YIP Engagement Worker's letter explaining Child G's refusal to remain involved with their service, these two pieces of communication did not elicit any response from the GP, either as an initiative towards Child G and her parents to offer an appointment, or to seek further information or collaboration with the other professionals recently involved.

8.5 There appeared to be a level of tension in the working relationship between Targeted Services and Children's Social Care at the time of the referral being made in February 2010. Whilst there was apparent concern that the referral was not being accepted, although respective first line managers did discuss the situation, there was no evidence that this constituted an escalation process in order to get resolution of the issue at a management level.

[9] National Institute for Clinical Excellence - 2005

[10] "Improving the Quality of Care in General Practice" – Sir Ian Kennedy et al, The Kings Fund – 2011

8.6 Whilst this was a recognised procedure to employ in such circumstances (an LSCB Escalation Policy was in existence locally), the resolution of such issues is usually part of everyday inter agency practice, and so to take additional steps to address the different perspectives on Child G's circumstances and risk levels, was possibly not considered as pertinent. However, the levels of frustrations that were being felt by those workers who were trying to engage the more specialist services to help Child G, were very apparent and well founded. It was perhaps significant that one manager in Targeted Service stated that there appeared to be multiple barriers to getting access to services, which prevented the timely delivery of important services to meet the needs of Child G. The YIP Engagement Worker also expressed the view that it was difficult to understand how the case did not meet Children's Social Care thresholds for intervention, particularly when considering the complex needs she was presenting. Similarly the school described its decision-making process when considering child protection referrals that they "were heavily influenced by its history of referrals to Children's Social Care being refused when students were unwilling to engage". Again there was no attempt to challenge this principle via the management route. Therefore, there appeared to be established views of the difficulty of gaining statutory involvement in cases which potentially led to professionals who wanted to refer, accepting a "fait accompli" that it would not be successful if such a referral was made.

8.7 There was a "Threshold Matrix and Assessment of need Categories chart" in existence locally, and this was used as a reference point in discussions between Targeted Services and the School about whether Child G met certain referral criteria. Similarly there was some consideration by Targeted Services of its relevance to Child G's circumstances when considering the need to make a referral to Children's Social Care. The application of thresholds is a complex dynamic within inter agency communications, and whilst an agreed matrix document should make objective decisions easier to reach, this did not appear to be the case in this respect. In fact, it was concerning that Child G was not formally seen as reaching either the Child in Need or Child Protection level. The finding from a recent review of Serious Case Reviews that "The passing around of vulnerable families who are at or just below the threshold of child protection should be avoided"[11] is not only pertinent to "families" but could also be applied to Child G in the way that she appeared to fall through gaps in thresholds and service provision . *(See Recommendation 13.5)*

8.8 Whilst the CAMHS IMR clarifies that the referral route via the Tier 2 provision of Healthy Minds should have been used prior to any referral to CAMHS, ultimately their involvement was very minor overall. In fact CAMHS seemed to accept referrals which were not identified as urgent and other agencies such as the school, the GP and Targeted Services did not seem to understand or use the correct referral routes via Healthy Minds. This lack of clarity and coherence between agencies seemed to impact on the ability of Child G to receive the correct adolescent mental health service at the correct time. *(See Recommendation 13.6)*

[11] "Understanding Serious Case Reviews and their Impact" – A biennial analysis of SCRs 2005-07 – DCSF 2009

8.9 There was no "Team Around the Child" approach to work with Child G, and involvement tended to be on an individual agency basis. In effect there was nothing to prevent such an initiative with those who were working with Child G, even if it would have been difficult to have achieved Children's Social Care and CAMHS attendance. Multi agency meetings could have been called at times when CAMHS were failing to engage Child G as well as other occasions when interventions were not reducing the risk to Child G. The occasion that the YIP Engagement Worker requested the GP to keep a watching brief on Child G's situation in September 2010, would have been an ideal scenario for such a meeting. Unfortunately even if this had been initiated, it would likely not have been called in time to prevent Child G's death just over a week later. *(See Recommendation 13.7)*

9. Addressing the wishes and needs of Child G – Confidentiality Issues

9.1 There was no doubt that in many ways Child G presented as being very difficult to engage in services, and some innovative initiatives were employed by the school and by Targeted Services professionals in endeavouring to gain her commitment to receive help.

9.2 One of the features of Child G's behaviours was to agree at the outset to interventions taking place, only to then withdraw or deny the need for the service once it had been put in place. This was no doubt highly frustrating for the professionals working with Child G. She claimed that her mother had seen records on the GP's computer screen in relation to her request for counselling, and this appeared to be one of her reasons for considering that her information could not be kept confidential. The IMR author for the GP surgery was specifically asked about this issue, although their stance was that this breach of confidentiality did not in fact occur. Whatever the accuracy of what occurred, it was nevertheless an issue for Child G and therefore, at the time it was raised as an issue, the GP should have been told. This would at least have reassured Child G that her concerns were being taken seriously. In fact it was apparent that in a later letter to the GP surgery, this concern about the break in confidentiality was mentioned.

9.3 In order to work successfully with "hard to reach"/"difficult to engage" service users, first of all there is a need to assess the reasons for the individual's unwillingness to engage effectively in interventions. The assessments which were undertaken with Child G never really addressed or understood this issue. Additionally it was important for professionals to respect some of Child G's initial requirements in order to make interventions acceptable to her. These included meeting her within the school boundaries, not informing her parents of the problems she had or the help she was receiving, and agreeing the need for a female CAMHS Worker. Whilst these were agreed to in general by professionals at the outset, unfortunately the latter in respect of the female worker was an example of adhering to Child G's request, but taking so long to arrange it that in effect it downgraded the validity or urgency of her needs being addressed.

9.4 A range of different techniques can be employed to try to engage young people in services which they are reluctant to engage in, but in these circumstances, for much of the time Child G was a "voluntary service user", as she was not receiving services within the mandatory child protection

process. The fact that there was limited multi agency working with those agencies who possessed the greatest degree of organisational authority and expertise such as CAMHS and Children's Social Care, meant that the difficulty of consistently engaging Child G was additionally problematic. Although CAMHS proposed to discuss issues of Child G's stance re confidentiality at a follow up appointment following their first period of involvement in July 2009, she did not attend for these to be discussed with her.

9.5 The difficulties which professionals found themselves in was evidenced by the referral letter to Children's Social Care by the Substance Misuse Team in February 2010, which although seeking their involvement, stated that the she had discussed with her manager about telling Child G that she intended to breach confidentiality in making a referral to Children's Social Care, but had decided against this as being in Child G's best interests. In effect, this made this "referral letter" contradictory. Also at this time the Substance Misuse Team was under the impression that an agreement had been made that Children's Social Care would be seeing Child G without informing the parents. This was not corroborated by the IMR in relation to Children's Social Care, and in fact there was no record that such an action was given any consideration at all.

9.6 Although consistent engagement by Child G was not easily achieved, she had in fact demonstrated that she sometimes wanted and requested services, so at least she was not completely averse to the notion of receiving help. "The practitioner can capitalise on available motivation instead of judging it as inadequate".[12] When Child G wished to cease services, these were sometimes too readily accepted, as evidenced by the CAMHS failure to follow its own policy regarding how to deal with failed appointments. Furthermore Children's Social Care view that they could not become involved because Child G did not want it and would not accept it, was unhelpfully accepted at face value. In reality Child G no doubt had stereotypical views of what involvement with Children's Social Care would mean for her, although no opportunity was created for a social worker to discuss her concerns with her, whether real or imagined. "Practitioners may be (inappropriately) wishing for involuntary clients to quickly and genuinely acknowledge the error of their ways, and espouse rapid, genuine insight into the harm their behaviour has caused to them and others. Rather than label such clients as unmotivated, it may be more useful to view them as not sharing the same motivation as those putting pressure on them"[13].

9.7 One of the GPs when interviewed for the respective IMR, gave an example of using the fact of a minor injury to ask Child G to come in for a review, which was seen as a non threatening way of contacting her and that it would give her the opportunity to talk about family problems without it raising issues of concern for her mother and stepfather. This was an innovative way of trying to engage Child G, although unfortunately it ultimately did not prove successful.

[12] "Contracting strategies for working with involuntary clients", Ronald Rooney in "The Carrot and the Stick – Towards effective practice with involuntary clients in safeguarding children work", Martin Calder, 2006.

[13] "Contracting strategies for working with involuntary clients", Ronald Rooney in "The Carrot and the Stick – Towards effective practice with involuntary clients in safeguarding children work", Martin Calder, 2006.

9.8 Overall, it was certainly the case that in most instances Child G's wishes and feelings were taken into consideration in terms of the way in which she chose to receive services and in deciding which services she was prepared to work with. Whilst in a number of respects this was indicative of good child-centred practice, the degree to which her wishes and feelings were made paramount became questionable as the degree of her risky behaviours began to escalate, rather than decrease. In this sense a different and more innovative professional approach to providing support was needed in getting Child G to accept help and in engaging the family. Once again, the lack of any multi agency component to the interventions meant that it would have been additionally difficult to provide a collaborative and robust challenge to Child G's continuing control of professional involvement.

Family Context

9.9 Clearly a major factor in the work with Child G was her continued and strong stance that in no circumstances should her mother and stepfather be involved in any of the interventions nor informed of the difficulties that were facing her. The concern that Child G would disengage with services if this request for confidentiality was broken, seemed to be an overriding factor in the decisions to accede to Child G's requests. It cannot be underestimated the level of anxiety that Child G expressed at the thought of her parents being provided with information.

9.10 This was a difficult judgement call to make for all the professionals involved, which was no doubt influenced by their wish to provide the most helpful service to Child G, and in the way that she would find most acceptable. In this context Child G's views were given "due weight"[14]. Whilst there was a clear and understandable view that Child G was "Fraser competent", as her difficulties became more worrying, this needed to be balanced against her needs for protection from harm. In fact it appeared to be the case that Child G's angst about her parents finding out about her situation never reduced despite continual assurances from professionals. In this way, this issue was potentially a factor in itself which added to Child G's levels of anxiety, rather than reduced it. No fresh appraisal of the stance of not engaging the family that was being taken was utilised to consider whether this continuing component of the professional relationship with Child G required new challenge. In effect the lack of the ability to engage the parents was a risk factor that should have been separately identified within the assessment activity that was undertaken.

9.11 The stance that was being taken to some extent led to professionals taking a pseudo parental role in respect of Child G. Whilst this was perhaps an inevitable and unintentional outcome, good management and supervisory practice should have helped professionals to consider whether unhealthy and unproductive relationships may have been developing. Although there were generally some appropriate examples of management oversight and involvement in decision making, it was not apparent to what extent the reality and appropriateness of continuing to

[14] Article 12 – The UN Convention on the Rights of the Child – "A child or young person's views must be given 'due weight' depending on his or her age and maturity".

adhere to Child G's unbending request for complete confidentiality was in fact appropriately meeting her needs. *(See Recommendation 13.3)*

9.12 Relevant government guidance on information sharing[15] clarifies that "when there is concern that the child may be suffering or at risk of significant harm, the child's safety and welfare must be the overriding consideration". Whilst the guidance identifies the need to respect the wishes of young people who do not consent to share information, it nevertheless adds that "You may still share information, if in your judgement on the facts of the case, there is sufficient need to override the lack of consent". Whilst the guidance helpfully suggests that practitioners should seek advice if in doubt, it was not apparent that the professionals involved in this case regularly sought advice from colleagues or managers. This issue of course also depended on to what extent professionals considered that the prevailing situation was that Child G's safety and welfare was an overriding concern. The fact that neither Children's Social Care, nor CAMHS considered that Child G had reached the threshold for child protection or for more urgent actions, did not help in this respect. In fact one piece of advice from Children's Social Care that Child G's unwillingness to engage meant that they could not become involved, seemed to support rather than question the stance being taken.

9.13 The strength of Child G's control of professional relationships was graphically evidenced by the fact that she threatened to harm Subs Misuse Wker2 if she told her family of her situation or if she referred her to Children's Social Care. In this way the worker considered that she was perpetuating an unhealthy situation and was providing interventions on Child G's terms only. It was apparent that this issue was not shared with the relevant manager, but it clearly should have been, and should have been recognised as a very worrying aspect of Child G's developing attitude to professional intervention. It was a missed opportunity to not have given this matter determined consideration and challenged Child G in an appropriate manner. In some respect to have allowed this situation to remain, must have given the feeling to Child G that she was in charge of the professional relationship, when no doubt in reality she needed guidance supported by boundary setting and authority.

9.14 In effect when the working relationships became untenable at times when Child G refused help, as happened with all the services apart from within school, rather than these being robustly challenged and new strategies applied, the eventual outcome was to close the case. It is acknowledged that some strategies were in fact employed successfully at certain stages to maintain involvement, as evidenced by the work of Subs Misuse Wker2, but ultimately Child G's request to cease involvement with services was agreed to, even at times of crisis. The voluntary nature of the working arrangements and the lack of involvement of statutory agencies made it difficult to retain effective involvement. It was perhaps significant that despite creating behavioural difficulties within school, she generally maintained her commitment to attending,

[15] Information Sharing: Practitioner's Guide – Integrated working to improve outcomes for children and young people – Every Child Matters – HM Government - 2006

which perhaps reflected that ultimately she could work within clear boundaries which remained constant.

9.15 Whilst the school unsuccessfully tried to elicit appropriate support from Child G's mother in the early stages of concerns about possible drug misuse, the fact that these appeared to create more problems than they solved, clearly remained as evidence to professionals that Child G was correct in her continued assertion that to involve the parents would make matters much worse rather than better. Interestingly, it was quite unexpected when Child G apparently agreed for a letter from CAMHS to be sent to her home address.

9.16 Clearly the issue about Child G's wish not to involve her parents regarding any of the interventions she received, was a significant part of the interview with the mother and stepfather in terms of their contribution to this SCR. The mother's description of the two early occasions when the school contacted her with concerns about potential drug misuse, tended to match those of the school although she maintained that their early concerns about drug misuse were misplaced or that it was a case of mistaken identity. Whilst it would have been very challenging for professionals to have successfully involved the mother in their work with Child G and who may have been hostile to involvement, it still should have been formally considered. As the latest review of Serious Case Review highlights "Patterns of non-cooperation, for example hostility, non-compliance and deception by families were recurring themes……..Hostility is not necessarily unchangeable and can be modified by practitioners' positive engagement and relationship skills"[16]

9.17 The mother and stepfather considered that Child G did not tell them of her problems "because she did not wish to disappoint them" but they considered that professionals should have informed and involved them when the problems were not solved.

9.18 Whilst assessments inevitably lacked the essential component of knowledge and understanding of the family relationships and the context in which Child G lived, as concerns about Child G tended to increase up until the summer holidays of 2010, then there were sufficient concerns for a professional approach to the parents to be explored as an option. The lack of any formal child protection concerns as well as the lack of any coordinated approach to the interventions, appeared to mean that such an intervention was considered as too risky to undertake. However it needed a much more considered discussion, perhaps in the form of a consultation with Children's Social Care or a multi agency meeting, to consider the pros and cons of such an action, and strategies that could be employed to undertake it. The fact that the school would not be able to provide support during the school holidays and that there were no other agencies providing consistent interventions at this time in the summer of 2010, should have triggered the consideration of how or whether the parents should be involved in some way in addressing Child G's needs. If a decision had been made to involve the parents, potentially against Child G's wishes, it would have been important to have had a clearly thought out strategy about the means

[16] Building on the learning from serious case reviews : a two year analysis of child protection database notifications 2007-2009 – Research Brief September 2010 – DFE RB040

by which this could be done and how to manage the outcome. A multi agency meeting may have been the way to have done this. It was concerning that such an initiative was not taken.

Sensitivity to racial, cultural, linguistic and religious identity and issues of disability.

9.19 Again, the lack of contact with the family meant that little was understood about the family's culture, religion and background. In fact it was apparent that none of the agencies involved in providing services to Child G made any record of her or her family's circumstances in terms of any aspect of their background, culture and beliefs.

9.20 Although there was some reference to Child G having some long term conditions, there were no confirmed diagnoses. The Health Overview Report states "none noted" in respect of disability. There was insufficient understanding of to what extent Child G suffered from any form of incapacity or disability, and no professional appeared to clarify with any certainty whether Child G suffered from any medical condition. However from the direct work undertaken with Child G as a teenager, there seemed to be no evidence that she had any special needs in this respect.

10. Case Management Systems and Management Oversight

10.1 There were some issues of poor quality case recording in this case, some examples being the inefficiencies and inaccessibility of Subs Misuse Wker2's hand written notes, and the fact that Children's Social Care appeared not to have recorded many of the telephone calls made to them by other professionals from the school and Targeted Services when seeking advice or help in respect of Child G. Also, greater recording of detail of the knowledge of the family within the GP records would have been helpful, rather than a reliance on GP memory for some of the content of the IMR. The level of recording of actions and decisions within the school did not always reflect the amount of work that was undertaken. Some explanation of this may be the fact that as Child G's circumstances were not seen as reaching the Child Protection threshold, and that she was also not formally viewed as a Child In Need, then recording systems were either not formalised or less priority was given to their completion. Whatever the reason, Child G was nevertheless recognised as a vulnerable young person and therefore accurate records of actions and decisions should have been an important component of the work with Child G.

10.2 Management advice and intervention was not routinely recorded and yet in this case it could be argued that management oversight was particularly important. In respect of CAMHS services, Child G was primarily seen as a routine clinical case, and as such would not lead to senior managers becoming directly involved. However, it was the lack of engagement, and therefore the lack of direct information from Child G, which no doubt meant that there was insufficient information to have moved the circumstances above the level of routine.

10.3 With workers from the school, and from Targeted Services all feeling concerned about their inability to improve Child G's situation, and their accumulating anxiety about retaining her

confidentiality, then these were prime circumstances for management support and direction which should have figured strongly within the management of the case. Whilst it was certainly apparent that line managers did often appropriately become involved, evidence that their additional perspective of escalating issues and challenging decisions by managers in other agencies, was not regularly in evidence. *(See Recommendation 13.4)*

10.4 As frustrations grew for certain professionals in their inability to obtain or retain the services of Children's Social Care or of CAMHS in working with Child G, then it should have been a management initiative to escalate the situation to more senior managers or across to managers of other agencies, rather than to only await such requests from practitioners. In the supervision of the substance misuse and crime prevention manager, the supervisor identified that no escalation issues were raised and was said to be assured that the worker would be retaining a "watching brief" in respect of Child G, and that safeguarding cases were "operating within normal parameters". It is unclear what this actually meant in practice and greater detail of the success or otherwise of the practitioner's interventions with Child G, should have been sought.

10.5 At the time of the second period of CAMHS involvement from the GP's referral in Spring 2010, this was the beginning of a period of major organisational change when the management of CAMHS moved from the AWP to the OBMH. Whilst staff interviewed for the IMR reported that there were capacity issues and that they felt under pressure, there was no objective evidence to support this. There was also no evidence that the organisational change, commencing from the 1st April 2010, created any operational difficulties.

10.6 In respect of Children's Social Care limited involvement with Child G as an adolescent, the team manager identified that there was limited capacity in the social work team and some complex staffing issues. The respective IMR identified that the relevant Children's Social Care team "had a very difficult year" in 2010 when morale was low, capacity was poor and a backlog of work needed to be worked through. This issue was addressed by remedial action in January 2010 and then more formally by the merging of this team with another in July 2010.

10.7 Some of the confused responses by Children's Social Care to referrals and request for advice from Targeted Services and from the school should have had greater management oversight in order to ensure that much more appropriate advice was given at such times. As Targeted Services also included the Youth Offending Service (YOS), there seemed to have been an unfortunate confusion by Children's Social Care staff that as Child G was not subject to statutory YOS intervention, that she did not meet the threshold for their intervention. The referral system between Targeted Services and Children's Social Care appeared to be inadequate, was unclear to the professionals involved, and alongside poor communication, Child G's circumstances were never really fully considered by Children's Social Care.

11. Summary - Prevention and Predictability

11.1 To what extent Child G's death was predictable or preventable is a difficult question to answer.

11.2 The fact that Child G spoke of suicide of course raised high levels of concern in respect of her welfare, although it was not apparent that the collective concerns of the school and the different elements of the Targeted Services were sufficient to elevate the concerns to the level of child protection which would hopefully have led to more purposeful and coordinated interventions to address the potential for significant harm. There was no effective piece of assessment activity that was completed or utilised to help identify the level of risk that Child G was at in terms of her suicidal ideation or whether in reality there were any intentions re self-harming were . *(See Recommendation 13.10)*

11.3 Whilst no professional probably seriously considered that Child G would kill herself, there were nevertheless concerns in respect of possible self harming behaviours or from drug misuse. The SCR has the benefit of hindsight which was obviously not available to professionals who worked with Child G as a very challenging individual. The fact that neither CAMHS nor Children's Social Care considered the risks serious enough to become consistently involved also had the potential to downgrade the concerns, or reassure those who were working with Child G, that the situation had not reached a crisis point.

11.4 Research tells us[17] that depression has been found to be one of the best predictors of adolescent suicidal behaviour and yet Child G was not assessed as being depressed. However, hopelessness, low self esteem, substance misuse, hostility and anger have also been found to be associated with adolescent suicide[18] and to some extent these traits correlated to Child G's presentation at times. However these presentations were not consistent and no formal assessment was undertaken in respect of her suicidal ideation, although the most recent CAMHS involvement with Child G in May 2010 said that there was no indication that Child G had suicidal thoughts. Nevertheless, later requests for more urgent follow up appointments were made because of Child G's increasing comments about wanting to kill her self. *(See Recommendations 13.2, 13.9 and 3.10)*

11.5 In terms of the contributions by the parents and by Child G's siblings (via their statements) to this SCR, none of them felt able to give clear reasons whey they thought Child G would want to take her own life. Whilst some of the siblings viewed Child G as being very troubled, there was no consistent view given about why this was and why she might feel suicidal. The natural father's apparent rejection of Child G as well as relationship problems with her boyfriend, were reasons which were suggested as possibly leading her to feel very desperate. However all of the siblings as well the mother and stepfather were very shocked about the circumstances of Child G's death. Additionally, in respect of her natural father, Child G had not shared her feelings about discovering his identity and then meeting him, with any professional.

11.6 Paradoxically, prior to Child G's death, on her return to school after the holidays, she appeared in a positive mood with apparent excitement about her placement with the Army. In fact this was the most positive that Child G had been for many months, and so in this way her death was even

[17] "A longitudinal study of suicide ideation in young adolescents" – Garrison et al, 1991

[18] "Deliberate self harm in Adolescence" – Fox, C and Hawton, K - 2004

more shocking. Some studies[19] have in fact identified that "most adolescent suicides are unplanned and that only 25% of completed suicides by adolescents show some evidence of planning. Most adolescent suicides are impulsive acts".

11.7 "A supportive school environment appears to offer some protection against suicide as does good access to health care professionals" are identified as protective factors for at–risk adolescents[20], and whilst the school did offer much support to Child G, in essence, whilst being very committed, this was insufficient to address Child G's complex needs. Whilst it could be argued that she had reasonable access to health care professionals, it was Child G's reluctance to work consistently with them, and their inability to be more proactive in sustaining her commitment, which meant that this essential component of relevant services was missing.

12. Lessons Learned

The following issues have been identified as key lessons that have been learned by the evaluation of Child G's circumstances and the evaluation of the professional practice which attempted to address her needs: -

12.1 To continue to respect the rights to confidentiality of a young person when safeguarding concerns are increasing, will likely mean that interventions are becoming increasingly ineffective and that different strategies are needed. It is appropriate for professionals to challenge the appropriateness of adhering to a principle of complete confidentiality when it may not be in the best interests of the young person.

12.2 Whilst adhering to and addressing the wishes and needs of children and young people is an important component of child centred practice, it needs to be acknowledged that young people are unlikely to have all the necessary experience, knowledge and confidence to be the only arbiter of the sorts of services and interventions that are needed.

12.3 To become resigned to difficulties in inter agency relationships that create obstacles to achieving effective multi agency practice, is an aspect of professional dangerousness. For such difficulties to go unchallenged potentially maintains children and young people in at-risk situations. Professional frustrations about poor inter agency relationships need to be channelled upwards via line management.

12.4 An essential role of line managers is for them to escalate matters when the successful management of a case is impeded by an impasse about referral discussions, when there is

[19] Contained within "Deliberate self harm in Adolescence" – Fox, C and Hawton, K - 2004

[20] Understanding Serious Case Reviews and their Impact – A biennial study of Serious Case Reviews 2005-07 – Brandon et al DFS June 2009

evidence of ineffective inter agency working, or when the agency is unable to manage the level of risk being presented by the service user.

12.5 The inability to engage key family members in the delivery of services to an adolescent is potentially a risk factor in its own right.

12.6 The first step to successfully working with adolescents who are difficult to engage, is to gain a clear understanding of the reasons and motivators for the individual's attitude to help.

12.7 An additional risk factor for an adolescent, who is presenting with self harming or suicide ideation, is the suicide or attempted suicide by an adolescent peer.

12.8 For self harming or the expression of suicidal intentions by a young person, not to be seen as a child protection issue, or as part of a Care Programme Approach will likely mean that levels of risk will not be fully assessed or multi agency interventions effectively coordinated.

12.9 For an agency to close a case because they consider themselves unable to manage the level of risk being presented by the service user, without ensuring that an appropriate and more suited agency takes over responsibility, will not address the risk and potentially lead to it increasing.

12.10 Professional communication is a two way process, meaning that there are responsibilities for both the communicator and the recipient of that communication, in making sure that information is properly understood and that follow-up actions are clear.

12.11 The greater the complexity of threshold criteria and of referral processes and pathways to tiered mental health services, then the greater the likelihood that they will be misinterpreted and misused by professionals, leaving children and young people to fall through the gaps that are left.

12.12 The consistent and structured recording of incidents of concern, interventions, communications and decisions, provides the essential framework to aid effective assessments and gives direction to appropriate interventions.

12.13 The innovative use of inter agency meetings or professional network meetings at times of apparent impasse in achieving change with a troubled adolescent, can generate useful new inter agency initiatives to address problems.

12.14 Incomplete assessments will lead to uninformed interventions.

13. Recommendations

13.1 The South West Child Protection Procedures must be reviewed in order to consider the inclusion of the management of serious mental health issues for young people (e.g. threats to self harm or suicide ideation), so as their circumstances can if necessary be considered from a Child Protection perspective. This will mean formal consideration of whether there is the need to make a child protection referral or to invoke child protection procedures.

13.2 A good practice guidance reflecting effective multi agency interventions regarding deliberate self harm, high risk behaviours and suicide ideation in adolescents, should be developed and promoted as part of local LSCB policies, and should also inform the local CAMHS strategy and relevant LSCB training.

13.3 The handling of confidentiality as it applies to vulnerable children and young people, including in what circumstances it is appropriate to challenge a commitment to confidentiality when not to do so may leave a young person at risk of significant harm, needs to be addressed within relevant practice guidance and/or as part of the dissemination process and training initiatives following this SCR.

13.4 To review the LSCB's escalation protocol in the light of the findings of this Serious Case Review, and ensure that following such a review, it is re-launched and put into operational practice by all constituent agencies.

13.5 Threshold criteria for access to CAMHS and/or Children's Social Care services for adolescents who are presenting high risk behaviours must be clarified and disseminated to all LSCB constituent agencies. The LSCB needs to be reassured that operational staff and first line managers of its constituent agencies are able to use the threshold criteria to support effective and appropriate referrals in respect of adolescents who present with complex needs.

13.6 In order to ensure that there is clarity in respect of referral pathways into mental health, there must be a single point of entry in respect of adolescents presenting with high risk behaviours. This should ensure that adolescents are able to get their needs appropriately assessed and gain access to specialist services.

13.7 The LSCB should identify whether there is a need for a specific inter agency forum to be developed that will have the ability to promptly and collectively address the needs of vulnerable young people who are presenting with high risk behaviours.

13.8 When it is identified that a Common Assessment Framework is necessary for the future well being of a child or young person, but that for whatever reason it is unable to be completed and as a result risks will remain unaddressed, then a referral for an Initial Assessment or other form of assessment should be made to the appropriate agency.

13.9 The LSCB Training sub group should consider how the recognition and effective interventions to address highly vulnerable young people who are presenting with risk taking behaviours can be promoted via multi agency training.

13.10 The LSCB recommends that NICE review the evidence to inform the assessment and management of self harming behaviours in adolescents. (National Recommendation)