

**SERIOUS CASE
REVIEW
OVERVIEW REPORT**

S18

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1: INTRODUCTION

This Serious Case Review (SCR) concerns a 15-year-old girl who took her own life in the summer of 2014. To protect her privacy the child is known as Mary, her boyfriend as Daniel and Mary's mother as Ms Michael.

Mary lived with her mother, step-father and siblings. She had been in a relationship with an older boyfriend and had become pregnant and had a termination when she was 13. In the early stages of the relationship the police investigated allegations of abuse and Children's Services carried out an assessment. The school and the GP monitored Mary's well-being and made several referrals to therapeutic services including the local Child and Adolescent Mental Health Service. (CAMHS)

At the inquest into Mary's death the Coroner stated that, "[Mary] was a deeply troubled girl but I find that she chose to end her life on this occasion".

1.1 CONDUCTING A SERIOUS CASE REVIEW

When abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

The Dorset Safeguarding Children Board (DSCB) under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, decided the criteria for a SCR was met. The recommendation was confirmed by the Chair of the DSCB and notification of the decision was made to the Department for Education. Hampshire Safeguarding Children Board was informed and arrangements were made to facilitate collaboration.

(See Appendix 1 for details.)

The purpose of the Review was:

- *To explore and understand the circumstances for this child during the review period;*
- *To explore the support services provided and interventions made;*
- *To understand who did what and why and the organisational context and pressures during the period of the review.*

From Family S18, Terms of Reference

1.2 METHOD

The Review Group agreed the review period would be from June 2012, Mary's pregnancy, to September 2014, the date of her death.

The Review must be conducted in line with Government guidance, Working Together to Safeguard Children 2015. In view of the move towards using systemic models and practitioner involvement

to promote learning, the Board decided to use a review model known as a Partnership Learning Review.

The principles of the model echo those prescribed in Working Together, that Reviews should be:

“proportionate, that professionals involved in the case should be engaged in the learning and that the family have every opportunity to contribute to the Review.”

Key aspects of the Partnership Learning Review model are:

- Appointment of a suitably qualified and experienced Independent Reviewer to review practice, facilitate meetings and to write the report;
- Preparation of a detailed chronology and analysis of practice by managers independent of the case but with knowledge of the local context;
- Involvement of family members to contribute their views about the service they received;
- “Learning Events” for chronology authors and all those involved with the case to discuss their role in the system, their actions and what they were thinking at the time; what worked well, the practice challenges and what can be learnt from this case;
- Oversight of the process by a Review Group chaired by the Safeguarding Manager and comprising multi-agency partners, none of whom had involvement with the case including representatives from the neighbouring Hampshire LSCB.

The agencies involved in the Review are listed in Appendix 2.

1.3 FAMILY INVOLVEMENT

Mary’s family were invited to contribute to the Review and met with the Independent Reviewer. Their views are reflected throughout the report.

1.4 INVOLVEMENT OF OTHER RELEVANT PEOPLE

The Review Group, with the Independent Reviewer, gave consideration to inviting Mary’s boy-friend, Daniel, to participate in the Review and took the decision not to interview him. The reasons were that his health and personal circumstances indicated he was very vulnerable and also he was involved in an ongoing criminal investigation. He was kept fully informed of the process.

Some of Mary’s friends expressed a wish to share their views and were interviewed by the Independent Reviewer. Their views are reflected in the report.

1.5 FINDINGS

Information was collated from the written reports, discussion with practitioners and the Review Group, relevant documents, research and findings from other SCRs. The report includes a detailed description of key practice events, what happened and why, followed by an analysis of any learning.

The findings are presented as Themes, these are:

- Investigation, Assessment and Safeguarding;

- Therapeutic Interventions;
- Teenage Suicide and Risk Assessment.

Footnotes are included to explain the terminology.

1.6 CROSS-BOUNDARY ISSUES

Mary's family live on the boundary of two counties: Dorset and Hampshire.

Agencies involved with the family were:

- Dorset Children's Services, Social Work;
- Hampshire Children's Services, Education;
- Sussex Partnership NHS Foundation Trust – CAMHS;
- Hampshire Police;
- Dorset Police;
- Hampshire Clinical Commissioning Group – GP;
- Southern Health NHS Foundation Trust, School Nurse;
- British Pregnancy Advisory Service – Hampshire;
- No Limits (Youth Mentoring and Support Service).

This report was shared with both LSCBs.

2: KEY EVENTS

2.1 2012

- Mary lived with her mother, step-father, older sister and younger brother. In the spring of 2012 Mary met Daniel. She was 13 and he was 17; the age gap was almost five years. They began a sexual relationship and within a few weeks Mary became pregnant.
- Concerns about the relationship were reported to the police by Ms Michael and Mary's school. The police investigated the situation, interviewed Daniel, and in consultation with Children's Services, arranged an ABE interview¹ for Mary.
- Mary insisted she had been a willing participant in the sexual relationship and did not want to make a complaint. Daniel was given a caution by the police and Children's Services completed a Core Assessment.²
- Ms Michael allegedly told Children's Services that she intended to ensure the relationship between Mary and Daniel ended. On this basis, Children's Services saw no role and closed the case. Mary was referred by her GP to the British Pregnancy Advisory Service (BPAS) and had the pregnancy terminated.
- Towards the end of the year, the school became increasingly concerned about Mary's school attendance, weight loss and apparent isolation from her peers. They made a referral to CAMHS.³
- The GP, at the request of Mary's mother, also made a referral to CAMHS noting Mary's low mood and self-harming behaviour.
- At the end of the year Mary was still seeing Daniel. Mary was by then nearly 14 years old and Daniel 18½.
- Mary and her mother were seen twice by CAMHS, at the end of the year and then again in early 2013. Following an assessment, Mary said she did not want counselling or any other service but CAMHS asked the GP to monitor her weight and agreed to keep the case under review.

2.2 2013

- In early 2013 Daniel was involved in a domestic incident with his mother and step-father which

1. *ABE interview: An Achieving Best Evidence (ABE) Interview is a specially-arranged interview based on guidelines from the Ministry of Justice designed to ensure that vulnerable witnesses, including children, are given the best chance to give effective evidence in criminal proceedings. Definitions and guidance can be found in: Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures, Ministry of Justice, March 2011.*

<http://www.justice.gov.uk/downloads/victims-and-witnesses/vulnerable-witnesses/achieving-best-evidence-criminal-proceedings.pdf>.

2. *Core Assessment: This was an assessment model commonly used by Children's Social Care when working with families to collect and analyse information about the family's needs and parenting capacity. A "single assessment" model based on the guidance in Working Together to Safeguard Children 2013, was introduced in Dorset in April 2013. The procedure allows for a proportional response to a referral which is based on the circumstances of the individual child and family. The assessment must be completed within 45 working days and a clearly-recorded decision made at the conclusion of the assessment.*

3. *CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. The response to a referral depends on the level of need.*

resulted in his being remanded in custody for a few weeks. A DASH risk assessment⁴ concluded his mother was at “high risk”. Daniel expressed suicidal thoughts to the police. He was convicted of affray and possession of a knife/bladed article and given a suspended custodial sentence and probation supervision. A MARAC⁵ referral was made but due to an administrative oversight the case was never discussed.

- A few months after this incident Ms Michael reported to CAMHS that Daniel had moved away and Mary appeared to be better. CAMHS closed the case on the basis Mary could be re-referred if necessary.
- For the rest of 2013 there is very little information in the chronology, no concerns expressed and no key events noted.

2.3 2014

- At the beginning of the year, Mary’s school was again becoming concerned about her emotional well-being and made a referral to a local Youth Support/Mentoring service. Mary engaged well and appeared to benefit from the work.
- Mary was still seeing Daniel who had moved back to the area.
- In the spring, a second referral was made to CAMHS by the school. They had noted “serious concerns” including Mary’s low weight. CAMHS tried to contact the family but had no response so assumed they didn’t want their service and closed the case, in line with their policy regarding engagement.
- Ms Michael said she never heard from CAMHS and did not receive a letter. About six weeks after the referral she contacted CAMHS to ask what was happening.
- In the summer, a further referral was made to CAMHS by the school nurse, and also by Mary’s GP, and Mary’s name was placed on the waiting list.
- Ms Michael was worried about Mary self-harming and had removed sharp objects from the family home. Mary had been seeing the youth support worker but there had been a staff change and Mary was finding it hard to engage with the new person.
- A few weeks later, on her return to school for the autumn term, Mary spoke to school staff about her feelings and said she was ready “to talk to someone”. The school contacted CAMHS who noted that Mary was having “suicidal ideas” and they assessed the referral as a high priority.
- The day the referral was made was a Friday. A CAMHS worker tried, without success, to contact the school for further information. The following Monday they tried to contact Mary but, sadly, she had taken her own life over the weekend.

4. The introduction of the new Domestic Abuse, Stalking and Harassment and Honour-Based Violence (DASH 2009) Risk Identification, Assessment and Management Model means that all police services and a large number of partner agencies across the UK use a common checklist for identifying and assessing risk.

5. A Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

3: MARY'S EXPERIENCE

It was especially valuable that Mary's family, her friends and those professionals who had met and spent time with her were able to provide insight into her interests, personality and character, as well as what she enjoyed and what was important to her. They were also able to report some of what she had to say about her life and relationships during the period leading up to her death.

Mary was aged 13 when she became pregnant and a few weeks short of her 16th birthday when she took her own life. In many ways, descriptions of Mary indicate she was a teenager who displayed the emotional ups and downs typical of that age group.

She was, by all accounts, a young woman who wanted to be different. She was bright and doing well at school and immediately before her death had expressed an interest in becoming a school prefect. She showed both a feisty and determined side to her character and was described as stubborn and with strong views which she freely shared. She also, at times, presented a very vulnerable, sad and confused picture.

Mary witnessed conflict in her parents' relationship and her birth father had spent several years in custody. It appears likely her early life had an impact upon her relationships: she was described as finding it hard to trust people but, when she did, was a loyal friend.

Her family say they had some happy times together and Mary enjoyed several family holidays. She was close to her brother and a compliant child in many ways, and she spent time at home and contributed to family life.

Daniel was obviously a big part of Mary's life and those who knew her share the view that she loved him and the relationship was very intense with many ups and downs. She had hoped the relationship would last and they would share a family life together, and she had planned to move in with him as soon as she could.

Towards the end of her life Mary is alleged to have thought that Daniel was seeing someone else. This appears to have caused Mary sadness and anxiety. After her death the coroner said, "It's clear that she had a boyfriend [Daniel], and I find that she was very much in love with him to a degree that only a teenager can be".

4: THEMES FOR LEARNING

4.1: INVESTIGATION, ASSESSMENT AND SAFEGUARDING

4.11 FIRST REFERRAL AND THE CHILD PROTECTION PROCEDURES

When a teacher or member of staff in a school is concerned a child may be at risk they are obliged to follow the local Child Protection Procedures and inform Children's Services. Children's Services will then decide what to do next, if appropriate they will inform the police.

In 2012 a referral was made to the police and Children's Services that Mary was having a sexual relationship with an older male and was thought to be pregnant. Initially the information came from the school. However in this case the school did not follow procedures, choosing instead to contact the local neighbourhood police officer by email.

The reasons the school decided to make direct contact with the police were that they thought that a serious crime might have been committed, they had an established relationship with the local police officer and therefore were confident that appropriate action would be taken swiftly. The school were also confident that the police would contact Children's Services.

The police officer did pass the information on to Children's Services and, in this case, failure to follow procedures did not adversely affect the outcome.

The school acted promptly but how they chose to respond raises questions about their training, understanding of the procedures and the risks of unilateral action.

LSCB NOTE

Both LSCBs should satisfy themselves that schools understand the Child Protection Procedures, whether there are any outstanding training needs and that there is an acceptable level of compliance.

4.12 ACHIEVING BEST EVIDENCE (ABE) INTERVIEW

When an allegation is made that a child may be involved in a sexual relationship and a crime may be being committed, the police and Children's Services have a duty to investigate. A planning meeting is held involving both agencies and sometimes other professionals who know the child, this is known as a Section 47 Strategy Meeting.⁶

6. Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of "significant harm" and, where these inquiries indicate the need, to decide what action, if any,

The outcome of the discussion may be a decision to interview the child, and often a police officer and social worker will do this together. The interview is known as an ABE interview (Achieving Best Evidence). The purpose of the interview is to gather information in order to decide whether a crime has been committed and whether there is sufficient evidence for a prosecution. The social worker will also use the information as part of their risk assessment and any subsequent child protection planning.

In this case all the proper procedures were followed and Mary was interviewed by a police officer and a social worker.

Mary reported that she had agreed to the sexual relationship. Daniel's statement indicated that although they had met when Mary was 12, the relationship had not become sexual until Mary was 13 and he was still 17. (A sexual relationship with a child under 13 is subject in law to a more substantial sentence.⁷)

In the absence of support from Mary for a prosecution and after considering other "gravity factors",⁸ for example, the age of the individuals concerned and circumstances of the relationship, the local police decided to issue Daniel with a caution.⁹

The issuing of cautions in circumstances like this was accepted practice at the time and police officers in this case report it continues to be the practice in cases of sexual relationships between children over the age of 13 if the circumstances meet the gravity factors.

4.13 UNDERSTANDING OF THE LAW

The law on sexual offences says that, "A boy or girl under the age of 16 cannot consent in law", although in practice the implications of this for young people and their families can be difficult to understand.

Mary's family expressed confusion about the law, taking the view that sex under the age of 16 is illegal and the police should have taken more robust action. Issuing Daniel with a caution was a legal sanction, although it was difficult for Mary's family and friends to understand its actual effect as both Daniel and Mary indicated to them that they intended to continue with their relationship.

4.14 CHILD SEXUAL EXPLOITATION

Since 2012 there has been a growing awareness, changes in policy and practice and additional resources to manage cases of Child Sexual Exploitation (CSE).

it may need to take to safeguard and promote the child's welfare. A strategy meeting is the first step to decide whether and how an investigation should be conducted.

7. See Sexual Offences Act 2003 S8.

8. The Association of Chief Police Officers (ACPO) produces a matrix of factors to be considered when a charging decision is to be made. Known as "gravity factors", for sexual offences these include the age of the offender and victim, previous history, the seriousness of the offence and public interest.

9. A simple caution is a non-statutory disposal that may be used for offences when specified public interest and eligibility are met. The suspect must have made a clear and reliable admission of the offence and the admission must be supported by some corroborated supporting evidence. The offender signs a declaration which includes the understanding that if more evidence comes to light, further legal action can be taken.

In discussing this case and reflecting on practice, police officers consider that, since these changes, officers are more aware of the risks posed to children by older men, and in particular that whether to take action should not depend solely on whether they have a complaint or the (usually younger) female perceives herself as a victim. There are a number of risk assessment models which ask questions designed to clarify whether a child is being sexually exploited.

One of the risk assessment formats, known as the “boyfriend model”, is specifically designed to consider whether a child who considers herself to be in a loving relationship is being exploited.

In this case it is possible that further investigation might have identified some risk factors. If that had been the case, more thought might have been given to alternative courses of action aimed at disrupting the relationship, for example issuing a Child Abduction Warning Notice, more investigation or referral for longer-term engagement with Mary.¹⁰

On the other hand, whilst developments in CSE practice are to be welcomed, there is a risk that all relationships between troubled young people and especially those where there is a significant age gap, will be seen as falling into this category.

The risk is this: if the aim of intervention is disruption of the relationship, resources might be wrongly targeted and opportunities for more productive interventions overlooked.

It is also important to consider that, if a relationship by definition does not fall into the CSE category, it doesn't mean it is necessarily problem-free. Mary's family and friends, after her death, gave descriptions of the relationship between Mary and Daniel which included strong indicators commonly associated with domestic abuse.

We cannot know whether a more robust approach to disrupting their relationship would have made a difference to the outcome in this case, but we do know that Mary and Daniel continued their relationship until her death.

LEARNING POINT

Not all relationships between young people where there is a significant age gap are CSE. Understanding the young person's views and acknowledging their choices will help with effective assessment, planning and appropriate intervention.

4.15 CORE ASSESSMENT

An ABE interview forms part of a Child Protection Investigation which is followed up with a

10. *Child Abduction Warning Notice: The Child Abduction Warning Notice procedure is for the occasions when police become aware of children spending time with an adult whom they believe could be harmful to the children: for example, when there is previous intelligence that suggests the adult has a sexual interest in children. In essence, the Notices identify the child and confirm that the suspect has no permission to associate with or to contact or communicate with the child and that if the suspect continues to do so, the suspect may be arrested and prosecuted for an offence under s.2 Child Abduction Act 1984 or s.49 Children and Young Persons Act 1989, or for any other criminal offence committed in relation to that child. The procedure is aimed at tackling those incidences where young people under the age of 16 years (or under 18 if in local authority care) place themselves at risk of significant harm due to their associations and the forming of inappropriate relationships, sometimes with individuals who are much older than them.*
http://www.dorset.police.uk/pdf/P05-2012Child_Abduction_Warning_Notice_PolicyV1.pdf.

broader assessment of the family. In 2012 this was known as a Core Assessment. At that time Core Assessments were carried out by social workers, they had to be completed within prescribed timescales and they often included background information about the family and the views of other professionals who knew them.

In this case the assessment was completed promptly and the outcome was based on information from the ABE interview and two further visits to the family home. The report indicates that Mary's school was spoken to.

The outcome of the assessment was that Mary and her family did not require any intervention from Children's Services. The case was closed.

The decision to close the case was based on Mary's regular school attendance, seen as a safety-net and factor in her resilience, Mary's mothers comments that she intended to protect her daughter from Daniel, that Mary had agreed to a termination of her pregnancy and that the family did not require any extra help.

The assessment did not make any reference to the family's previous history which, if it had been explored, would have raised questions including the effect on Mary of her early childhood experiences, her siblings' experiences, family functioning and relationships and, ultimately, whether it was reasonable to expect Mary's mother to manage this complex situation without help.

4.16 DANIEL'S INVOLVEMENT

Daniel was not included in the assessment and it is notable that during the whole period of this review, except for being interviewed in connection with the alleged sexual offence, he was only known to a probation officer who was supervising him following his suspended custodial sentence and a community police officer who had tried to support him and help him find accommodation. This police officer described him as "a vulnerable young man with a complex and difficult family history".

The dilemma for social workers is just how much depth an assessment requires. Practice has evolved so that there is discretion about the range and depth of enquiries and how much time is spent with each child and family, depending on the circumstances. The guidance at the time indicated it should have been "proportionate" and the latest guidance says it should be "needs-led".

Discussion at the Learning Event highlighted the difficulties of deciding when sufficient information had been gathered, analysed and a decision about future action made.

In this case there was significant information available about this family and about Daniel and his history which was not sought out and considered. The reasons for the lack of rigour were:

- The ABE interview had concluded that Mary was content with her relationship with Daniel and did not see it in any way as abusive or exploitative;
- The police had concluded their investigation and, following the caution, were taking no further action. This indicated to Children's Services that the matter was not particularly serious;
- Mary's mother was seen as able to "protect" Mary;
- Daniel was by then over 18, and accessing his records was viewed as complicated;
- Daniel lived in another county (although only a few miles from Mary) and this led to practitioners seeing him as beyond the reach of Children's Services;

- At that time, a Core Assessment was always required after a Section 47 investigation. There was a common view among staff that it was often an unnecessary procedural requirement and therefore not always given the time and effort needed for a comprehensive report.

Insufficient weight was given to Mary's needs and the fact that it is still very rare for a 13-year-old to have a pregnancy termination.¹¹ Also there was an over-optimism about Mary's resilience, along with assumptions made about family relationships and her mother's ability to cope with the stress and difficulty of the situation.

The Core Assessment lacked detail, which if considered at the time, might have led to some ongoing work or a referral on to another agency for added support for the family. The emphasis was on Mary's relationship with Daniel with too little thought given to Mary's relationship with her family.

Mary's mother, looking back to that time, says she felt that both the police and Children's Services "dropped the family" and "abandoned them to get on with sorting out a difficult situation without help".

The decision of the police and Children's Services to close the case at this point had far-reaching effects. Later in Mary's life, when other professionals were concerned for her well-being, they chose not to refer her to Children's Services because the case had not met the threshold for intervention previously and, as far as they could see, nothing had changed for Mary and her family since the first judgements were made. No-one at a later date re-considered whether child protection was an issue or requested a multi agency assessment through the CAF route or Early Help.¹²

LEARNING POINTS

The outcome of the Assessment in this case draws attention to the continued need for clear guidance and good quality supervision to enable social workers to plan and deliver assessments which are both proportionate and robust.

Consideration should be given to the participation in an assessment of all those closely involved with the family including the child's boyfriend/girlfriend.

The number of 13-year-olds seeking a termination is very small – far fewer than many of the practitioners involved in this case thought. This knowledge must prompt staff working with young people and their families to consider the impact of the termination on the young person, their family and other relationships.

All staff should be reminded that a judgement about risk and the need for intervention is only valid at the time it is made. As circumstances change, more information comes to light or concern continues, practitioners may need to consider further action.

11. BPAS statistics: 2012 – 54,090 terminations, 31 children aged 13; 2013 – 57,380 terminations, 26 children aged 13; 2014 – 58,735 terminations, 33 children aged 13.

12. Early Help is a multi-agency response bringing together a range of professionals to provide a coordinated assessment and planned intervention. In some authorities Early Help is accessed through a CAF (Common Assessment Framework), which enables professionals to discuss their concerns with the family and other agencies. Any actions are then coordinated through a Team Around the Child (TAC) meeting. Families engage with the support services voluntarily and, if there are any safeguarding concerns, a referral will be made to Children's Services.

4.17 MULTI-AGENCY RISK ASSESSMENT CONFERENCE – MARAC

In 2013 Daniel was arrested following an incident where he threatened members of his family with a weapon.

Following a domestic incident the police routinely carry out a DASH risk assessment to ascertain the level of risk to the victim. If the risk is assessed as high, the case is referred to a multi-agency group, known as a MARAC, and a meeting held in order to agree a protection plan for the victim.

In this case the DASH assessment concluded Daniel's mother was at high risk and a referral for a MARAC was submitted.

There are several administrative steps to be followed in order to bring a case before the MARAC. In this case there was an error in the procedures which led to the case being closed before the referral to MARAC was completed. No one made a manual check of the administrative system to ensure all actions were completed and as a result, the incident concerning Daniel and his mother was not discussed by the multi-agency group.

Was this a missed opportunity?

The guidance for MARACs indicates their purpose is to:

- *Share information to increase the safety, health and well-being of victims and their children;*
- *Determine whether the perpetrator poses a significant risk to any particular individual or the general community;*
- *Construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;*
- *Reduce repeat victimisation;*
- *Improve agency accountability;*
- *Improve support for staff involved in high risk domestic violence cases.*

Pan Dorset MARACs Operating Protocol February 2015

In discussion with staff at the Learning Event, some staff were unclear about the purpose of the MARAC and took the view that it should only discuss children of the victim of the current incident.

Whilst this may be the general understanding, guidance indicates this is not correct and the MARAC also has to consider whether the perpetrator poses a risk to other individuals.

In this case Daniel was still in a relationship with a, by then, 14-year-old who had been pregnant with his baby. It is reasonable to assume that if a MARAC had been convened this would have given the multi-agency group an opportunity to discuss any risk to Daniel's partner and if necessary make a referral to the appropriate agency.

Although there was never any evidence of domestic abuse between Daniel and Mary at the time, this confusion about the role of the MARAC should be addressed.

The police have reviewed the error in their procedures and made the necessary changes to practice.

LEARNING POINT

It is imperative that the MARAC considers whether a perpetrator poses any risk to a particular individual, especially if that individual is a child with whom they are in an intimate relationship.

LSCB NOTE

The LSCBs should consider reviewing the MARAC guidance to ensure it is clear that the risk to any person in a relationship with a perpetrator is considered and what action must be taken if that person is a child. The LSCB will need assurance that all agencies are clear about the links between the MARAC and the Child Protection Procedures.

4.2: THERAPEUTIC INTERVENTIONS AND SUPPORT SERVICES

During the period of this Review concerns about Mary included that she was underweight, had a “low mood”, slept badly and continued to be upset and grieving after the termination of her pregnancy. She talked about problems with relationships both with her peer group and family. She cut herself on at least two occasions and threatened to harm herself on others.

Although there were times when Mary appeared to be happy and the degree of concern varied, there seems to have been a consistent underlying worry about her.

During the period of the Review Mary was:

- Seen nine times by a GP, by six different doctors;
- Seen once by BPAS for the termination of pregnancy;
- Seen twice by CAMHS (and she was on their waiting list when she died);
- Supported by a number of staff at her school;
- Referred to three different support services by her school;
- Seen seven times by a young persons’ advice and support service.

Daniel was seen by the probation service although he never really engaged with them. The local police officer tried to support him and gave him advice about housing.

4.21 GENERAL PRACTITIONER – GP

During the period of this review, Mary was seen nine times and six different doctors were involved in her care; the records indicate she was seen alone three times. The GP contact falls generally into three areas:

- Mary’s pregnancy and termination;
- Concern, expressed largely by Mary’s mother, about Mary’s mental health and asking for a refer-ral to CAMHS;
- Two contacts for general health matters.

When the GP became aware of Mary’s pregnancy, the referral to BPAS was appropriate and timely. It was not usual practice for the GP to follow up a termination unless the patient required contra-ception advice.

Following the termination the surgery was aware that Mary continued to experience “low mood”, reduced appetite and poor sleep. The surgery was kept informed by Mary’s mother, the school nurse and CAMHS.

Following Mary’s initial assessment with CAMHS they asked the GP to monitor her weight. Mary attended the surgery weekly for eight weeks and her weight remained relatively stable. There is no indication that there was a plan about what to do if she lost or failed to gain weight. When Mary stopped attending the surgery to be weighed, there was no follow up by the GP or CAMHS.

As a result of Mary’s death the GPs carried out an internal review. Findings include:

- Following the GP’s second referral to CAMHS in spring 2014, the surgery was not aware until

four months later that she had not been seen. They are looking at ways of introducing a system to follow-up on referrals;

- Many of Mary's attendances at the surgery drew attention to her physical needs. Links could have been made with other available information which may have led to more in-depth exploration of her emotional and mental health and appropriate support being sought.

The practice has implemented some changes since Mary's death including the introduction of a process to identify vulnerable patients, with discussion about adopting a more holistic approach to patient care. Through the process of this SCR, the surgery has also learned about the local Early Help arrangements and is reviewing their safeguarding training needs.

The combined chronology prepared for this review showed that the GPs had significant other information about the family which, if sought or shared, could have influenced the outcome of the core assessment or contributed to a greater understanding of the family.

Although the surgery were willing to work with other agencies and were kept up-to-date, the lack of a formal planning process meant that opportunities for effective information sharing were very limited.

An independent inquiry, commissioned by The King's Fund in 2011, discusses the need for improved links between GPs and other services when patients have complex needs. It identifies the need for clarity regarding the role of GPs in care pathways and states:

“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”¹³

LEARNING POINT

GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.

4.22 BRITISH PREGNANCY ADVISORY SERVICE – BPAS

BPAS is a national organisation and one of the main providers of sexual health services and pregnancy terminations in the UK.

BPAS had one contact with Mary at the beginning of the review period when she was referred by her GP for a termination of pregnancy. Mary was 13 years old.

BPAS have a clear and comprehensive Safeguarding Policy and staff have access to safeguarding advisors if they have any concerns. The policy differentiates what is to be done if a child is 13 years or under, stating that contact must be made with a safeguarding advisor.

¹³ Improving the Quality of Care in General Practice, Report of an Independent Inquiry commissioned by The King's Fund, 2011.

Any child under the age of 17 who attends a clinic is seen by a trained member of staff who carries out a safeguarding risk assessment. (This is also used with some over-17s if there are indications of risk.) The assessment document was updated in April 2014 to comply with the national pro-forma “Spotting the Signs – a national pro-forma identifying the risk of child sexual exploitation in sexual health services”.¹⁴

If any safeguarding concerns are noted, contact is made with the police or children’s services and, if the young person agrees, there may be liaison with any other agencies the young person is working with.

BPAS publishes details of its services on line and in various leaflets. In addition to clinic appointments, advice and terminations, BPAS offers post-termination counselling. This is a free service for women who have had treatment at BPAS.

In this case Mary attended the clinic accompanied by her mother but she chose to see the BPAS worker alone. The risk assessment was carried out and, although the process at that time pre-dates the current risk assessment, it was comprehensive and the discussion did address the nature of Mary’s sexual relationship and seek to identify if there were any elements of coercion or exploitation.

Because Mary was 13, in line with BPAS policy, advice was sought from a safeguarding advisor.

Mary gave a similar story to BPAS to the one she had told the police: that there was no coercion and she had agreed to the sexual relationship. BPAS checked the story by contacting the police. Mary also admitted to BPAS that she was self-harming by cutting herself. BPAS, with Mary’s permission, talked to the school nurse about this to ensure Mary had access to ongoing support.

BPAS had no further contact with Mary or her family.

4.23 ONGOING SUPPORT

Mary was 13 when she had the termination and it is unsurprising that it appears she continued to struggle with her feelings right up to her death.

At no point was it suggested to Mary that she contact BPAS and ask for help from their counselling service and no one contacted them on her behalf. Whether Mary would have engaged with them we cannot know but it is notable that none of the agencies considered referring her to the service which specialised in post-termination counselling when this appears to be one of the key issues causing Mary intermittent distress.

14. “Spotting the Signs – a national pro-forma identifying the risk of child sexual exploitation in sexual health services”, compiled by Dr Karen Rogstad and Georgia Johnston, April 2014. The booklet provides background and context for the development of a national pro-forma to help health professionals working with young people to identify and assess the risk of child sexual exploitation (CSE) as a first step to ensuring they get the support and protection they need to be safe. http://www.brook.org.uk/attachments/Spotting-the-signs-CSE-_a_national_proforma_April_2014_online.pdf.

LEARNING POINT

BPAS provides a free post-termination counselling service for women and girls who have had treatment. BPAS might consider how to ensure this service is well-publicised, particularly for their most vulnerable patients.

BPAS should consider the possibility of pro-active follow up of 13- and 14-year-olds to offer their counselling services.

GPs and other agencies working with girls in similar situations should ensure they have access to information about the range of specialist services available. This would ensure services are well targeted and help reduce the reliance on CAMHS.

4.24 CHILD AND ADOLESCENT MENTAL HEALTH SERVICE – CAMHS

During the 27 months covered by this Review, Mary was seen twice by CAMHS: once in late 2012 and again about a month later. After this initial contact there were two further referrals, one in the spring of 2014 and one just before Mary died in the autumn of 2014.

4.25 FIRST REFERRAL TO CAMHS

About six months after the termination of her pregnancy, Mary became increasingly upset. The school and her GP noted her low mood, poor appetite and isolation from her peers. The GP and the school both made a referral to CAMHS.

Mary was offered an appointment within a few days of the referral but Mary's mother was unable to get her there because of the short notice and her other commitments. CAMHS spoke to Mary's mother and gave her some advice, they also talked to the staff at Mary's school. The family were offered a new appointment at a more convenient location and Mary and her mother were seen, both separately and together, two months later.

CAMHS set out a plan for some therapeutic intervention and agreed to see Mary again in six weeks. As part of their plan, CAMHS asked the GP to monitor Mary's weight. By this time Mary's mother reported she was unable to get to appointments and things were better at home. Mary said she didn't want any counselling or support. CAMHS staff spoke to school staff who had no particular concerns and knew they could re-refer if necessary.

The case was closed three months later on the understanding Mary could refer herself at a later date if she felt the need. The weight monitoring came to an end without any particular concerns being identified.

4.26 SECOND REFERRAL TO CAMHS

Eight months later, in the spring of 2014, the school's concern about Mary was increasing and they again referred her to CAMHS. The school had also referred Mary to a local support service for young people which offered support and mentoring around relationship issues.

Mary's mother was also worried about her and went to see the GP, who referred Mary to CAMHS at her mothers' request.

CAMHS assessed the urgency of the referral as "routine" and responded by trying to contact Mary's mother. There was no-one in when they phoned (they do not leave a message because of the need for confidentiality) and Mary's mother says she never received a letter. Assuming the service was not required and in line with their policy, CAMHS closed the case. They did not inform the GP.

Mary's mother was upset and angry that CAMHS didn't take any action and what she perceived as the lack of a response. She spoke to her GP who contacted CAMHS again and was informed that Mary would be offered an appointment in due course. On the basis of the information they had, CAMHS did not assess the referral as urgent.

4.27 THIRD CONTACT WITH CAMHS

At the start of the autumn term, Mary's mother contacted CAMHS asking when Mary was likely to be seen as she needed time to make arrangements to get to any appointment. She was asked about the current situation with Mary and is alleged to have reported there was no change.

Ten days later, on a Friday afternoon, the school rang CAMHS to discuss Mary. The school record says Mary had been upset at the recent anniversary of the pregnancy termination, had discussed eating issues and some problems at home. The school record, made a few days after Mary's death, also says, "there was no suggestion of suicidal ideation and [Mary] was not crying or upset".

In contrast, the CAMHS record says the school reported Mary was depressed and self-harming and having suicidal ideas. The CAMHS duty worker got the information later that day and he rang the school but couldn't find anyone to talk to about the earlier call.

When a CAMHS worker rang the school on the following Monday, Mary had taken her life during the weekend.

4.28 POLICY AND PROCEDURE

CAMHS were limited in their effectiveness by the following factors:

- Mary did not reach the threshold for urgent intervention;
- Mary didn't want to engage with CAMHS;
- Mary's family appeared to be ambivalent about their need for help as Mary had periods when she appeared to be coping well.

4.29 THRESHOLDS

The CAMHS team which covers the area where Mary lived, in common with all CAMHS services, describes itself as under "sustained pressure" due to the number of referrals and complexity of work. Referrals have increased year on year, which has resulted in the need to prioritise the young people in greatest need.

Risk is assessed using a model which determines whether a young person's need is routine, urgent or requires emergency intervention.

In this case, based on Mary's presentation, her need was assessed as routine and in this category the waiting list for a service in this area is 12 months.

In carrying out their internal review after Mary's death, CAMHS discussed their assessment of Mary's needs, and it was also discussed with practitioners during the Learning Event. There was a shared view that there was no indication that Mary needed urgent intervention and staff were visibly shocked and upset on hearing about her death: those who knew her well, although worried about her, had never considered her to be at risk of suicide.

4.30 ENGAGEMENT

Although the waiting list is an obvious resource issue, CAMHS dealt with the referrals appropriately and in accordance with their own procedures. Staff communicated regularly with the school, the GP and with Mary's mother. It is notable that although they were actively talking to the adults, they only had direct contact with Mary twice during the two-year period, and they may wish to review this to ensure they are sufficiently child-focused.

CAMHS' internal review indicates that they are considering alternative communication channels with young people where engagement is a factor: for example via Facebook, instant messaging and texts.

4.31 RECENT DEVELOPMENTS

In response to Mary's death, actions from the internal review include providing support for staff and pupils at Mary's school, awareness training for staff on self-harm and suicide and anxiety management.

The wider issues of demand on the service and capacity are described in the CAMHS Benchmarking Report, December 2014, and the local picture in a document about CAMHS services provided by Hampshire, Needs and Resources, December 2014. These are currently being looked at by com-missioning bodies.

4.32 OVER-RELIANCE ON CAMHS?

At the beginning of the review of this case, the Reviewer, the professionals involved and the Review Group thought that CAMHS were at the centre of the case. In fact they only saw Mary twice, and the last time was 20 months before she died.

The reason for the initial thinking appears to be that CAMHS were the main point of contact for Mary's family, the school and the GP. Mary's mother feels that had CAMHS been more proactive, this might have made a difference to the outcome for Mary.

Other SCRs have documented an over-reliance on CAMHS as a theme for learning. For example, a Serious Case Review into the death of a young person in Buckinghamshire referred to CAMHS

as being seen as the answer to all the young person's problems, describing it as "the universal panacea".¹⁵

This case draws attention to the same risk. It appears to be the case that once CAMHS had been contacted, the family, the school and the GP saw them as being the best and possibly only choice to work with Mary.

It was CAMHS who remained on their radar as the concern for Mary continued. In discussion at the Learning Events, it was interesting to note that the other practitioners had little understanding of the CAMHS assessment process, didn't know and were surprised to learn that CAMHS have a substantial waiting list.

LEARNING POINT

CAMHS has a clear threshold for intervention and a waiting list for non-urgent referrals. Agencies should be aware of the risk of relying exclusively on CAMHS and consider the benefits of sharing of information, needs assessment and multi-agency planning. (See also multi-agency working.)

4.33 YOUTH MENTORING AND SUPPORT SERVICE

This service provided information, advice, counselling and support service for young people under the age of 26. During the period of this review they were providing one-to-one work with young people at risk of CSE, concentrating on work around healthy relationships and the right to be safe. Because of resource issues, the service is no longer operational.

Mary's school were aware of the work of the project and referred Mary to them at the start of 2014, nine months before she died. Although Mary did not strictly meet the criteria, the allocated worker was responsive to Mary's obvious need and met with her seven times over 2½ months. Their discussions included Mary's relationships, with her boyfriend, her family and her self-esteem.

The worker also texted Mary in between meetings, encouraging her to come to appointments and asking her how she was. Notes of the contacts indicate Mary engaged with the worker and was able to share some of her thoughts and feelings. It appears that Mary had poor self-esteem and body image, she was still seeing Daniel and felt he understood and supported her. Mary was also still struggling with her feelings about the termination of pregnancy and felt only Daniel understood. The worker suggested Mary might benefit from counselling but Mary said she didn't want this.

It was usual practice for the project staff to carry out a risk assessment at the beginning and then again towards the end of their work, to assess a young person's suicidal thinking.

Mary had indicated to the worker that she had self-harmed and had suicidal thoughts but neither were current. The first risk assessment gave Mary a high score, the second assessment, two months before she died, indicated the risk had dropped to the lowest level.

15. Serious Case Review, Buckinghamshire LSCB, Young Person J, April 2015.

Towards the end of the summer term, the person who had been working with Mary changed roles and moved on and a new worker was introduced. The records show Mary was unhappy at the change and never engaged with the new person, despite efforts at a planned handover and introductions. To compound the problem, school holidays made it hard for Mary to get to meetings, the school were no longer able to facilitate appointments and Mary said she was busy babysitting her younger sibling. Mary didn't respond to text messages and didn't have any further contact with this service.

4.34 SAFEGUARDING

This service had a clear safeguarding policy, their staff had up-to-date safeguarding training and were regularly supervised. They had good access to safeguarding advice.

The kind of issues that Mary was sharing with her worker in this case were not seen as exceptional and the worker and managers were experienced at managing the level of risk Mary presented. Based on the information they had, there was no reason for any further action to be taken.

4.35 LISTENING TO YOUNG PEOPLE

In discussion with practitioners at the Learning Events it was interesting to observe the differences in approach to this case from the various agencies represented. Participants were aware that, in general, their knowledge and experience tended to lead them to be suspicious and generally disapproving of relationships between younger girls and older men, a view often reflected in the publicity around Child Sexual Exploitation. Although understandable, this view can be a barrier to effective engagement.

On the other hand, some Serious Case Reviews have commented on the need to get alongside young people and to take into consideration their age and developmental needs. For example an SCR in Cumbria into the death of a teenager says:

“A lack of appreciation of the ‘inner world of teenagers’ and their perceptions of themselves leaves professionals drawing naïve/over-simplistic conclusions about what they know from their communication with teenagers and what it means.”

Cumbria LSCB, Serious Case Review, Child J, September 2011

In this case, although the service only saw Mary for a relatively short period of time, they stood out as being able to get alongside her and demonstrated an understanding of how she saw her life at that time. The benefits of this type of service are also evident in feedback from Mary's friends who commented that “while [the youth worker] was there, Mary's mood went up”.

LEARNING POINT

It is important to keep an open mind when discussing relationships with young people and to listen to their views before forming a view about potential risk.

4.36 PROBATION

In early 2013, about a year after he had met Mary, Daniel was made subject to a suspended custodial sentence and 18 months' probation supervision as a result of the domestic incident with his family. The order expired a week after Mary's death.

Probation were unaware of Daniel's relationship with Mary and had no reason to contact other agencies.

4.37 SUPPORT FROM SCHOOL

The local secondary school has about 1,000 pupils and it is located near Mary's home. Mary attended regularly although there were periods when her attendance levels dropped.

The school has strong links with the community and knew Mary and her family, and they were in regular contact with Mary's mother who found the staff accessible and approachable. They had links with Mary's GP, CAMHS, the youth service and the local police.

It was the school who first raised concern about Mary's relationship with Daniel (see section on Investigation, Assessment and Safeguarding).

After the initial investigation the school monitored Mary's well-being and they referred her to the school counselling service but Mary did not engage with them. The school nurse knew Mary and saw her regularly. She was helpful in facilitating the referral to CAMHS when it became clear Mary was occasionally self-harming and "not eating".

The school, through the nurse, had some communication with the GP about the CAMHS referral and the GP monitoring Mary's weight.

In 2014 the school:

- Referred Mary to the youth mentoring/support service;
- Were helpful in arranging appointments at school;
- Re-referred Mary to CAMHS just before her death.

From the chronology and discussion with staff it is evident the school were mindful of Mary, cared about her and provided as much support as they could. They also tried to support Mary's mother.

4.38 ANTI-BULLYING POLICY

Mary's family and friends reported that although Mary enjoyed school and to some extent saw it as a "safe haven", bullying at school was a contributory factor affecting her vulnerability and mood. Her friends gave examples of how Mary's pregnancy and the termination were the source of gossip at school and how some students used the information in attempts to embarrass and humiliate her.

The school has a "behaviour policy" which states:

"The [School] is committed to high standards of behaviour. All members of the [school] community are expected to behave appropriately and to treat other people and their property with respect. Anti-social behaviour, bullying and harassment will not be tolerated."

The policy is dated 2012 and the annual review is overdue. This SCR did not specifically look at the effectiveness of the response to bullying at Mary's school. However, information which came to the Reviewer late in the process suggests the school might wish to review the effectiveness of their policy.

Although the school gave a lot of time to Mary, at no time did they consider her to be at risk of suicide. There are other children in the school who have emotional or mental health problems and self-harming is not unusual. Even with the benefit of hindsight, Mary didn't stand out as having exceptional needs or causing exceptional anxiety.

4.39 MARY'S PEER GROUP

Mary's friends' participation in this SCR provided a valuable insight into Mary's life during the period of this Review. Her friends were able to describe their view of Mary's personality, her likes and dis-likes, her relationships and worries and her suicidal thinking. From the descriptions given by her close friends, it seems that Mary speculated about her own death from time to time although she did not disclose any specific plans.

Although Mary's friends did talk to school staff about their general concern for Mary's emotional well-being, they did not disclose Mary's conversations about death. This was because they did not know that she actually intended to kill herself at the time she did and because they respected her privacy.

Mary's friends, being of a similar age, had experienced and understood the power and impact of gossip and the potential damage caused by the misuse of social media. They were trusted and loyal friends who wanted to help and support Mary.

The learning from this highlights the challenge for young people who have to negotiate the tensions between the expectation of extensive sharing of personal information, the gossip and bullying this can lead to and the pressure of keeping important confidences.

Learning also indicates that there are inadequate resources to capture the voice of young people who may have concern for a friend or information suggesting a friend is at risk of suicide.

Mary's friends thought that she was generally resistant to help but considered there were two potential missed opportunities for more effective work. These were:

- Counselling or support immediately after her pregnancy termination;
- More effective intervention to disrupt her relationship with Daniel (a relationship which they consistently viewed as having a very negative impact on Mary).

LEARNING POINT

Those providing e-safety training and other interventions in schools should ensure information is included on what young people can do if they have serious concerns about another person's safety.

4.40 MULTI-AGENCY WORKING

Notable from the chronologies of each agency who knew this family is the lack of multi-agency working or joined up thinking. There was a good deal of activity, talking to each other, monitoring Mary's weight and making referrals to relevant services – but the activity lacked focus.

There was an absence of a holistic assessment of the needs of the family and any multi-agency plan.

With hindsight, the SCR Group identified this case “as crying out for a CAF”.

4.41 THE BENEFITS OF CAF/EARLY HELP

At the beginning of the review period, both authorities had Child Assessment Framework arrangements in place. Known as a CAF, the purpose of the framework was to bring together the family, and professionals who knew them, to create a “team around the child” (TAC). This team would share information, assess need, identify desired outcomes and create a plan with defined roles and timescales for improvement. Safeguarding would be considered and, if the threshold for a referral was met, Children's Services would be informed.

In Hampshire the process has since been updated and is now defined as “early help”. The principles remain the same although the process differs slightly.

4.42 WHY WASN'T A CAF INITIATED IN THIS CASE?

There was extensive discussion in the practitioner Learning Events and among the SCR Review Group to identify why there the opportunity for joint planning and intervention was missed in this case.

The conclusions were:

- Workers were unclear about what could be done for children and families if the threshold for safeguarding was not met;
- For schools on county boundaries, the differences in how to access a CAF/Early Help make the process confusing, and this was compounded by ongoing changes in the process for accessing a CAF/Early Help;
- Some agencies, for example GPs, didn't know about Early Help/CAF;
- In general, the concept of Early Help/CAF was not part of everyday thinking.

For staff in this case there was general agreement that what works well is having a named service with one point of access which is well publicised. Awareness of the benefits of Early Help/CAF have been thoroughly explored with those who participated in this Review.

LEARNING POINT

The Team Around the Child (TAC) or Early Help is an effective mechanism for sharing information, assessing need holistically and planning and coordinating intervention. It is aimed at families where there are ongoing concerns about a child and several agencies are involved with the family but the case does not meet the threshold for intervention from Children's Services.

LSCB NOTE

Both LSCBs should consider reviewing the effectiveness of their CAF/Early Help arrangements to ensure they are well known and understood by partner agencies, especially those agencies who operate close to the county border and who may access both procedures.

5: TEENAGE SUICIDE AND RISK ASSESSMENT

Preventing teenage suicide is a national challenge. Research shows that accurately assessing risk is very difficult.

Figures from Child Death Overview Panels show that the combined figure for Hampshire and the pan-Dorset area is five teenage suicides in 2013/14 and five in 2014/2015. Given the relatively low numbers of children who commit suicide, it is likely that few professionals, especially those involved in delivering universal services, will have had experience of suicidal behaviour.

Prior to her death Mary gave no indication to the practitioners who knew her that she was planning suicide. She appeared to have very few of the risk factors often associated with teenage suicide, for example anger, substance misuse or hostility.

Research also tells us that depression is one of the best predictors of adolescent suicidal behaviour and Mary had not been diagnosed as depressed although she had shown some signs of this: she was crying at home, was unwilling to get out of bed, had sleep problems and a poor appetite.

Discussion in the Learning Events during this SCR explored what staff described as a “current culture of self-harming, dark thoughts and depression” among young people which makes it very difficult to differentiate those at most risk. Mary’s friends also described their experiences of the number of young people in their own year group who express emotional problems, their view is that it is often the most quiet young people who are at greatest risk.

Some studies have 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.”¹⁶

Mary’s friends were able to shed light on Mary’s thinking about death. She had talked of wanting to be with her baby and, in their view, to have a rest from her painful feelings. They believe her suicide was an impulsive act prompted by an emotional few days. Impulsivity may well have been a factor. Someone who knew Mary well says of her, “She wanted to die but wake up the next morning”, and another friend said, “She didn’t realise death was forever”.

The challenges of preventative work with young people are described by Hanson and Holmes in their paper “That Difficult Age: Developing a more effective response to risks in adolescence”.

They point out:

“the pathways leading to a number of the harms that adolescents experience are complex, not least because they involve adolescent choices and behaviours.”

16. “Deliberate Self-Harm in Adolescence” by Fox, C and Hawton, K, Jessica Kingsley, 2004. The authors discuss risk factors for self-harm, including depression, substance abuse and antisocial behaviour, and critically examine key screening instruments that can be used to assess risk. They describe how suicidal behaviour can be managed and prevented, and look at the effectiveness of aftercare treatment for those who self-harm.

They also say that:

“the adolescent stage involves increased risk-taking, emotional highs and lows and the sensitivity to peer influence, all underpinned by interacting social and neurobiological change.”¹⁷

Marion Brandon describes teenagers who take their own lives as “lost young people” or “hard to help” young people, pointing out that if they won’t engage with help offered, “often services are withdrawn at the point of greatest need”.¹⁸

It is likely that even with the best risk assessment models, prevention of teenage suicide is often an impossible task: the best practitioners can do is listen and try and understand the teenage mindset. For agencies and commissioners of services, allocation of limited resources continues to be a major challenge.

LEARNING POINT

Practitioners working with troubled young people must recognise and work with the complex factors which affect the day-to-day experiences of adolescents, to find out about, understand and work with their view of their situation or problem.

17. *“That Difficult Age: Developing a more effective response to risks in adolescence”* by Dr Elly Hanson and Dez Holmes, *Research in Practice* 2014.

18. *From a presentation given by Marion Brandon, “Young Suicide and Serious Case Reviews: The developmental needs of young people”, University of East Anglia.*

6: SUMMARY

Studies show that many young people who take their own life give little or no warning of their intentions. This case is an example of a situation when a young person either acted on impulse or chose not to share her plans prior to her death. It seems that, until the very last day, Mary gave no indication that she planned to kill herself.

The learning therefore comes not, as in some other cases, from the need for practitioners to develop their knowledge of suicidal ideation but in how to effectively work with and support a young person who, at times, self-harmed, felt isolated, had problems sleeping, didn't eat well and struggled to live with loss.

It highlights the difficulty of how to help a young person whose needs are complex but do not fall neatly into the criminal justice system, mental health system, reach the threshold for urgent intervention or for child protection. The risk is that these young people either fall between services or are supported by a range of professionals who struggle to know how best to help. This is especially challenging when the young person is unwilling or unable to engage with the services offered.

Understanding of family functioning, the nature of relationships, risks and parental capacity underpin the work, and this case draws attention to the challenge of carrying out an assessment which is both robust and proportionate. The opportunity for this came early in the period of the Review but it was not well-used. The Core Assessment failed to include the relevant people and didn't properly consider family history. This was a missed opportunity for what might have been a more effective early intervention. The opportunity to meet and include Daniel in the assessment was lost.

Termination of pregnancy for a 13-year-old girl is an exceptional event. BPAS statistics for the UK show that the average number of terminations carried out by them each year (statistics from 2012–2014) is 56,735. Of these, only approximately 30 are 13-year-olds. In this case all agencies gave insufficient attention to the potential impact on Mary of the termination experience.

To their credit, those who knew and worked with Mary were genuinely concerned for her well-being, gave her time and tried to encourage her to share her feelings. For staff, especially when child protection is a paramount responsibility, working with teenagers is a challenge. Achieving the balance between listening to them, respecting their decisions, even if they seem unwise, and expressing concern for their choices is hard. Young people are less likely to engage with services if they feel their wishes are being ignored and although Child Sexual Exploitation practice should not be seen as the way forward in every case, it does provide helpful direction about the benefits of engaging young people over time.

The most obvious missed opportunity in this case was the failure to take advantage of the systems which were in place in order to enable agencies to work together, analyse and assess risk, think creatively and plan interventions. None of these – the Child Protection procedures, the MARAC or the CAF/Early Help provisions – were used in this case.

Brandon et al in their paper “New Learning from Serious Case Reviews: a two year report for 2009–2011”, in discussing how learning takes place say that:

“Recommendations can be helpful if they lead to definitive action but implementing them should not be seen to imply that learning has taken place. The best learning from serious case reviews may come from the process of carrying out the review.”¹⁹

In this case the use of agency representatives to produce chronologies with an analysis of their agency’s practice followed by practitioner learning events provided a chance to reflect on why actions were taken or not taken. It is that evidence which informs this Review and there is also evidence that learning from this case is ongoing. Dissemination of learning has already begun to raise the profile of Early Help/CAF, there has been a sharing of information between agencies about service provision and some procedural changes in general practice to reduce the risk of overlooking the needs of vulnerable young people.

FINALLY

The author acknowledges the importance of the contribution to this Review made by Mary’s family and friends. Mary was a much-loved child, sibling and friend, and she is sadly missed by all those who knew her.

19. Brandon et al, “New Learning from Serious Case Reviews: a two year report for 2009–2011”, Centre for Research on the Child and Family in the School of Social Work and Psychology, University of East Anglia Health Sciences Research Institute, Warwick Medical School, University of Warwick.

7: SUMMARY OF LEARNING

ASSESSMENT, INVESTIGATION AND SAFEGUARDING

- Not all relationships between young people where there is a significant age gap are CSE. Understanding the young person's views and acknowledging their choices will help with effective assessment, planning and appropriate intervention.
- The outcome of the Assessment in this case draws attention to the continued need for clear guidance and good quality supervision to enable social workers to plan and deliver assessments which are both proportionate and robust.
- Consideration must be given to the participation in an assessment of all those closely involved with the family including the child's boyfriend/girlfriend.
- The number of 13-year-olds seeking a termination is very small – far fewer than many of the practitioners involved in this case thought. This knowledge must prompt staff working with young people and their families to consider the impact of the termination on the young person, their family and other relationships.
- All staff should be reminded that a judgement about risk and the need for intervention is only valid at the time it is made. As circumstances change, more information comes to light or concern continues, practitioners may need to consider further action.
- It is imperative that the MARAC considers whether a perpetrator poses any risk to a particular individual, especially if that individual is a child with whom they are in an intimate relationship.

INTERVENTION

- GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.
- BPAS provides a free post-termination counselling service for women and girls who have had treatment. BPAS might consider how to ensure this service is well-publicised, particularly for their most vulnerable patients.
- BPAS should consider the possibility of proactive follow up of 13- and 14-year-olds to offer their counselling services.
- GPs and other agencies working with girls in similar situations should ensure they have access to information about the range of specialist services available. This would ensure services are well-targeted and help reduce the reliance on CAMHS.
- CAMHS has a clear threshold for intervention and a waiting list for non-urgent referrals. Agencies should be aware of the risk of relying exclusively on CAMHS and consider the benefits of sharing of information, needs assessment and multi-agency planning (see also multi-agency working).
- It is important to keep an open mind when discussing relationships with young people and to listen to their views *before* forming a view about potential risk.

- Those providing e-safety training and other interventions in schools should ensure information is included on what young people can do if they have serious concerns about another person's safety.

MULTI-AGENCY WORKING

- The Team Around the Child (TAC) or Early Help is an effective mechanism for sharing information, assessing need holistically and planning and co-ordinating intervention. It is aimed at families where there are ongoing concerns about a child and several agencies are involved with the family where the case does not meet the threshold for intervention from Children's Services.
- Practitioners working with troubled young people must recognise and work with the complex factors which affect the day-to-day experiences of adolescents, to find out about, understand and work with their view of their situation or problem.

FOR LSCBs

- Both LSCBs should satisfy themselves that schools understand the Child Protection Procedures, whether there are any outstanding training needs and that there is an acceptable level of compliance.
- The LSCBs should consider reviewing the MARAC guidance to ensure it is clear that the risk to any person in a relationship with a perpetrator is considered and what action must be taken if that person is a child. The LSCB will need assurance that all agencies are clear about the links between the MARAC and the Child Protection Procedures.
- Both LSCBs should consider reviewing the effectiveness of their CAF/Early Help arrangements to ensure they are well-known and understood and by partner agencies especially those agencies who operate close to the border and who may access both procedures.
- The LSCBs will need to consider how best to disseminate the learning from this SCR in order that it reaches as many relevant child care practitioners as possible and can improve child care practice especially in the care and protection of adolescents with complex needs.

8: APPENDICES

APPENDIX 1 – GUIDANCE FROM WORKING TOGETHER

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances, known as Serious Case Reviews.

Working Together to Safeguard Children 2013 and 2015 sets out how Reviews are to be carried out.

In line with the principles set out in Working Together to Safeguard Children this Serious Case Review:

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

The Guidance states:

Final SCR reports should provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence; be written in plain English and in a way that can be easily understood by professionals and the public alike; and be suitable for publication without needing to be amended or redacted.

APPENDIX 2 – LIST OF AGENCIES

The following agencies participated in the SCR:

- Dorset Children's Services;
- Hampshire Children's Services, Education;
- Sussex Partnership NHS Foundation Trust – CAMHS;
- Hampshire Police;
- Dorset police;
- School;
- No limits;
- Probation;
- Hampshire CCG, GP;
- Southern Health NHS Foundation Trust, School Nurse;
- BPAS.

Dorset Safeguarding Children Board

Response by the DSCB to the findings identified in the Serious Case Review Family S18

- 1. Both LSCBs (Dorset and Hampshire) should satisfy themselves that schools understand the Child Protection Procedures, whether there are any outstanding training needs and that there is an acceptable level of compliance.**

What were we doing prior to this Serious Case Review finding?

- Dorset Safeguarding Children Board were able to satisfy themselves that the Dorset Safeguarding Schools advisor maintained a robust plan to ensure that all schools follow a self-audit process which ensures safeguarding practices are up to date and robust on a yearly basis. This included high quality, appropriate supervision, support, guidance and training in order to appropriately safeguard children in their care.
- Dorset Safeguarding Children Board were also able to satisfy themselves that there is a robust training schedule to support Designated Safeguarding Leads (DSL's) in a range of safeguarding practices and emerging concerns.
- Dorset Safeguarding Children Board receive a yearly Schools Report from the Safeguarding Schools team and as such can satisfy itself that there are robust plans and policies in place to Safeguard children in Education

What has already changed and what further changes will be made?

- Dorset Safeguarding Children Board will continue to seek assurance from the Board member which represents Education as to how they are challenging these deficits within school Safeguarding practice.
- Dorset Safeguarding Children Board recognises that schools are likely to be the agency that has most regular contact with the child or young person. Schools will continue to be supported to ensure the concerns they raise are appropriately actioned by the relevant agencies and that schools are aware of the escalation procedures to follow if they believe actions are not being undertaken and/or risks are escalating.

When will this be completed by?

- Dorset Safeguarding Children Board will ask for a response from the member for Education by Sept 16 in regard to on-going self-Audit responses and actions from schools

What impact will this have on children?

- Dorset Safeguarding Children Board recognises that this robust response ensuring schools are fulfilling their own responsibilities within Safeguarding will help to ensure all children are Safeguarded within Dorset's schools.

- 2. The LSCBs should consider reviewing the MARAC guidance to ensure it is clear that the risk to any person in a relationship with a perpetrator is considered and what action must be taken if that person is a child. The LSCB will need assurance that all agencies are clear about the links between the MARAC and the Child Protection procedures.**

What were we doing prior to this Serious Case Review finding?

- Dorset Police have already amended the MARAC process to include consideration of children. This was due to the change of definition of DA nationally to include 16 year olds and above, and also due to the learning from a Domestic Homicide Review

where a son killed his mother in a domestic abuse setting. This has led to the Dorset MARAC Steering Group taking a position of considering children who in relationships with perpetrators.

What has already changed and what further changes will be made?

- Changes as above. Further reassurance is needed that the learning from this SCR is considered by the MARAC Steering Group and the above finding is shared with members of MARAC followed by an audit of MARAC by the SG as part of the MARAC Steering Group Audit Sub Group.

When will this be completed by?

- The DSCB will seek assurances of the Pan Dorset DA Strategic Group that this consideration is in place as a matter of practice within 6 months.

What impact will this have on children?

- The position that Dorset MARAC will consider all children with relationships to perpetrators will ensure that the safeguarding of children is paramount in the considerations of the MARAC process

3. Both LSCBs should consider reviewing the effectiveness of their CAF/Early Help arrangements to ensure they are well-known and understood and by partner agencies especially those agencies who operate close to the border and who may access both procedures.

What were we doing prior to this Serious Case Review finding?

- The common assessment framework was not fully embedded and understood by professionals working with children. Thresholds for safeguarding were not always clear across the multi-agency partnership. Common assessment and team around the family work were seen as the preserve of the Dorset County Council early intervention teams.

What has already changed and what further changes will be made?

- The development of **a new threshold tool** and decision making matrix, launched with partners in 2015 by the Safeguarding Board, to help agencies identify levels of need among children and the appropriate level of response.
- The **eCAF** system was refreshed as it had been used as a referral route into early intervention. The engagement of partners in this process has resulted in more of them completing common assessments. It was accompanied by a major training roll out to partners.
- A Children's Trust Board member (a local head teacher) has agreed to lead a multi-agency group to look at how common assessment arrangements will work in future.

When will this be completed by?

- September 2016

What impact will this have on children?

- Professionals working with children in Dorset will have greater confidence in completing common assessments, and convening team around the family arrangements. It will result in more information sharing between professionals and more effectively coordinated early help for children and families. Professional will also be clearer about when to escalate safeguarding concerns. All of these changes will produce more positive outcomes for children and families.

4. **The LSCBs will need to consider how best to disseminate the learning from this SCR in order that it reaches as many relevant child care practitioners as possible and can improve child care practice especially in the care and protection of adolescents with complex needs.**

What were we doing prior to this Serious Case Review finding?

- The current process for disseminating learning from Serious Case Reviews is to take feedback from learning events and publication of Synopsis of learning. This is then reviewed on a yearly cycle to establish how the learning from SCRs has impacted on practice.

What has already changed and what further changes will be made?

- Dorset SCR panel are currently in the planning stage for a new, more concise and fluid process for SCR learning. There is a plan to revitalise the current format of feedback from learning events and publication of Synopsis of learning. Dorset's SCR panel will then be able to satisfy itself and the DSCB that actions are taken forward from reviews of practice. This will then compliment the current Pan-Dorset National Tracker reviewing National SCRs and disseminating appropriate practice evidence

When will this be completed by?

- The DSCB can be assured that the SCR group will have completed a review of practises and will have implemented a new format for learning from SCR by September 2016

What impact will this have on children?

- The imperative for Serious Case Reviews and any Case Audit is that the workforce takes away the learning from the reviews. The DSCB will be able to recognise how Serious Case Reviews have impacted on practice through the feedback loop built in to the new learning cycle



Hampshire Safeguarding Children Board

Response by the HSCB to the findings identified in the Serious Case Review Family S18

1. **Both LSCBs (Dorset and Hampshire) should satisfy themselves that schools understand the Child Protection Procedures, whether there are any outstanding training needs and that there is an acceptable level of compliance.**

What were we doing prior to this Serious Case Review finding?

- Hampshire Safeguarding Children Board (HSCB) has an established programme of training for Designated Safeguarding Leads (DSLs) in schools. This includes initial and refresher training on a broad range of safeguarding areas and emerging issues.
- In 2015 HSCB conducted a Section 157 and Section 175 audit on local authority maintained schools, Academies, and independent schools across Hampshire. There was a 99% return rate which provided a good overview of safeguarding arrangements in schools. 98% of the state schools and Academies, and 100% of independent schools, confirmed that they have clear policies, strategies and procedures in place to ensure safeguarding and welfare of pupils, and, that staff receive up-to-date, high quality,

appropriate training, guidance, support and supervision to undertake effective safeguarding of pupils.

- In addition, in 2015 the HSCB conducted a staff survey on awareness of the multi-agency child protection procedures which indicated that 72% of respondents were aware of the procedures and how to access them.

What has already changed and what further changes will be made?

- During 2015/2016 a number of Designated Safeguarding Leads (DSL) networking sessions have been held across Hampshire to raise awareness of key safeguarding policy updates to staff working in schools. This programme will continue during 2016/17.
- Hampshire County Council have also provided the PREVENT WRAP training, Governor training, and training on safeguarding children in education with medical conditions to a large number of schools across Hampshire. There have also been Head teacher briefings on the updated 'Keeping Children Safe in Education' guidance.
- In addition the HSCB has held safeguarding briefings with independent schools in 2015 and 2016 to highlight lessons from serious case reviews and policy changes, and, strengthen the lines of communication between the board and independent schools.
- Also, in February 2016 the HSCB held two regional education events open to Designated Safeguarding Leads (DSLs) and other staff from all schools across Hampshire to feedback lessons from serious case reviews and provide another avenue to discuss updates to local and national policy.

Further changes:

- HSCB, in partnership with the LSCBs in Portsmouth, Southampton and the IoW are currently undertaking a complete review of the multi-agency policies used by professionals across Hampshire. This includes child protection policies, and, the multi-agency escalation policy to incorporate feedback received from schools.
- Health partners in Hampshire are working with Children's Social Care to more effectively share information on welfare concerns between schools and health professionals. This will include the Public Health School Nursing Service reviewing information sharing with schools.

When will this be completed by?

- The policy review will be completed in May 2016.

What impact will this have on children?

- All of the above will ensure partners are working with to up to date policies and that children in Hampshire receive consistent support from agency professionals. Also, staff in schools are clear on how and when to escalate safeguarding concerns when their internal escalation routes have been exhausted.

2. The LSCBs should consider reviewing the MARAC guidance to ensure it is clear that the risk to any person in any form of relationship with a perpetrator is considered and what action must be taken if that person is a child. The LSCB will need assurance that all agencies are clear about the links between the MARAC and the Child Protection procedures.

What were we doing prior to this Serious Case Review finding?

- In Hampshire, a confidentiality statement is read at the beginning of the MARAC which highlights for agencies to be aware of risks of the perpetrator to others- this includes the community and other victims.
- The role of MARAC should always consider what information is known and the ages of those involved due to the definition of domestic abuse now including those 16 years and above. If a perpetrator has a known new partner at the MARAC, regardless of age, then whilst that case is specific in risk assessment and information between the

perpetrator/victim is the first part of the MARAC discussion, agencies are all expected to identify risks to others.

- Outcomes do include review for referring a perpetrator for MAPPA consideration by the relevant police team. Actions are also given, such as, completing the relevant police children and young person referral form (or an agency creating their referral) back through the Multi Agency Safeguarding Hub (MASH) so as to start that process of assessment and action for a secondary person at risk. Any immediate action is prioritised alongside that route too.
- Children not living at the primary address, but whom may have a relationship or connection to the victim or the perpetrator are often brought in a case to MARAC by the pre-MARAC research and are discussed as to risk of harm. The obvious example to this is extended family (siblings who live elsewhere), or children from an earlier relationship, but this can also include children who are in a relationship with the perpetrator.

What has already changed and what further changes will be made?

- A force wide review group (covering Hampshire County) has met recently and is reviewing all policies including this area of work, and also within the Multi-Agency Safeguarding Hub (MASH).

When will this be completed by?

- The review is envisaged to finish in its entirety in early 2017. However HSCB will seek assurance that those policies relating to children being identified to MARAC are effective and being followed by agencies currently.

What impact will this have on children?

- The review will ensure that policies are clear that any child at risk either by association with the perpetrator or the victim is identified and included in any agency's submissions to the MARAC.

3. Both LSCBs should consider reviewing the effectiveness of their CAF/Early Help arrangements to ensure they are well-known and understood and by partner agencies especially those agencies who operate close to the border and who may access both procedures.

What were we doing prior to this Serious Case Review finding?

- During the time of the review, CAF arrangements were transitioning to Early Help and the new Early Help Hubs were not well established in all areas in Hampshire.

What has already changed and what further changes will be made?

- Early Help is now fully embedded across Hampshire and there are ten early Help Hubs across the county. The Hubs include professionals working across all key partner agencies including schools and health partners and Children and Adult Mental Health Services (CAMHS).

Further changes:

- Consideration will be given to re-promoting the early help offer to agencies and settings that operate on Hampshire borders and may need to access services from more than one local authority area.
- In the north of the county, there is a good working relationship with Surrey secondary schools who attend the Hart and Rushmoor early help hub as appropriate. Hampshire early help practitioners also attend networking events linked with the Surrey early help offer. In the south of the county the Test Valley area works with Southampton City Council.

- Hampshire County Council is also in the process of a county-wide consultation on all early help services. The results of this will be known later this year and will provide a fully integrated 0-19 early help offer.

When will this be completed by?

- The consultation is live from 23 February until 3 May 2016. The Executive Member decision day will be held during the summer

What impact will this have on children?

- Hampshire children will be referred to / access the full range of appropriate early help support depending on their needs as assessed at a given time. Through the integrated 0-19 offer families will be better able to access the right support at the right time.

4. The LSCBs will need to consider how best to disseminate the learning from this SCR in order that it reaches as many relevant child care practitioners as possible and can improve child care practice especially in the care and protection of adolescents with complex needs.

What were we doing prior to this Serious Case Review finding?

- HSCB hold workshops on each serious case review to feed lessons and learning back to the professionals involved. In addition, learning from any review is incorporated into the programme of 'Lessons Learnt' workshops available to all professionals across Hampshire and delivered regionally in each of the Early Help hubs.
- Also, key lessons from SCRs and other reviews are incorporated into specific / themed multi-agency training over and above the lessons learnt sessions.

What has already changed and what further changes will be made?

- During 2016/17 HSCB will extend the length of the Lessons Learnt Workshops during 16/17 and broaden attendance to beyond Early Help Hub members.
- To aid learning, as well as publishing the SCRs and Board response documents in full, HSCB will also produce a 'lessons learnt' summary document. This will provide a short synopsis of the learning from a review and can be used throughout agencies as part of their training and learning programmes.
- The lessons learnt will also feature in a SCR newsletter that will be produced at regular intervals.

When will this be completed by?

- June 2016

What impact will this have on children?

- Lessons learnt are already disseminated to a wide professional audience and reflected in multi-agency and single agency policy and training. There is good evidence of the impact on professionals of their learning from these events.