Cumbria Local Safeguarding Children Board
Serious Case Review

Child J

Final Report

November 2013
1. Introduction

1.1 Why this case was chosen to be reviewed

Child J died on 4th January 2013. The circumstances of her death were considered at a meeting of the Case Review Panel on 15th January 2013 where it was agreed that the criteria for undertaking a Serious Case Review (SCR) had been met. The decision was made with reference to the guidance contained in Working Together 2010 (at 8.9):

“When a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family.”

The Case Review Panel was aware that Child J had been the victim of a sexual assault some 18 months before her death and believed that this satisfied the ‘abuse is known or suspected to be a factor’ element of the criteria for convening a SCR.

In addition to these considerations the Case Review Panel was influenced in its decision to recommend a SCR by concerns that the lessons from previous reviews, some of which were addressed in a paper to the Board in September 2012*, had not been learned and had not impacted on multi-agency practice.

At the first meeting of the Review Team on 3rd June 2013 the issue of whether Child J’s case did in fact meet the criteria for a SCR was discussed. The Review Team questioned whether the sexual assault that she suffered constituted abuse and whether the learning from the process would be enhanced if it were deemed to be a ‘learning lessons’ review, rather than a SCR.

This proposition was considered by the Case Review Panel and the Chair of the SCB in mid-June 2013 and a decision was made to proceed with a SCR.

*See:
Preventing Suicide in Children & Young People in Cumbria
J Mathieson
1.2 Succinct Summary of the Case

Child J began at School 1 in September 2011 aged 15 years. She settled well into her new school and quickly revealed herself to be academically able and gifted in sports and music.

In November 2012 she disclosed that she was suffering from bulimia, the start of which she attributed to a sexual assault that she had experienced about 18 months earlier. Following this disclosure Child J self-harmed (taking a Paracetamol overdose) and she was referred to CAMHS for help and support.

There was delay in Child J being seen at CAMHS and in the intervening period there was at least one (and possibly two) further incidents of self-harm. During this period also school based staff became aware of evidence of Child J's suicidal ideation and planning through the emergence of suicide letters that she had written and disclosures by her friends that she intended to kill herself.

Child J was seen at CAMHS in early 2013 and a plan was agreed to offer her ongoing assessment and treatment. Child J killed herself before the plan could be implemented.

1.3 Methodology

The case review used the systems methodology called Learning Together (Fish, Munro & Bairstow, 2009). The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the ‘deeper’, underlying issues that are influencing practice more generally. It is these generic patterns that count as ‘findings’ or ‘lessons’ from a case and changing them will contribute to improving practice more widely.

The methodological heart of the Learning Together model has three main components:

- Reconstructing what happened – unearthing the ‘view from the tunnel’ and understanding the ‘local rationality’.
- Appraising practice and explaining why it happened through the analysis of Key Practice Episodes (KPE’s).
- Assessing relevance and understanding what the implications are for wider practice – using the particular case as a ‘window on the system’.
Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation from organisations.

1.4 Review Team

The review has been carried out by a Review Team led by Mick Muir, an Accredited Learning Together Lead Reviewer. The Review Team received support throughout part of the process from the CLSCB Business Manager and LSCB Business Support Officer.

It is usual for ‘Learning Together’ reviews to be undertaken using two Lead Reviewers. However, in this case, it was decided due to time and financial constraints to proceed with one Lead Reviewer with additional support from SCIE. This was provided by the SCIE Head of Learning Together in the form of case consultation, supervision and a findings clinic for the Lead Reviewer.

Collectively, the role of the Review Team is to undertake the data collection and analysis and author the final report. Ownership of the final report lies with the CSCB as a commissioner of the SCR.

The Review Team was made up of senior representatives from the different agencies that had been directly involved with Child J. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development of the findings from the review. No members of the Review Team had any direct case management responsibility in relation to the services offered to Child J.

The Review Team was made up as follows:

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<thead>
<tr>
<th>Designation &amp; Role within Review Team</th>
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<tr>
<td>Accredited Lead Reviewer – Mick Muir, CMS Ltd</td>
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<tr>
<td>Designated Nurse Safeguarding, NHS Cumbria CCG</td>
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<tr>
<td>School Governor, School 1</td>
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<tr>
<td>SEND Manager, Children’s Services, Cumbria County Council</td>
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<tr>
<td>GP Lead for Children &amp; Safeguarding, NHS Cumbria CCG</td>
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<tr>
<td>Deputy Director of Nursing Quality &amp; Patient Safety, Cumbria Partnership NHS Foundation Trust</td>
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1.5 Structure of the review process

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings between the Lead Reviewer, Review Team and Case Group members. Initially there was a meeting between the Lead Reviewer and the Review Team to explain the SCIE Learning Together model and the role of the Review Team in the process. The Review Team then decided the membership of the Case Group based on their individual involvement in the case.

An introductory meeting took place with the Case Group at which the Review Team was also present. At this meeting the SCIE model was explained to the Case Group and their role in the review process was clarified. Case Group members were informed they would be involved in individual conversations with Review Team members and Lead Reviewer and given the opportunity to reflect on and explain their involvement with the case. They were also informed that they could be accompanied by a supporter at the conversation if they wished. There were ten individual conversations which took place over a period of three days. In addition, there was a telephone conversation between the Lead Reviewer and an individual who would have been part of the Case Group had she not emigrated to Australia.

During the course of the review the Review Team met for three half and four full days and, in addition, attended a reading day. The Case Group met on three occasions, one for the introductory session and then for two full day Follow-on meetings, where the emerging analysis was discussed and challenged. The Review Team were also present in these meetings.

The review followed the process and meeting structures as outlined by SCIE with one additional final meeting of the Review Team to agree and sign off the report and reflect on the experience of using the SCIE model. In total, the Review Team met on ten occasions, including three which involved Case Group members.

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<thead>
<tr>
<th>Date</th>
<th>Meeting Purpose</th>
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<tr>
<td>09/04/2013</td>
<td>Initial meeting between Lead Reviewer and CLSCB members</td>
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<td>20/05/2013</td>
<td>Review Team Initial Planning Meeting</td>
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<td>29/05/2013</td>
<td>Allocated for reading time</td>
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<tr>
<td>03/06/2013</td>
<td>Introductory meeting with Case Group (with Review Team)</td>
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<td>12, 13, 14/06/2013</td>
<td>Ten Individual Conversations with Case Group</td>
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<td>26/06/2013</td>
<td>First Analysis Meeting with Review Team</td>
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<td>09/07/2013</td>
<td>First Follow-on Meeting with Case Group (involving all Review Team)</td>
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<td>22/07/2013</td>
<td>Second Analysis Meeting with Review Team</td>
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03/10/2013  Second Follow-on Meeting of Case Group (involving all Review Team)

15/11/2013  Final Meeting with Review Team to sign off report and reflect on the experience of using the SCIE model

26/11/2013  CSCB Meeting – presentation of final report

1.6 Timeframe and mandate

In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. This replaces the terms of reference (that have a specific focus of analysis before the review process has begun) which are a fundamental feature of traditional Serious Case Reviews.

The timeframe for the review was set at the initial meeting between the Lead Reviewer and the Review Team on 20th May 2013. The agreed timeframe was from September 2011 (the date that Child J joined School 1) until 4th January 2013. In the event even this relatively short timescale proved too long as the period between September 2011 and November 2012 was entirely uneventful in relation to any issues or concerns about Child J’s welfare or progress.

Within the period under review, seven key practice episodes were identified (covering the period from 30th November 2012 until 4th January 2013). These KPE’s were then analysed in detail to provide insight into not only what happened with Child J but also why things happened as they did. It was from this process of detailed analysis that the learning from the review (presented later as findings) was generated.

1.7 Sources of data

The systems approach requires the Review Team to avoid hindsight bias and to learn how people saw things at the time – the ‘view from the tunnel’. Identifying and examining Key Practice Episodes allows the Review Team to understand the way that things happened and explore the contributory factors that were influencing the Case Group’s working practice. This is known as the ‘local rationality’. It requires those who had direct involvement in the case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.
Data from Practitioners

Information was provided by members of the Case Group who were directly involved with the family through a process of individual conversations. They were invited to share their experiences of working with Child J and her parents in the context of their knowledge, systems and practice at that time. A total of ten conversations were held with individual practitioners (who fulfil the roles outlined below), who together formed the Case Group for the review. Two members of the Review Team were involved in each conversation.

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<tr>
<th>Agency</th>
<th>Case Group Members</th>
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<tr>
<td>Education</td>
<td>Deputy Head Teacher</td>
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<td></td>
<td>Assistant Head Teacher</td>
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<td>Head of Year</td>
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<td>Health</td>
<td>CAMHS Social Worker</td>
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<td></td>
<td>CAMHS Nurse</td>
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<td>CAMHS Psychologist</td>
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<td>CAMHS Interim Manager</td>
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<td>School Nurse</td>
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<td></td>
<td>General Practitioner</td>
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<tr>
<td>Independent</td>
<td>School Counsellor</td>
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Data from Documentation

In the course of the review the Review Team members had access to the following documentation:

- GP notes of consultations on 10th and 13th December 2012
- CAMHS records covering the period from 12th December 2012 to 4th January 2013
- School Nurse records from 3rd December 2012 to 4th January 2013
- School 1 records from 30th November to 21st December 2012
- GRiST assessment completed by CAMHS Social Worker
- Standard Risk Assessment completed by School Nurse
In addition, the Lead Reviewer had sight of the following, the content of which he shared with the Review Team:

- Sudden Untoward Incident Report completed by Cumbria Partnership NHS Foundation Trust
- Witness Statements from three of Child J’s friends
- Suicide letters written by Child J on or before 17th December 2012 and on or before 4th January 2013

Data from Family, Friends and Community

The CLSCB Business Manager wrote to Child J’s parents shortly after the decision was made to conduct a SCR in January 2013 to inform them that a review into the circumstances of Child J’s death was to be completed. She wrote to them again on 29th April 2013 to explain the delay which had entered the review process and to inform them that they would be contacted in the near future by the Lead Reviewer to invite them to contribute to the Review if they wished to do so.

The Lead Reviewer contacted Child J’s parents in June 2013 when both indicated that they did wish to be involved in the review and that they would prefer to make their contributions through face-to-face conversations. The Lead Reviewer met with Child J’s father on 22nd July 2013 and her mother on 7th August 2013. In addition, there was an exchange of email correspondence between the Lead Reviewer and Child J’s father in which he provided additional information and clarifications about the sequence of events prior to Child J’s death.

The contributions of both parents was extremely helpful, both in terms of providing an understanding of what Child J was like, as well as the problems and frustrations they experienced in trying to understand her difficulties and provide her with the help that she needed.

The information provided gave a useful insight into the limitations of the services provided to Child J and the differences in the perceptions between professionals and Child J’s parents of the expectations and usefulness of the ‘partnership’ arrangements that were in place which it was believed would help to keep Child J safe.
1.8 Methodological Comment and Limitations

The SCIE model attributes value to the data obtained from records and that obtained through conversations with professional staff, family and friends. It is a process of looking at the child protection system through the illustration of a specific case – a ‘window on the system’. During the review the following limitations on access to data were identified:

♦ The absence of the School Counsellor from the Case Group

By the time the Case Group met for the first time the School Counsellor had emigrated to Australia. Information obtained from other participants in the review indicated that the Counsellor had played an important part in offering support to Child J and also determining the course of events after it was known that Child J had written suicide letters. The Lead Reviewer exchanged email correspondence with the Counsellor and was able to have a brief telephone contact, but the line was poor and communication was difficult. The absence of the School Counsellor from the two follow-on meetings of the Case Group was seen as a significant loss by the Review Team.

♦ The inability to talk to Child J’s friends

In the course of the conversations with staff and in the two Follow-on meetings it became clear that the friends of Child J who had tried to help her by disclosing the existence of the suicide letters and the fact that she was planning to kill herself had a great deal of information about Child J and the circumstances and events leading to her death. The Review Team believed that conversations with Child J’s friends would have provided useful insight into her ‘inner world’ which would have contributed significantly to the learning from the review.

The Review Team were advised by the staff from School 1 of the dangers associated with speaking to Child J’s friends, both in terms of their own emotional welfare and the impact it could have on their academic performance in the upcoming exams. There were also concerns that raising the issue of Child J’s death again might have wider implications for the more emotionally vulnerable young people who attend School 1. It was the view of the Review Team that the potential costs of engaging Child J’s friends in the review far outweighed the benefits and, as a consequence, they were not invited to become involved.

The Review Team had similar thoughts in relation to Child J’s younger sibling and decided not to invite him to contribute to the review.
2. The Findings

What light has this case review shed on the reliability of our systems to keep children safe?

2.1 Introduction

A case review plays an important part in efforts to achieve a safer child protection system. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. The particular case acts as a ‘window on the system’ (Vincent 2004: 13).

For this to happen, the outcome of the review has to say more than what happened in this particular case and needs to provide messages to the LSCB about usual practice and normal patterns of working. These messages are presented as Findings and they provide the LSCB with an insight into the underlying patterns that influence professional practice and outcomes for children. These Findings exist in the present and potentially impact on the future. By responding positively to the Findings the LSCB has the opportunity to change how the child protection system operates and to make it safer. It makes sense, therefore, to prioritise the Findings to identify those that need to be tackled most urgently for the benefit of children and families, even though these may not be the issues that appeared most critical in the context of this particular case.

In order to help with the identification and prioritisation of Findings, the systems model that SCIE has developed includes six broad categories of these underlying patterns. The ordering of these in any analysis is not fixed and will change according to which issues are felt to be most fundamental for systemic change. The categorisation of Findings is as follows:

1. Innate human biases (cognitive and emotional)
2. Family-professional interaction
3. Responses to incidents
4. Longer term work
5. Tools
6. Management systems

The Findings from each category convey a message to the CLSCB about how that element of the child protection system was working at the time of Child J’s death. They state succinctly what is or was problematic about the system and are therefore helpful to the reader. It is not uncommon for there to be overlap between the categories of findings.
2.2 Appraisal of professional practice in this case – a synopsis

Family Structure:

Parent 1 – Child J’s father  
Parent 2 – Child J’s mother  
Child J – female (14+ years)

Child J also had a younger (10+ years) brother

At its heart this is a case of an able, high achieving young person with apparently everything to live for who took her own life, despite the best efforts of her parents and those professionals who were closest to her to keep her safe.

The failure of professionals from all agencies to recognise the full extent of Child J’s difficulties and take protective action is at first baffling in the face of mounting evidence that she was at high risk of suicide. It is the strength of the Learning Together model that allows the review to look behind what (with hindsight) appears to be simply poor practice to understand why the case was managed as it was and the factors that influenced decision making and practice throughout.

It is important to recognise that all of the practitioners involved in this case were concerned about Child J and obviously none of them wanted her to die. Almost without exception the members of the Case Group that were involved in the review found the process challenging and they are to be commended for their commitment and fortitude throughout what has been a difficult process.

It is equally important to acknowledge the contribution to the review made by both of Child J’s parents. Their insights and reflections on professional practice and the impact it had on themselves and Child J were extremely helpful to the Review Team and were obtained at no little emotional cost to themselves. They agreed to contribute to the review to try to understand better what happened to their daughter and to help prevent similar tragedies occurring in future. They are to be thanked for their contribution.

Just as it was difficult for Child J’s parents and all of the professionals involved to undertake the review, it will be difficult for the Board to receive its Findings. The messages from the review are, in effect, feedback to the Board on how well the child protection system functions in Cumbria provided by those who have the responsibility to make it work. These messages may be painful to hear and the solutions to the problems the Findings identify will not necessarily be easy to find. Nonetheless, it is important if Cumbria is to become a safer place for children to live for the Board to embrace the Findings of the review and take steps to address the issues identified.
Concerns about Child J first emerged at the end of November 2012 when she disclosed that she had been suffering from bulimia for 18 months. She was referred to the School Nurse and School Counsellor for support.

Shortly after this, Child J took a Paracetamol overdose. This became known to her parents who decided not to take her to hospital (one of Child J's parents is a doctor). On the following day the events of the previous evening were discussed with Child J's parents who were not challenged over their decision not to seek treatment and assessment of Child J. This decision was based on the belief that Child J's parents were able to make rational decisions about their daughter's situation and take appropriate action. This pattern of investing heavily in Child J's parents knowing best what to do for their daughter was a feature throughout the management of this case.

The consensus view of all the professionals involved at this time (shared by Child J's parents) was that Child J's behaviour was a 'normal', histrionic adolescent response to a romantic disappointment (she had recently broken up with her boyfriend).

Following this incident Child J was referred to CAMHS. She was also offered support from the School Counsellor. The referral to CAMHS was triaged on 12th December and a decision was made to offer an urgent appointment, meaning that she would be seen within five days. However, Child J's case was not allocated and, as a consequence, she was not seen. This was evidence of poor practice and poor management oversight from CAMHS.

It was noted by all the professionals who came into contact with Child J after her overdose that she had quickly reverted to her normal self, in that she was actively involved in her academic studies and contributed significantly to the preparations for the Christmas celebrations. It was generally believed that Child J had overcome her difficulties and she was her normal self again.

Child J attended a party on 15th December 2012 where she became upset, got drunk and self-harmed again (by cutting herself). On the following Monday some of her friends disclosed that Child J had a number of suicide letters in her possession. Following a difficult conversation Child J was persuaded to surrender the letters and it was agreed they would not be opened, but would be stored in a safe place. The decision not to open the letters appears baffling. It seems incomprehensible that the staff involved did not override Child J's wishes (for them not to be opened), open the letters and seek immediate expert advice. The explanation for why professionals acted as they did is offered in the Findings of this review.

Once again, following this incident and subsequent conversation, Child J appeared to be unaffected. She presented as positively engaged, outgoing and forward-looking to all professionals with whom she came into contact.
A few days later Child J’s friends disclosed to two different members of staff that she had a plan to kill herself after Christmas. The staff involved had had no experience of managing potentially suicidal ideation and planning, and they consulted the School Counsellor who told them that she did not believe Child J was suicidal and that the letters that she had surrendered had no significance. The staff involved were reassured when they received this information.

Following the second incident of self-harming and the disclosure of the suicide letters Child J was re-referred to CAMHS. There was a delay in this re-referral being processed and when it was, there was further delay in Child J’s case being allocated. She was not seen until 3rd January 2013 following a direct contact from her mother on 2nd January 2013. This was further evidence of poor practice and a lack of structure and organisation in CAMHS.

Following the disclosure that Child J had a plan to kill herself after Christmas, her parents were phoned and informed, but were advised that it was generally believed Child J was not suicidal. Child J’s father was angry and confused by this message and he was extremely anxious that he had been given almost sole responsibility for keeping his daughter safe when he did not know how to do this and had no access to services on which he could call.

Child J was seen at CAMHS on 3rd January 2013 for an initial assessment. The outcome of the assessment was a conclusion that Child J was at high risk of future self-harm and medium risk of suicide. At the end of the assessment Child J and her father were informed that her case would be discussed at a multi-disciplinary meeting and they would be contacted.

Child J took her own life on the following evening.

2.3 In what way does this case provide a useful window into our systems?

As with all cases there are features of this case that are unique to Child J in terms of her gifts and talents, family background and circumstances. However, it was the view of the practitioners involved from the Case Group and Review Team that there were a number of aspects of this case that were typical of the difficulties that professionals have in recognising and responding to young people’s vulnerabilities and distinguishing between risky self-harming behaviour and potentially life-threatening suicidal ideation and planning.

This case also illustrates the challenge for professionals in understanding adolescent behaviour in the context of the pressures they experience from their ‘inner world’, including the massive influence of peer pressure and social media.
It also highlighted a more general need for services to be easily accessible and available to make a timely and proportionate response to young people at risk of suicide and a need for professionals to be more demanding of their colleagues from other disciplines.

The Review Team also noted that this case represented an example of professionals failing to take full account of the impact of sexual abuse or assault on the emotional wellbeing of young people. This is an issue that has emerged in other SCR’s conducted by CLSCB.

Another important issue which emerged in this case which it was felt was representative of practice generally was the dilemma for professionals in balancing their duty of care with the rights of young people to be self-determining.

In the light of the above, this case was felt to be a useful window into the system providing an insight into how the agencies work together and the challenges they face in seeking to safeguard and promote the welfare of young people at risk of suicide in Cumbria.

The Review Team have identified nine findings for the Board to consider. They are presented in priority order and represent the underlying patterns which explain the functioning of the current Safeguarding system. The nine findings are:

♦ Finding 1

The lack of knowledge among a range of professionals about the evidence base related to the high risk indicators for teenage suicide leaves them ill equipped to recognise the signs and respond accordingly. (Response to incidents)

♦ Finding 2

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. (Family-Professional interactions)

♦ Finding 3

The misperception that young people who may wish to kill themselves will exhibit symptoms of depression limit the ability of professionals to recognise and respond to young people at risk of suicide. (Longer term work)

♦ Finding 4

There are insufficient established processes within schools to challenge fixed mindsets that have developed around a case, meaning that initial perceptions about risks are not revised in the light of evidence of increasing vulnerability making prevention of teenage suicide less likely. (Management systems)
Finding 5

The pattern of agencies ‘investing in’ a referral to CAMHS as if it’s a functioning service and the solution to young people’s difficulties when they know it’s not, creates a false reassurance that children will receive the help that they need in a timely fashion, leading vulnerable young people to become even more vulnerable. (Longer term work)

* Finding 6

Does the reliance of professionals on the perceived ability of apparently engaged, professional, parents to protect their children from the risk of suicide effect professional judgement and the need for professional safeguarding activity? (Family-Professional interaction)

* Finding 7

Does the structure of the risk assessment tools and the way that they are used provide an aid to professional understanding of the true level of risk of suicide in vulnerable young people? (Tools)

* Finding 8

Does the absence of quality assurance measures in relation to the recruitment and activities of independent people providing counselling and emotional support services to schools compromise the safety and welfare of vulnerable young people? (Management systems)

* Finding 9

The general lack of confidence by partner agencies in CSC to accept referrals and take protective action reduces the likelihood that partner agencies will make contact about young people at risk of suicide. (Longer term work)
Finding 1

A lack of knowledge among a range of professionals about the evidence base related to high risk indicators for teenage suicide leaves them ill equipped to recognise the signs and respond accordingly. (Response to incidents)

It was just over one month between the concerns about Child J’s bulimia coming to light and the point that she committed suicide. During this time there were a number of incidents and events which signalled increased risk of suicide that went unnoticed by School based professionals.

How did this issue manifest itself in this case?

When Child J disclosed that she suffered from bulimia appropriate action was taken to signpost her to the specialist service it was believed would best meet her needs. The fact that Child J had suffered bulimia for 18 months was not recognised as evidence of serious and longstanding self-harming behaviour.

Following the disclosure there were two definite (and a possible third) incidents of self-harming which included a Paracetamol overdose and an episode of (slight) cutting. The professionals involved interpreted this behaviour as a ‘normal’ teenage melodramatic response to romantic disappointment. On 17th December 2012 Child J was found to have what were believed to be suicide letters in her possession. The staff involved were persuaded not to open the letters and failed to recognise their significance as indicators of higher risk of suicide. On 20th December 2012 staff were informed that Child J had a plan to kill herself, but believed because the information was third-hand (via a young person via Facebook) and that the plan was to be implemented after Christmas, that this did not signal increased risk for Child J.

The evidence trail from this sequence of events for increased risk of suicide is clear and included sexual victimisation1; eating disorder2; previous suicide attempt (incident of 3rd December); non-suicidal self-injury3 (incident of 15th December 2012); suicidal ideation and intent4 (letters disclosed on 17th December 2012); suicidal planning5 (20th December 2012).

4. Levinsohn, Rohde, Seeley, 2006
5. King, Foster, Rogalski, 2012
How do we know it is an underlying issue and not something unique to this case?

Except for one person (who never met Child J) none of the other professionals who were members of the Case Group had any experience of managing suicidal behaviour in young people in the past. They had considerable experience in dealing with the histrionic behaviour of adolescent girls and all had some experience in dealing with drug overdoses. The Case Group members confirmed that the way they dealt with Child J and the way they responded to her difficulties and behaviours was how they would typically manage such cases. They accepted that they were unable to recognise the difference between risky, potentially harmful behaviours and suicidal, potentially life-threatening behaviours. The reasons for this were:

- None of the professional (except the person identified above) had any training and they were not aware of the high risk indicators for suicide in teenagers.
- They dealt with each incident in isolation and they did not recognise the growing pattern of concern.
- They accepted at face value Child J’s statements that she had no intention of killing herself.
- They were deceived by the absence of symptoms of depression and their daily experiences of Child J’s presentation (between incidents) as vivacious, outgoing, engaged and forward looking.

How prevalent and widespread is this issue?

It is estimated that 25,000 adolescents present to general hospitals in England and Wales each year, but this is likely to be a relatively small proportion of the total number of teenagers who deliberately self harm. It is known that females are 3 to 4 more times likely to self harm than males and that self harming behaviour is more commonly found in teenagers than in the adult population*.

The last SCR in Cumbria was on Child F who killed himself by hanging.

In March 2011 a presentation was made to the CLSCB on suicide prevention. This was followed by the publication of a report entitled ‘Preventing Suicide in Children and Young People in Cumbria’. The report noted that the rate of suicide in Cumbria was higher than the national average.

*See:
Deliberate Self-Harm in Adolescents
Fox, Hawton 2004
Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Professionals who have daily contact with young people get to know them well and they are uniquely placed to identify difficulties at an early stage and either provide (or direct) young people to the help that they need. They play a vital role in the safeguarding system. If they are not adequately equipped to recognise increasing levels of risk of suicide in the presenting behaviours of young people, then it is unlikely that the protective potential of these important relationships will be realised.

Finding 1

A lack of knowledge among a range of professionals about the evidence base related to high risk indicators for teenage suicide leaves them ill equipped to recognise the signs and respond accordingly.

Even though Child J never admitted that she intended to kill herself and that she consistently denied, when asked, that she had such thoughts, her behaviour to the trained and experienced practitioner provided clear evidence about her intentions. The fact that the professionals involved in this case, despite their best intentions, were unable to recognise the emergence of high risk indicators for suicide in Child J and take appropriate protective action was an important missed opportunity and must be a source of considerable concern for the CLSCB if this practice is replicated across the County.

Questions for the Board

♦ Is the Board aware of ongoing difficulties in relation to recognition and response to young people at risk of suicide in Cumbria?

♦ How effective is the Cumbria Suicide Prevention Strategy and Action Plan for children and young people?

♦ Is the Board aware of the uptake and impact of guidance about the risk indicators for suicide in children produced in response to the death of Child F?

♦ What options are available to embed the learning from this review into everyday practice in partner agencies?

♦ How will the Board assure itself that Cumbria is a safer place for children and young people following this review?
Finding 2

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. (Longer term work)

Information that came to light following Child J’s death suggests that she had a ‘secret life’ that impacted significantly on what she thought and how she behaved which was almost entirely unknown to the adults in her life.

How did this issue manifest itself in this case?

There is no particular incident or event that illustrates this finding because the information about some of the influences that impacted on Child J’s decision to kill herself only came to light after her death.

What we saw in this case was two distinct worlds that never met. There was the world that Child J appeared to share with adults and the one that she deliberately concealed.

It would appear that Child J had a secret life, some of which she shared with her friends. She was in contact with a number of people about the fact that she was going to kill herself. She had difficult on-line relationships with people, some of whom were encouraging her and putting pressure on her to kill herself. She accessed websites that confirmed her belief that suicide was the solution to her difficulties and offered advice on how to do it.

In addition to this, she had low self-esteem and self-worth. She appeared to set herself impossibly high standards that she was afraid she could not meet. She was afraid of failing, of letting people down and of being unworthy. She disclosed this in one of her conversations with SC1, but this information was not shared with other School based colleagues.

Apart from SC1, none of this world was known to the adults with whom Child J was involved. The professionals who knew her were seduced by her high levels of achievement and her ability to maintain them despite the difficulties she was willing to talk about. They perceived her to be actively seeking help and they took their interactions with her at face value. They assumed that Child J shared their value base and that she prized the same things that they did. Everyone associated with Child J believed she was marvellously gifted and she had everything to live for and they believed she thought that too, so that when she said she wasn’t going to kill herself, that made sense because she had so much to look forward to.
How do we know it is an underlying issue and not something unique to this case?

The members of the Case Group who knew Child J were genuinely shocked and surprised when the details of her ‘inner world’ began to emerge after her death. The professionals involved did not consider that Child J was being secretive or that their engagement with her was anything other than meaningful. On the other hand it became clear in the period after Child J died that her friends (and lots of young people who weren’t her friends) knew a great deal about what she was going to do and why she was going to do it.

How prevalent and widespread is this issue?

There is little formal data available to evidence this finding, but recent publications* would suggest that there is a considerable body of evidence to support the proposition that adolescents live in a world almost entirely unknown to adults.

According to the literature, teenage girls experience changes in the development of the brain that lead to intense mood swings and levels of serotonin fall to the lowest level they will reach in normal development. They are also prone to high levels of emotional stress and impulsivity. At the same time they are seeking to establish their own identity, leading them to withdraw from and actively reject those adults with whom they had the closest relationships in the past. They withdraw, become secretive and fall back on small, intense friendship groups who support them and reinforce their view of the world and their place in it.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

If adults don’t recognise the impact of the changes that adolescent development has on young people, then they will not be able to communicate with them effectively. In order to do this adults need to take account of the blocks to ‘straight’ communication between themselves and teenagers and articulate it, including challenging young people when there is a discrepancy between what they do and what they say they are doing.

*See:
Raising Girls
S Biddulph
Harper Publications, 2013

Decoding Your 21st Century Daughter
H Wright
emBooks (2013)
Adults that take at face value what they are told, or assume that what they are told by adolescents when under pressure represents the true nature of affairs, are likely to be misled. Such a naïve response can persuade adults that young people are safer than they in fact are and may provide an obstacle to take protective action for those at risk of suicide.

Finding 2

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.

Adolescence is the stage of normal development that is characterised by maximum stress and confusion for young people. They are in a state of almost constant flux without the necessary equipment to navigate their way safely through the difficulties and challenges they face. At the same time, in their struggle for independence, they reject and withdraw from those who could keep them safe.

It is important that adults recognise the normal consequences and effects of adolescent development and take these into account when attempting to safeguard and promote their welfare.

Questions for the Board

♦ Was the Board aware of this issue before this review?

♦ What, realistically, can be known about the inner world of teenagers and the things that influence what they think and what they do?

♦ Is it sufficient to identify such a state exists and the part it plays in directing adolescent behaviour?

♦ If this is not sufficient, then what are the options available to explore this inner world that respects the individual’s right to privacy, but safeguards and promotes their welfare?
Finding 3

The misperception that high achieving young people who might wish to kill themselves will exhibit symptoms of depression limit the ability of professionals to recognise and respond to young people at risk of suicide. (Longer term work)

The members of the Case Group who knew Child J were genuinely shocked when she committed suicide. They saw her as a positive, forward looking young person who had everything to live for. Her day-to-day presentation did not conform to stereotypical presentation of somebody intent on killing herself.

How did this issue manifest itself in this case?

Before the concerns about bulimia arose in November 2012 Child J had always presented as an able, composed, talented and high-achieving young person. She was actively engaged in all aspects of school life and beyond and appeared confident and outgoing. In the following month there were two (and possibly three) incidents of self-harming behaviour which Child J seemed to overcome with relative ease and she was reported to have quickly re-engaged with school life and reverted to her normal self.

Following the overdose on 3rd December 2012 she was seen by GP1 on 10th December 2012 and GP2 on 13th December 2012. Both doctors noted her striking presentation, her apparent openness about her difficulties with bulimia and her willingness to receive help. GP2 noted that Child J displayed no signs of mental illness.

Child J’s presentation suggested that she wasn’t depressed. She had several conversations about her self-harming behaviour and was asked on a number of occasions whether she was likely to kill herself and she always said that she was not. The professionals believed that they understood Child J’s self harming behaviour (as a ‘normal’ teenage response to her romantic disappointment), they took Child J’s denials at face value and were reassured by what they heard. They did not entertain the possibility that she may have taken an existential position about her continued being (and concluded that it was not sustainable) or that her denials of her intent to kill herself and her ongoing ‘normal’ presentation were a subterfuge (this Finding overlaps with Finding 2).

Child J clearly did not present as being depressed and her behaviour and words did not conform to the general perceptions about suicide (you have to be mentally ill to want to kill yourself).
How do we know it is an underlying issue and not something unique to this case?

All of the members of the Case Group (with the exception of one CAMHS practitioner) shared the same belief about the connection between evidence of depression and suicidal behaviour and it was the absence of such evidence that persuaded them, in part, that Child J was not suicidal.

How prevalent and widespread is this issue?

Even though teenage suicide is a relatively low frequency event, it is still the second most likely cause of death for 15-19 year olds worldwide. The data about how prevalent the unexpected deaths of high-achieving young people is difficult to obtain but newspaper reports back to 1996 (death of Katherine Jane Morrison) and most recently June 2013 (deaths of Charlie Dibley and Mert Karaoglan reported in The Times) suggest that it is a longstanding, widespread phenomenon.

There is research available* about the suicide rates among gifted but highly self-critical young people which suggests that in the absence of any evidence of depression, a failure to meet impossibly high, self-imposed standards can provide a trigger for suicide. The research also comments that for such individuals romantic disappointment or other inter-personal upset may be more likely to precipitate suicidal action.

Child J satisfied both these criteria.

The Review Team noted that a similar misperception is held for all children and young people, not just for those who are high achievers.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

The evidence from this review would indicate that there does not have to be explicit evidence of depression for a high-achieving young person to wish to kill themselves. This finding seems to be counterintuitive and is a challenge to usual thinking about suicidal behaviour. The fact that professional people who are in daily contact with such able young people may be ‘dazzled’ by their presentation, so that they are blinded to the risks to which they are exposed make it less likely that their vulnerability will be recognised and protective measures taken.

*See:
Suicide in Children & Adolescents
Edited by Robert A King & Alan Apter
Cambridge University Press
Finding 3

The misperception that high achieving young people who might wish to kill themselves will exhibit symptoms of depression limit the ability of professionals to recognise and respond to young people at risk of suicide.

The connection between depressive illness and suicidal behaviour is well known and the presence of the former alerts professionals to the likelihood of the latter. The evidence from this review has identified that a relatively small number of highly intelligent and gifted young people, driven by the need to maintain a self-presentation of high achievement and to suppress acknowledgement of personal limitations or dysphonic feelings make the absence of reported symptoms (of depression) hard to assess. This is a difficult lesson to learn.

Questions for the Board

◆ Is it sufficient to acknowledge this as a lesson from this review and disseminate to partner agencies?

◆ Could this information be used more creatively to offer greater protection for high-achieving young people?
Finding 4

There are insufficient established processes within schools to challenge fixed mindsets that have developed around a case, meaning that initial perceptions about risks are not revised in the light of evidence of increasing vulnerability, making the prevention of teenage suicide less likely. (Management systems)

In the course of the review, the Review Team were left with a clear impression of the time demands placed on the professionals working within School 1 and the limited opportunities they had for reflective communication.

How did this issue manifest itself in this case?

Following Child J's disclosures on 30th November 2012 the staff involved believed that the core issue was that Child J needed help to recover from bulimia and overcome the traumatic experience of her sexual assault.

When Child J overdosed on 3rd December 2012 staff perceived her actions to be 'normal' teenage melodrama following the break-up with her boyfriend. The conversation between staff members about the events of 3rd December 2012 were 'snatched' hurriedly between the demands of their normal daily roles. A similar pattern of brief 'information exchange' conversations was repeated throughout the period under review. These conversations took place in the context of extremely busy school days and their purpose was to keep up-to-date with Child J's presentation and progress. There was no opportunity to stop and think about what was happening or to check out the hypothesis about the nature and meaning of Child J's behaviour in the light of changing information. These conversations worked successfully to reassure the professionals involved that their understanding of what was happening was correct and there was no need to be more concerned (the influences of Findings 1 and 3 were important factors in this process).

How do we know it is an underlying issue and not something unique to this case?

The input to the review from the professionals who worked at School 1 reported that this pattern of communication was typical of normal practice. The opportunities to speak to colleagues tend to occur between and after classes when there are invariably time pressures to complete other aspects of their jobs.
How prevalent and widespread is this issue?

There was limited data from the review on how widespread this issue is, but anecdotal evidence from the Lead Reviewer and members of the Review Team would suggest that the pattern of information exchange and non-reflective practice evident in this case was fairly common locally and nationally. It is not uncommon for pastoral responsibilities to be added on to the individual’s substantive role responsibilities so opportunities to challenge and reflect on the sense they are making about each particular young person’s situation are quite rare.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Schools are ideally placed to identify children who might be at risk of harm or self-harm, to monitor their progress and take action when necessary. In order to do this effectively, professionals must be able and prepared to challenge the sense they are making of young people’s situations as they unfold. The difficulties associated with challenging our own cognitive biases and reviewing initial formulations of risk are well known and in work cultures that demand constant activity at the expense of reflective practice it is highly likely that initial, possibly erroneous, assessments of risk will go unchallenged. This situation clearly introduces an additional level of risk into the child protection system.
Finding 4

There are insufficient established processes within schools to challenge fixed mindsets that have developed around a case, meaning that initial perceptions about risks are not revised in the light of evidence of increasing vulnerability, making the prevention of teenage suicide less likely.

The experiences of staff working with Child J are thought to be typical of professionals working in secondary schools generally. There is no question that the staff involved were deeply concerned about Child J and that they wanted to do the best that they could for her, but that the daily demands of their respective substantive roles precluded opportunities to stand back and reflect on her behaviour and presentation and challenge their original conclusions about what they were seeing and the risks to which she was exposed. The members of the Case Group were unable to offer any suggestions about how this situation could be resolved.

Questions for the Board

♦ What importance does the Board give to this finding?

♦ What are the options available to assist professionals in similar situations achieve different outcomes for young people at risk of suicide?

♦ Is it sufficient to articulate this issue and recognise it as an inevitable consequence of current secondary school life?
Finding 5

The pattern of agencies ‘investing in’ CAMHS as if it is a functioning service and the solution to young people’s difficulties when they know its not, creates a false reassurance that children will receive the help that they need in a timely fashion leading vulnerable young people to become even more vulnerable. (Longer term work)

In the course of the review it became evident that CAMHS staff recognised that the service it provided was not fit for purpose and that other professionals believed that a referral to CAMHS did not guarantee a safer outcome for a young person at risk of suicide.

How did this issue manifest itself in this case?

Following the incident on 3rd December 2012 when Child J took a Paracetamol overdose, she was seen on the following day by SN1 who agreed to make a referral to CAMHS. SN1 informed Teacher 1 and Teacher 2 of what she had done and they were reassured and relieved that Child J had been signposted to the Service they believed would help her deal with her difficulties. When Child J saw GP1 on 10th December 2012 and GP2 on 13th December 2012, both doctors were of the opinion that the referral to CAMHS was the appropriate course of action and that Child J would get the help she needed. SC1 was also aware that Child J had been referred to CAMHS and recognised that her role was to offer Child J support until the time she could access more specialist support.

In the event, the confidence that each of the professionals involved invested in CAMHS was misplaced. There was no response to the delayed referral from SN1 on 10th December 2012 and there was no response to the second referral on 20th December, despite clear evidence that the risk of Child J’s suicide had increased (due to the emergence of the suicide letters). When the second referral was re-triaged on 28th December 2012 and a decision was made to offer Child J an urgent appointment, her case was not allocated until Parent 2 made direct contact with CAMHS on 2nd January 2013.

How do we know it is an underlying issue and not something unique to this case?

In discussion with Case Group members it was revealed that professionals did not have very high expectations of the response from CAMHS to the referrals they made. Professionals commented on the extreme delays before any response is made to referrals and that when this does happen, it is not clear who is being seen by whom. Professionals reported that it was not uncommon for there to be no notification of the end of CAMHS involvement or the outcome of the intervention.
The staff from CAMHS described the Service as being in a state of chaos and that Child J’s case was not unusual. They reported long standing deep seated difficulties and referred to low levels of morale, high staff turnover and sickness absence. Staff commented on the frequent changes of senior managers and the consequent lack of leadership and direction.

How prevalent and widespread is this issue?

Following the death of Child F in September 2010 a Serious Case Review was commissioned which reported to CSCB in September 2011. The report identified significant failings in the services provided to Child F by the South CAMHS Team. These failings mirror almost exactly the issue and concerns identified by the members of the Case Group and Review Team in this case, namely: poor management systems, an absence of effective leadership, control and direction, low staff morale, high staff turnover and sickness levels, inadequate practice in relation to risk recognition and response, and poor information sharing.

The findings from this review would suggest therefore that the situation in January 2013 remained unchanged from what it was in 2010 and that the response to any young person with Child J’s difficulties would remain inconsistent across the South CAMHS catchment area.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

For the child protection system to be safe it requires CAMHS to provide effective, reliable, therapeutic help to young people who self-harm and may be at risk of suicide. For this to happen, the Service needs to be well organised, well managed and adequately resourced with practitioners with the necessary range of skills to provide a timely and effective response to young people at risk of suicide.

In the current situation, and in the absence of a viable alternative, professionals make referrals to CAMHS in the hope (but not necessarily the expectation) that they will receive the help that they need. They may be falsely reassured by this process, but in reality it does little to safeguard and promote the welfare of young people at risk of suicide.
Finding 5

The pattern of agencies ‘investing in’ CAMHS as if it is a functioning service and the solution to young people’s difficulties when they know it is not, creates a false reassurance that children will receive the help that they need in a timely fashion leading vulnerable young people to become even more vulnerable.

This case presents an example of professionals from other agencies recognising Child J’s difficulties (even though they did not appreciate their full extent) and making more than one attempt (via SN1’s referrals) to elicit a response from CAMHS. It could be argued that the information in the first referral warranted the measured response it attracted, but the information in the second referral, with clear evidence of suicidal ideation merited a more immediate response. The fact that such a presentation did not attract such a response introduces an unacceptable level of risk into the system.

Questions for the Board

♦ Given that similar concerns to those outlined above were reported to the Board in 2011, why was the situation in South CAMHS allowed to remain unchanged?

♦ What remedial action does the Board think is required to enable CAMHS to provide a safe and effective service for young people at risk of suicide?

♦ What does the Board think is an appropriate timescale for the necessary changes to be made?

♦ How will the Board assure itself that the necessary changes have been made and maintained?
Finding 6

Does the reliance of professionals on the perceived ability of apparently engaged, professional, parents to protect their children from the risk of suicide effect professional judgement and the need for safeguarding activity? (Family-professional interaction)

Child J’s parents were extremely concerned about her safety and welfare, and they were actively involved with professionals in trying to protect her. The review has identified a lack of clarity in the expectations of professionals when working in partnership with parents in trying to protect their children from risk of suicide.

How did this issue manifest itself in this case?

There were a number of occasions in the time between the concerns about Child J coming to light and her suicide when professional judgement about how to proceed were affected by their perceptions about her parents’ ability to keep her safe.

An example of this was the events of 3rd December 2012 when Child J took a Paracetamol overdose. When Teacher 1 and Teacher 2 were in conversation about how to proceed they became aware that Child J’s parents had been alerted to their daughter’s difficulties and decided that no further action was necessary. They did this because they believed Child J’s parents were in control of the situation and Parent 2 (as a doctor) was capable of making informed judgements. On the following day when it was learned that Child J had not been taken to hospital for treatment or psychiatric assessment, this course of action was accepted without demur by the professionals involved. In the course of the conversations and follow-on discussions with the Case Group, professionals said that if the same set of circumstances had arisen in a different family, then they would have certainly involved CSC and/or the Police.

A further example occurred on 21st December 2012 when Teacher 1 phoned Parent 1 to tell him about Child J’s stated intention to kill herself over Christmas. Teacher 1 felt that telling Parent 1 would offer Child J the protection she needed over the Christmas period when no other help was available. Parent 1’s response to the call was to become angry and anxious. He was desperate to keep his daughter safe, but he had no idea how he could do it and he had no access to help over the period when Child J was likely to be at the greatest risk.
How do we know it is an underlying issue and not something unique to this case?

It is difficult to generalise about this issue on the basis of this case and it is for this reason that the Finding is presented in the form of a question, rather than a statement. The Review Team did not wish to over-claim for this Finding on the basis of the limited data available.

It emerged from the conversations that Child J’s parents enjoyed (along with a number of other parents with equally gifted children) a special relationship with the School which impacted on the way they interacted with staff and affected the way they were dealt with.

How prevalent and widespread is this issue?

Again, the data on this issue is difficult to locate. The effects of class as a pseudo-protective factor are well known and the difficulties that agencies have in challenging the actions of ‘professional’ parents have been noted in a number of Serious Case Reviews nationally.

Very little is known about how prevalent or widespread this practice is in relation to young people at risk of suicide.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

We know that safer child protection systems need reliable ways of engaging with parents as well as the young people themselves who may be at risk of harm. There are tensions inherent in the relationships between professionals charged with safeguarding responsibilities working with professional parents in relation to shared values, language and the tendency to regard them as equals (‘people like us’). These tensions may lead to a confusion between working in partnership with such parents and treating them as partners. If we confuse working in partnership with treating parents as partners, it may limit professional safeguarding activity and prevent young people accessing the services they need. It may also put unrealistic expectations on otherwise helpful parents and place on them a burden of responsibility they are not equipped to carry.
Finding 6

Does the reliance of professionals on the perceived ability of apparently engaged, professional, parents to protect their children from the risk of suicide effect professional judgement and the need for safeguarding activity?

Since the implementation of the Children Act 1989 working in partnership with parents has been seen as a key element in achieving best outcomes for children at risk of significant harm. There is no question that in this case Child J’s parents were actively and positively involved with professionals in trying to keep their daughter safe. The professionals involved were reassured by their engagement and, as a consequence, did not act as they would have done if Child J’s parents had not been so apparently capable and involved. The professionals involved mistook parental activity for protection and did not recognise the stress it caused them to share equally the responsibility for keeping Child J safe.

Questions for the Board

♦ Was the Board aware of this issue?

♦ What would be an appropriate level of expectation for working in partnership with parents of children at risk of suicide?

♦ What guidance and support is needed for staff in relation to partnership working with professional parents?

♦ How could improvements in these arrangements be identified and reported back to the Board?
Finding 7

Does the structure of the risk assessment tools and the way they are used provide an aid to professional understanding of the true level of risk of suicide in vulnerable young people? (Tools)

Child J was the subject to two risk assessments throughout the period under review. One was conducted face-to-face at a meeting at CAMHS and the other was a paper exercise completed by SN1.

How did this issue manifest itself in this case?

Child J was the subject of a risk assessment when she attended CAMHS on 3rd January 2013. The worker that undertook the assessment used a standard GRiST assessment tool. The outcome of the assessment (that Child J was at medium risk of suicide and high risk of self-harm) was based entirely on Child J's self-reported information. There is no evidence that the information that was provided was interrogated by the assessor and there appears to have been no consideration of the sources of error and bias that are common with clinical assessments. There is no evidence that the information that was collected through the assessment was analysed for meaning and, in fairness to the assessor, no place on the recording tool where such an analysis is invited.

SN1 undertook a risk assessment on Child J on 18th December 2012. This assessment was completed entirely from records using a ‘standard risk assessment tool’. The outcome of the assessment is similar to that obtained from the GRiST assessment – essentially, a description of Child J’s presenting behaviours and circumstances, and a list of perceived protective factors.

How do we know it is an underlying issue and not something unique to this case?

The practitioners from CAMHS reported that the completion of the GRiST was standard practice and it is in effect the ‘ticket’ that young people have to have in order to access services from CAMHS. The CAMHS practitioner that completed the GRiST assessment had not received any training in its use.

SN1 reported that the standard risk assessment on Child J was completed to comply with a senior management directive. The forms were distributed with no directions on how to use them.
How prevalent and widespread is this issue?

It would appear that the GRiST and Standard Assessment Tool are used universally across Cumbria.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

The proper understanding of the nature of risk and the ability to assess it and analyse it to reach accurate formulations that inform effective intervention strategies is fundamental to any safe child protection system.

The assessment and analysis of risk needs to be founded on a sound understanding of the issues at hand with the tools (recording instruments) being used as an aid to professional practice, not a substitute for professional thinking. Without the necessary analytical rigour of the information obtained through the process of assessment (taking into account error and bias) there is a risk of practitioners reaching false negative conclusions about the likelihood of future self-harming and suicidal behaviour. The current reliance on risk assessment tools to complete this complex professional task introduces increased risk into the child protection system.
Finding 7

Does the structure of the risk assessment tools and the way they are used provide an aid to professional understanding of the true level of risk of suicide in vulnerable young people?

The poor quality of risk assessments is a common theme in Serious Case Review findings and has been commented on regularly in the biennial reports on SCR’s by Brandon et al (2003-2011). The focus on assessment tools and procedures as a means to unify the understanding of risk at the expense of developing sound professional understanding of the issues at hand has introduced a false sense of security into the child protection system. The risk assessments that were undertaken in this case, completed by practitioners who had little understanding of the risk of suicide and no training in how to assess it, added little to the understanding of what was going on for Child J or how she could be best supported. Deficiencies in the assessment and practice in relation to risk of suicide were clearly identified in the IMR completed by CAMHS following the death of Child F and an action plan was developed to address these shortfalls. It would appear from the outcome of this review that insufficient progress has been made on this issue.

Questions for the Board

♦ What is the Board’s view on this finding?

♦ Given that the issue of poor risk assessment was highlighted in the Child F SCR, does the Board understand why the issues raised in that review have not been addressed?

♦ Is the issue of inadequate risk assessment and analysis confined to the agencies that were involved in this review?

♦ What options are available to improve the quality of risk assessment and analysis across the County?

♦ How can the Board be assured that young people at risk of suicide are being effectively assessed and provided with timely and effective services?
Finding 8

Does the absence of quality assurance measures in relation to the recruitment and activities of independent people providing counselling and emotional support services to schools compromise the safety and welfare of young people? (Management systems)

A striking feature of this case is the degree of trust and confidence that was invested in the support that Child J was offered from School 1’s counselling service prior to her being seen by CAMHS and the subsequent concerns that arose as a consequence of this arrangement.

How did this issue manifest itself in this case?

Child J was referred to SC1 immediately following her disclosure of bulimia on 30th November 2012 and she was seen on three occasions before the end of term on 21st December 2012.

By virtue of her role, people invested confidence in the advice that SC1 gave, despite not known how she got the job or what her area of expertise was. Because she was independent and School 1 was keen to offer this support to young people, her activities were not monitored and the content of sessions she had with Child J were protected by client-professional confidentiality. Despite the implied status of her position, some of the advice that she is described as having provided proved misguided. School staff describe how they were reassured by the categorical, but false, reassurance from SC1 that Child J’s suicide letters were of no consequence.

The sessions between Child J and SC1 took place in school time and Parent 1 described how on at least one occasion Child J had told him she had been deeply upset in the course of the session with SC1, but had been allowed to return to her lessons.

How do we know it is an underlying issue and not something unique to this case?

There is limited data available to confirm whether the arrangements in School 1 are typical of the recruitment and management of counsellors generally. Members of the Case Group confirmed that because SC1 was in post, they simply assumed that she had the necessary qualifications, experience and expertise to practice. It was not known how she acquired her position.
How prevalent and widespread is this issue?

It is known that SC1 worked across a number of schools across Cumbria and that other schools, both locally and nationally, employ people like her. It is not clear whether the recruitment processes for such people are robust and whether there is any quality assurance of the services they provide.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

It is laudable that School 1 wished to provide access to independent counselling support for young people experiencing emotional distress or personal difficulties. However, such young people are entitled to safe, secure, nurturing help. School Counsellors can play an important part in the range of help and support offered to young people but there is a need to recognise the limitations of such a service. Over-investing in the capabilities of Counsellors to support young people in extreme distress can cause extra harm and give false reassurance to other professionals, parents and children and young people themselves.
Finding 8

Does the absence of quality assurance measures in relation to the recruitment and activities of independent people providing counselling and emotional support services to schools compromise the safety and welfare of young people?

It would appear that SC1 played a small, but highly significant role in this case. Her advice to School staff was instrumental in determining the course of events following the discovery of Child J’s suicide letters. She also had free access to Child J on three occasions without School staff being aware of the impact of these sessions on Child J’s welfare.

The process of the review has revealed that a number of professionals invested a degree of confidence in the services provided to Child J by SC1. However, no-one knew whether SC1 was qualified or sufficiently experienced to provide such services or whether whatever services were provided were helpful for Child J.

Questions for the Board

- Was the Board aware of this issue in Cumbria?
- What guidance does the Board think is necessary for those agencies wishing to recruit independent counselling services?
- What is the appropriate balance between the need to protect client-professional confidentiality and the need to quality-assure the services provided to vulnerable young people?
- What assistance can the Board offer in relation to this issue?
Finding 9

The general lack of confidence by partner agencies in Children’s Social Care (CSC) to accept referrals and take protective action reduces the likelihood that partner agencies will make contact about children at risk of suicide. (Longer term work)

When young people talk about or behave in ways that suggest they might want to kill themselves, this clearly raises the issue of likely significant harm. Assessing and managing significant harm is the core business of CSC. It was a characteristic of this case that, although a number of professionals were genuinely and seriously concerned about Child J’s safety, they did not consider making a referral to CSC.

How did this issue manifest itself in this case?

On the evening of 3rd December 2012 Teacher 2 was contacted by one of child J’s friends to report that she had sent a text saying that she had taken an overdose. This was a somewhat unusual experience for Teacher 2 and she was at first unsure how to proceed. She considered a call to CSC but did not do so and instead phoned her colleague, Teacher 1 (the events of the evening unfolded as described in the ‘appraisal of practice’ earlier).

On the following day Teacher 2 spoke again to Teacher 1 and they discussed the possibility of a referral to CSC but decided against this, as they believed such a referral would be unlikely to elicit a positive response.

How do we know it is an underlying issue and not something unique to this case?

The issue of making referrals to CSC was discussed by the Case Group and the Review Team at the second Follow-on meeting. Members of the Case Group gave numerous examples when they had made referrals to CSC, many of which they said were about children at greater perceived risk than Child J, that received no response. They talked about being fobbed off, having referrals ‘bounced back’ to the referrer and multiple requests to complete a CAF, even when this had proved ineffective in the past or when the referring professional believed the case had moved beyond the level of CAF intervention.

The Case Group did acknowledge some responses to individual cases were satisfactory, but the general feeling was that CSC as an agency were held in low regard and that the anticipation of a poor response deterred professionals from making contact.
How prevalent and widespread is this issue?

It is difficult to comment on how prevalent and widespread this issue is as it is evidenced by what people don’t do (have confidence and make contact) rather than what they do.

There is some evidence to support the view that the concerns of professionals in this case may be representative of wider concerns from the most recent Ofsted Inspection Report (May 2013) which found that the overall effectiveness of the arrangements to protect young people in Cumbria was inadequate, as was the quality of practice and the leadership and governance.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

A well functioning child protection system relies on the sharing of information between agencies. When there are concerns about children suffering or likely to suffer significant harm, CSC should be the central point of reference to take action where necessary, to provide advice and consultation and to maintain a record of concerns so that patterns and escalations can be identified. The services provided by CSC are dependent on the information they get from other agencies and the willingness of other agencies to communicate with CSC is dependent upon the response that they receive.

The lack of mutual trust, respect and confidence among key partner agencies which may impact on the willingness of professionals to communicate with CSC introduces an avoidable risk into the child protection system.
Finding 9

The general lack of confidence by partner agencies in CSC to accept referrals and take protective action reduces the likelihood that partner agencies will make contact about children at risk of suicide.

The safeguarding service provided by CSC is dependent on the information it receives from partner agencies about children thought to be at risk of significant harm. A lack of confidence by the partners in the willingness and ability of CSC to respond appropriately to expressions of concern makes it less likely that contact will be made and, as a consequence, young people at risk of suicide may not receive the protection they require.

Questions for the Board

♦ Was the Board aware that this was an issue within the multi-agency system?

♦ What changes do the Board think are necessary to restore partner agencies’ confidence in CSC?

♦ What is an appropriate timescale for these changes to be made?

♦ How will the Board be assured the necessary changes have been made and maintained?