CONFIDENTIAL

BUCKINGHAMSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD F

FERGUS SMITH

17.07.13

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1 INTRODUCTION

1.1 DEATH OF 'CHILD F' AND RESPONSE OF THE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

1.1.1 Child F was a young woman in her mid teens who had been born overseas, and was of Asian heritage. It is understood that the family had moved to the UK when child was about eight years old and that her parents had separated in 2011. Child F who had an older sibling at university, lived alone with her mother.

1.1.2 From late 2011, as a result of distress she attributed to her family, child F sought help from several professional sources. During the first half of 2012, child F was in receipt of pastoral services at her school and one-off or ongoing services from several other local agencies.

1.1.3 In the early Summer of 2012 child F is understood to have used a tie to hang herself from a door handle in her bedroom. The Coroner's verdict following an Inquest in early 2013 was that child F had taken her own life.

1.1.4 The serious case review sub-committee of Buckinghamshire's Local Safeguarding Children Board (LSCB) met soon after child F's death and consider whether the case satisfied the criteria for conducting a serious case review (SCR). Each of the agencies which had provided services to child F and/or her mother in the months prior to her child F' death was asked to submit a chronology of its involvement.

1.1.5 Having considered the then available evidence, the sub-committee concluded that the case did not *at that stage* satisfy the criteria for a SCR. It did though, agree that further checks and enquiries should be completed and a local 'partnership review' be completed.

1.1.6 This recommendation was made known to and agreed by the independent chairperson of Buckinghamshire's LSCB. It was also shared with and accepted by the Department for Education. At an 'extra-ordinary' meeting of the SCR sub-committee in November 2012, members debated the case at length, remained of the belief that learning and implementation of organisational lessons would best be facilitated by completion of a local partnership review but were again clear that the matter needed to be kept under review.

1.1.7 Information later received indicated there had been difficulties in inter agency communication and this caused panel members to conclude the case *should* be raised to the status of a formal SCR. This recommendation was put to and agreed by the LSCB chairperson on 19.11.12 and on the same day the Department for Education (DfE) and Ofsted were informed of that decision.

1.1.8 The parents were informed of the initiation of a SCR by letter and their further involvement in its conduct was sought as described later in this report.

1.2 PURPOSE OF THE SERIOUS CASE REVIEW

1.2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 (SI 2006/90) requires LSCBs to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children* HM Government 2010 [the relevant guidance at the time this SCR started].

1.2.2 An SCR should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and

As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.2.3 A SCR is not an inquiry into *how* a child died or any culpability for their death. These are matters for the Coroner and criminal court respectively.

OVERVIEW AUTHORSHIP

1.2.4 An independently authored overview report was commissioned from CAE Ltd (www.caeuk.org) (an independent social work consultancy with experience of some forty SCRs). It was agreed that upon submission of all relevant material, author Fergus Smith would, in accordance with the detailed terms of reference appended to this report:

Collate and critically appraise all IMRs and other documents

Develop for consideration by the SCR panel, an analysis, conclusions and recommendations for action by Buckinghamshire's Safeguarding Children Board, its member agencies and, (if relevant) other local or national agencies

INDEPENDENT CHAIRPERSON

1.2.5 The SCR panel was chaired by Paul Kerswell who had no connections with any of the agencies that provided services. Paul is a registered social worker who has extensive experience of practice and senior management in Children's Social Care Departments as well as chairing panels and developing reports for SCRs.

1.3 ARRANGEMENT OF THE OVERVIEW

1.3.1 So as to render more accessible a significant amount of detail, the remainder of this report is laid out as follows:

An executive summary of the full report

Conduct and effectiveness of the SCR process

Family details including a genogram of relevant family members

A brief description of agency involvement prior to the review period

A more detailed chronological account of agencies' involvement during the review period, highlighting key events and professional decisions

An analysis of the extent to which records demonstrate best practice with respect to the issues in the terms of reference i.e. general *Working Together to Safeguard Children* 2010 [the relevant statutory guidance when the SCR was started, though superseded in April 2013 by a revised edition] and additional case-specific points

Overall findings and conclusions

Practical recommendations for the LSCB and member agencies that are specific, measurable, achievable, realistic and timely

A glossary of abbreviations

A bibliography of general and case-specific literature of relevance

Appendix: terms of reference

1.4 EXECUTIVE SUMMARY

Background and decision to convene a serious case review

1.4.1 Child F was a young Asian woman who in July 2012, took her own life. During her last year of A level studies, child F had often shared with school staff and several other professional sources, a high level of distress which she attributed to her family.

1.4.2 After initial consideration of a less formal approach to the learning that might emerge from the loss of child F, the multi-agency serious case review sub-committee of Buckinghamshire's Local Safeguarding Children Board (LSCB) concluded the case *should* be raised to the status of a formal serious case review. The focus was to establish what lessons might be learned about the responses of local service providers and identify practical ways in which improvements might be made to better meet the needs of young people in similar circumstances to child F.

1.4.3 This recommendation was put to and agreed by the LSCB chairperson and the Department for Education and Ofsted were informed in December 2012. Parents were informed of the initiation of the serious case review and their involvement sought. For personal reasons they elected not to participate directly, but were informed of the recommendations, their acceptance and action plans of each agency as a result of the serious case review.

Conduct of serous case review

1.4.4 The individual management reviews provided by each of the six relevant agencies were drafted by a suitably experienced professional within the organisation who had had no involvement in the services provided to child F. These reports were of a good standard. The overview report was greatly assisted by the provision of an expert 'health overview' which pulled together and offered interpretation, when needed of health-related issues.

1.4.5 The independent overview author and independent chairperson of the panel which convened to discuss reports received, have considerable experience of serious case reviews and no personal or professional connections with any person or agency involved in work with child F.

1.4.6 Completion of this serious case review was delayed by about two months in part because some reports were submitted after agreed dates and in part because it emerged during the course of the review that information from two other agencies not originally identified would be relevant.

1.4.7 Only those details that might serve to identify the family have been removed from what is in all other respects a full and frank account of services provided to child F and her family. This section provides a very brief executive summary of the full report.

Findings of the serious case review

1.4.8 The full report provides a detailed analysis of the following broad findings.

1.4.9 There were examples of 'good' practice by professionals (i.e. *exceeding* what would be expected in comparable cases):

The school's persistence in offering pastoral and academic support and in its attempts to engage Children's Social Care

The speed and thoroughness of an initial Police response in January to a plea for help by child F

A dietician who responded to child F's request to consult her without her mother being present

The frequency of contact with, and efforts made to support child F by Child & Adolescent Mental Health Service (CAMHS) staff

The recognition by GPs of child F's right to confidentiality and the efforts made to strike a balance between that right and the overriding need to ensure her survival

1.4.10 There were also several examples of practice which fell below the minimum standard a service user might reasonably expect:

A widespread misunderstanding amongst local agencies (the exception being the Police) that for purposes of child protection, a child remains a child until s/he is eighteen and how to ensure that the provisions of s.20 Children Act 1989 (provision of accommodation) are made to work for vulnerable individuals

A *serious* Children's Social Care management failure to understand or comply with the duties of either s.17 (safeguarding and promoting the welfare of child in need), s.20 (provision of accommodation) or s.47 (duty to make enquires if significant harm is suspected) Children Act 1989

An unrecognised need across the involved agencies (in the context of that agency resisting involvement) to *escalate* concerns through the Children's Social Care hierarchy

A belated and ineffective involvement of the family support team and allocated social worker by a Children's Social Care manager (which undermined the value of the support worker's efforts)

Conclusions

1.4.11 Some agencies e.g. school and CAMHS expended a considerable amount of energy and time in commendable efforts to understand and respond to child F's high level of need and to mitigate the risks this posed.

1.4.12 Children's Social Care responses failed to assess need and risk and the need for alternative accommodation or care.

1.4.13 The consequences of the reluctance in Children's Social Care to meet its responsibilities were compounded by a number of factors:

A shared uncertainty across the network about relevant law and about the extent to which child F could or should use adult-oriented services

A lack of awareness of or a reluctance to use an 'escalation policy' so that the repeatedly poor responses of Children's Social Care could be challenged

Insufficient appreciation of the fact that without regard to the nature of child F's A psychiatric / psychological symptoms, her social needs could not be met by educational or CAMHS professionals alone i.e. Children's Social Care involvement was critical not optional

2 REVIEW PROCESS

2.1 RELEVANT AGENCIES

2.1.1 The following agencies were identified as having or likely to have information and opinions of relevance to the serious case review:

Child F's school (providing 'year 12' / '6th form' education and pastoral care – child F had been a pupil there since September 2006)

Thames Valley Police (completing a welfare check in response to an alert from child F's school)

GP Practice (providing community based medical services)

Children's Social Care (involvement of which had been sought by other agencies and which, in May 2012 allocated a social worker)

Buckinghamshire Healthcare NHS Trust (BHT) (emergency medical care and hospitalisation at a local General Hospital as well as dietetic and school nursing services)

Oxford Health NHS Foundation Trust (providing child and adolescent mental health services)

2.2 TIMETABLE FOR SERIOUS CASE REVIEW

ORIGINAL AND REVISED

2.2.1 Terms of reference (appx.1) were negotiated on 18.01.13 and the 08.02.13 was agreed as the deadline for receipt of chronologies from agencies. Individual management reviews were due by 01.03.13 and any required revisions by 22.03.13. First drafts of this report and a health overview were anticipated by 02.04.13 and the panel planned to consider and agree second drafts on 09.04.13 and 'sign off' final versions and agreed action plans on 24.04.13.

2.2.2 In the event, final versions of all required reports including a health overview were received by 21.05.13. In the course of the SCR, it also emerged that Connexions and Women's Aid had had some involvement with child F and brief reports were sought. This final draft reflects information derived from those agencies.

2.3 FAMILY INVOLVEMENT

2.3.1 The overview author wrote (separately) to parents to introduce himself and encourage their joint, or if preferred, separate contributions. No initial response was received and it was the author's intention to send a further invitation at the point when *all* relevant material became available. This was pre-empted when child F's father made contact by phone. The author re-iterated the value of hearing directly from the parents about their experiences and offered to meet wherever and whenever they preferred.

2.3.2 Child F's father explained that he and his wife were currently preoccupied by a significant family situation. They could not envisage even a postponed meeting to talk over the distressing details of child F's experiences.

2.3.3 The *major* point that the bereaved father wished to make was that when the consultant psychiatrist (psych.1) met him and his daughter shortly after a further episode of self-harming, her suicidal thoughts, *should* in his view, have been better recognised as an indicator of what was to come.

2.3.4 Child F's father was content to be informed of the progress of the serious case review and to be alerted when the overview report was to be published. To this end, he provided an email address and the author undertook to ensure that he and his wife were updated prior to publication.

2.4 TRANSPARENCY AND CRITIQUE OF PROCESS

2.4.1 The SCR panel had agreed at its first meeting that in order to maximise learning opportunities, make agencies' self-examination transparent, and to satisfy the legitimate need for professional accountability, the final overview report would be published in its entirety.

2.4.2 This report therefore provides a comprehensive account, though the provision of details such as dates of birth, death or any others that could lead to the identification of individuals in the family or within involved agencies have been minimised.

2.4.3 In the light of what was known then about child F and her family, the time period selected for the SCR was appropriate. The terms of reference also explicitly allowed for the possibility of an agency addressing any event that fell outside of the defined review period and one agency did so.

2.4.4 The merged chronology was well presented and the standard of most individual management reviews good. Premature (and different) ascription of anonymised labels for professionals within each report made it difficult to determine the identity of persons to whom reference was made. Following confirmation of relevant identities and roles, a common nomenclature is used in this overview.

2.4.5 All individual management reviews were drafted by sufficiently independent and experienced authors and the panel's scrutiny of each ensured that their final versions were of a high standard.

2.4.6 A 'health overview' report offered a *very* helpful summary of contacts with health agencies and professionals, invaluable references to relevant research and codes of practice / expectations of professional bodies and added a further recommendation to those identified in the individual management reviews from health agencies.

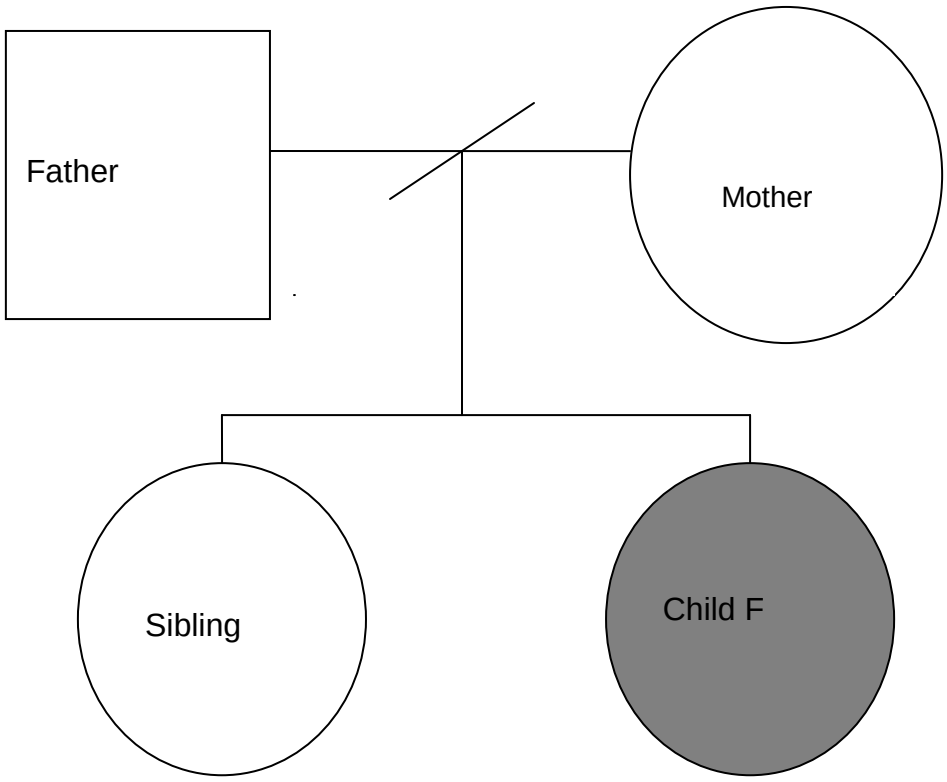
2.4.7 Though their inclusion reflected the thoroughness of the process, the contents of the material from Women's Aid and Connexions' essentially offered only corroboration of other agencies' records and overall findings.

2.5 FAMILY DETAILS

MEMBERSHIP & LOCATIONS

Name	Gender	Relationship	Ethnicity
Child F	Female	Subject	Asian
Sib		Sibling	Asian
Mr	Male	Father	Asian
Mrs	Female	Mother	Asian

GENOGRAM



3 AGENCY CONTACT WITH FAMILY PRIOR TO REVIEW PERIOD

3.1 INTRODUCTION

3.1.1 A merged chronology of the involvement of all agencies provided a summary of contacts from 2006 (when child F began attending her school) to her death in 2012. There are no indications of concern about child F before the period under review. She was described by her family as a loving and happy younger child, though her mother did indicate that she had observed a gradual change over the last two or three years and difficulties between mother and daughter and between the siblings.

3.1.2 Section 3.2 below outlines the only incident of note in this pre-review period.

3.2 INCIDENT AT SCHOOL

3.2.1 There were no incidents of concern in her first year but in early 2008, child F was recorded as claiming to be 'protected by Jeffree Star'[1], whose 'photo she was holding, because her teacher was said to be 'killing her in her dreams'. A subsequent record refers to a phone call from child F's mother, saying she had spoken to her about the difference between dreams and reality; her daughter was 'fine and there would be no more problems'.

3.2.2 Later the same month, child F brought in what was recorded as an 'unusual' handwritten letter and a gift for the same teacher. The letter again referred to her fear of this individual. Child F made no allegations.

3.2.3 The school responded by calling a meeting with the deputy head and head of school and both parents. It was agreed that the parents would consult their GP, supervise child F's use of the internet, and encourage her to spend more time with other family members, rather than alone in her room.

3.2.4 Later that month a letter was received from mother indicating that child F's GP 'did not feel that the child required professional help'. The individual management review of GP services confirmed that consultation.

3.2.5 A subsequent meeting was held in which the head of school explained to child F that she would be moving teaching groups for technology, that she should not contact the teacher to whom she had written, and could access support networks in school if she needed them.

[1] An American model, fashion designer, makeup artist, DJ, and singer-songwriter who started his music career on MySpace. He is known for his fashion line and his transgressive, 'gender-bending' appearance and persona.

4 PERIOD OF REVIEW: AUGUST 2011 – DATE OF DEATH

4.1 INTRODUCTION

4.1.1 This section provides in more detail the events and professional judgements in the period from August 2011 to child F's death. The first event of significance arose within child F's school.

4.2 EVENTS OF SIGNIFICANCE

ANXIETY ABOUT ACADEMIC RESULTS, MOTHER AND WEIGHT

4.2.1 At the end of Year 11, following GCSE results being published, child F met the '6th form student manager' and commented that her results were not as good as expected, and that her mother would be disappointed with her.

4.2.2 Child F began her 'year 12' studies in September 2011 and was supported by an academic mentor. During the initial weeks of that school year, the school noted some academic, and some other concerns relating to weight loss and child F's relationship with her mother. The academic mentor felt she was providing emotional rather than academic support.

4.2.3 In the course of September and October 2011, child F made frequent visits to the 6th form student manager, often in tears, complaining of being 'not very clever' and finding the work difficult. She is reported to have said 'it is not procrastination, it is paralysis'.

4.2.4 At a consultation with GP1 in early October, child F presented with problems of anxiety and anger and agreed to self-refer to the Youth Enquiry Service (YES) (a local self-referral counselling and advice centre). Her further concerns about chronic fatigue and eating-related issues were responded to by arranging blood tests and initiating a referral to a dietician.

FURTHER ANXIETY: WEIGHT AND MOOD STATE

4.2.5 Early in November, she spoke to her academic mentor about wanting to be thin, and not to have periods. The student welfare manager recommended speaking to her parents, and seeking Child and Adolescent Mental Health Service (CAMHS) involvement by means of a referral from her GP.

4.2.6 Further action was taken the following day, in a meeting to discuss the pupil's concerns about her weight. She agreed to talk to her mother, with whom the school also made contact. School records suggest that mother organised an appointment with a dietician in response to the school's alert (though a referral to the dietetic service had already been made by the GP).

4.2.7 Child F presented again at her GP Practice in early November 2011 and was seen by GP2 who noted the following:

Low mood
Not suicidal
Parents split
Not getting on with mum
Tearful at school and advised by teachers and friends to seek advice

4.2.8 The doctor organised a height and weight check and body mass index (BMI) was calculated. Child F was given written information about 'Healthy Minds' (a service for anyone aged eighteen or over feeling depressed, anxious or stressed and who has a GP in Buckinghamshire). Child F was then 17 years and 2 months old. Two weeks after her consultation with the GP, child F self-referred to the Youth Enquiry Service (YES) and was placed on its waiting list.

4.2.9 In late November child F was seen by the dietician who noted that mother's presence made discussion difficult. Mother confirmed the school's report of child F's eating difficulties, the parental separation and that, as an A* pupil, child F was under considerable pressure to do well. The relationship between mother and her daughter was seen to be strained

4.2.10 Within her school child F was still often distressed, walking out of lessons, and unable to put advice given into effect. In mid December 2011, the Youth Enquiry Service (YES) contacted child F to confirm she was on a waiting list because she was able to attend only at times when there is high demand.

ALLEGATION OF PHYSICAL ABUSE

4.2.11 In mid December 2011 child F disclosed at school that mother had pulled her hair while dragging her to a mirror, and that she had 'often been slapped' during rows. The student welfare manager contacted the 'Safeguarding in Education Team' (SIET) for advice, and spoke to the team manager. She advised that, bearing in mind child F's age (17 years 3 months) Children's Social Care would be unlikely to accept a referral.

4.2.12 A number of alternative options were considered:

Calling the Police
Seeking help from 'Women's Aid' and the Youth Enquiry Service
Moving out of mother's home

4.2.13 The SIET manager was also informed that child F's mother was a home tutor.

4.2.14 Child F was given relevant information, including a contact number for Women's Aid. She expressed relief that Children's Social Care was not to be involved, but was concerned about her mother and sibling 'ganging up on her' during the Xmas break.

SELF- REPORTING TO GP OF SELF-HARM

4.2.15 Four days after she made her allegation child F, accompanied by her mother consulted GP2. It was noted there was very little interaction between mother and daughter and that mother dominated the consultation. Child F asked to see a doctor *without* her mother. The doctor deferred making what was regarded as a necessary referral to CAMHS pending a one-to-one consultation with child F. In the event, child F did not initiate it and her next recorded appointment with a GP was not until February 2012.

4.2.16 In early January 2012 child F had her first appointment with the Youth Enquiry Service. She presented as anxious and stressed, initially only talking about school stress and not doing as well as expected. Child F also began to disclose stress about home, parental divorce and a difficult relationship with her mother.

REPORTED EPISODE OF SELF- HARM (CUTTING)

4.2.17 About a week later child F went to talk to the student welfare manager, saying the previous weekend had been very difficult, and she had been crying all the time. She indicated she had been invited to stay with a friend, but felt her mother would not allow it. She wanted the school to intervene.

4.2.18 Child F told the student welfare manager that she had used a razor to cut herself on the previous Sunday and Wednesday. A mediation meeting with mother was proposed, and arranged by the school.

4.2.19 The mediation meeting in late January was attended by child F's mother, head of 6th form, and the student welfare manager. It covered a broad range of concerns, including child F's recent wish to live elsewhere for a time. Mother acknowledged there were arguments at home.

4.2.20 Child F joined the meeting, but the school noted that there was 'no real resolution arrived at'. The school undertook to make a referral to CAMHS, which was completed on the following day, by the head of 6th form, student welfare manager and child F herself.

4.2.21 On the same day (whether before or after the above meeting is unclear) child F is reported to have met for the second time with the YES counsellor. She disclosed self harm, and that her school had made a referral to CAMHS. The school's designated 'child protection officer' was working with her and she was accessing support from pastoral care at the school.

4.2.22 The counsellor discussed this with child F and her manager. It was decided to continually monitor and assess, and for YES to 'hold' the case until transfer to CAMHS. At that point the involvement would (as was its standard practice) cease. Child F further disclosed Police had been called to her home and 'social services' involved due to a concerned parent of a friend making a call. Child F explained the school were aware of this; that no further action from Police was expected and that her mother had been called into the school for a meeting.

INVOLVEMENT OF POLICE

4.2.23 On the evening of a Friday late in January 2012 the head of 6th form received a message from her daughter (also a pupil at the same school) to check her messages on a web-based intranet used by the school.

4.2.24 She identified a message from child F, stating that her mother was being 'threatening and scary', and was planning to collect her from her friend's home. The message asked 'HELP ME'.

4.2.25 The head of 6th form phoned the deputy head teacher, then contacted child F via the intranet message, asking her to speak to her friend's parents, and if necessary, to ring Childline.

4.2.26 A return message from the father of child F's friend stated that her mother had collected child F, and he sought advice. The head of 6th form again spoke to the deputy head and advised this individual to contact the Police if he felt concerned for child F's wellbeing. He was reluctant to do so, and, on advice from the deputy head, the head of 6th form phoned the Police herself.

4.2.27 The Police individual management review confirms receipt of a phone call at 22.58 on that night from the teacher who explained the circumstances to the operator at the 'Police Enquiry Centre' [where 101 calls are processed]. A reference to child F having been recommended to stay at a friend's house to offer a breathing space was not explored by the operator. The referring teacher made a passing reference to the possibility that child F was 'being a drama queen'.

4.2.28 The operator confirmed with the teacher that child F's mother had already collected her daughter from her friend's house and asked her if she knew of any violence toward the young person. The teacher reported child F's allegation that her mother had dragged her in front of a mirror and said 'you are dreadful; look at the state of you.' There was apparently no reference to the claim made by child F on 15.12.11 that she was 'often slapped'.

4.2.29 The teacher reported she had met with the mother the previous day and formed the view she wanted to control everything about child F's life e.g. she did not want her to go to people's houses unless she knew the family.

4.2.30 The Police operator sought and was provided with details about how the message service on which child F's plea for help had been posted worked. The teacher was also able to confirm her understanding of the family structure i.e. that child F lived alone with mother; her father lived in a town approximately twenty miles away and her elder sibling was away at university.

4.2.31 The operator asked the referring teacher if she thought that the problems were a cultural issue and she said she believed some were. Child F's mother had explained to this teacher that the family were from the country of the young person's birth and in this country the children would only be allowed to play with children whom the parent/s knew.

4.2.32 The operator advised that police officers were on their way and she would ask the officers to contact her with an update.

4.2.33 A call was received from the Police forty five minutes later, confirming that a very prompt visit had been made to the home, child F and her mother had been spoken to and child F given relevant contact numbers to call if needed,

4.2.34 This episode appears to mark the start of a deterioration, with escalating distress, and correspondingly high-risk self-harm on the part of child F. Of child F's130 school days during 2012, school records indicate relevant contacts and concerns on 47 days (36%) and this rate accelerated latterly to daily contacts.

4.2.35 One of the police officers who attended the home of child F was subsequently asked to follow up the case. Her response was delayed by virtue of her shift pattern (a factor not anticipated by the senior officer initiating the request). In a later email exchange with the teacher who had made the 101 call, the officer confirmed that child F *had* been spoken to alone in the house and had also been offered an immediate chance to speak in the Police car or alternatively contact the Police Station.

4.2.36 School records had also noted a discrepancy between child F's version and that later relayed to it by Children's Social Care (presumably informed by Police notification of attendance and/or records of its Out of Office Hours Emergency Social Work Team), with respect to the question of whether child F had been spoken to other than in the presence of her mother.

CHILDREN'S SOCIAL CARE CONTACTED BY A FAMILY FRIEND

Information provided

4.2.37 On the day after Police attendance at her home, a phone call from an unidentified 'friend of child F's mother' was dealt with by the Out of Office Hours Emergency Social Work Team social worker (SW1). The caller reported that child F was not allowed to leave the house, was very frightened and self harms. The caller further reported that mother had been violent to child F in the past by hitting her and pulling her hair.

4.2.38 SW1 held a phone conversation with child F and obtained confirmation of the parental separation and child F's feelings of partial responsibility for it.

4.2.39 Child F indicated that she 'could not carry on like this'. She was finding the support of the Youth Enquiry Service helpful and alluded to the school being aware of her self harming. Child F also mentioned a CAMHS referral.

4.2.40 SW1's records confirm that child F sounded upset and alleged that her mother had hit her in the past. The duty worker was occasionally put 'on hold' and was then disconnected suddenly. She got no response when she rang back. SW1 then called the referrer who stated that child F had terminated the call because her mother had entered the room and that child F did not want her mother to know she was speaking with Children's Social Care. It is understood that this worker passed over relevant details for follow-up by the day service.

Response

4.2.41 SW1 was able to establish from Police that officers had called the 'previous evening' and child F had been seen alone. The officer to whom the duty worker spoke indicated that child F had not wanted to say anything about her mother and the officers had made a report which was seen by their Child Abuse Investigation Unit (CAIU) officer at 09:00 when the case was closed.

4.2.42 SW1 was advised that 'the day team might need to follow up due to the information child F has now given regarding her mother hitting her and self harming'. The reference to 'day team' is presumed to reflect the fact that officers had attended late at night on the Friday of that weekend and were anticipating follow up by day time services on the Monday.

4.2.43 SW1 subsequently rang the referrer back and gave her the Out of Office Hours Team number 'for over the weekend'. The worker also spoke with child F's friend who indicated child F had a dietician because of her eating difficulties.

Events following weekend incidents

4.2.44 On Monday the deputy head teacher and head of 6th form met with child F to talk about the weekend, and how things could have been managed differently. Child F had contacted Childline and the Out of Office Hours Social Work team. She had been told her mother *could* insist she returned home. The deputy head tried to clarify this by speaking to a member of SIET, and was told the advice was incorrect. Child F should seek advice and support from Women's Aid.

4.2.45 The school also referred to:

The poor relationship between mother and daughter

Child F's allegation that she had been slapped and had her hair pulled by mother

Seeing the superficial wound said by child F to have been self-inflicted

Its urgent referral to CAMHS made a week earlier

4.2.46 According to the information supplied, a duty worker from the Referral Team South made a call to CAMHS (where child F was 'not known') and to the school where it was confirmed that child F had been presenting as more and more distressed and emotional and unable to engage very well with lessons. Children's Social Care records indicate these calls were made at the end of January.

4.2.47 In an exchange between CAMHS and a duty worker SW2 from Children's Social Care, she concluded that the referral to CAMHS was appropriate and, (it is understood on the basis of her manager – SWM1's instruction) that there was no role for Children's Social Care.

4.2.48 A letter was subsequently sent on to parents by the duty worker confirming that Children's Social Care would not take the case further due to the school offering support and the referral to CAMHS. A copy of that letter (which carried an erroneous date) has been seen by the overview author.

INVOLVEMENT OF CAMHS

4.2.49 Shortly after the above incidents, the student welfare manager called CAMHS to seek feedback on the referral, and was told that child F would be sent a letter giving a first appointment. A week later, an agreement was signed between child F, parents and the head of 6th form to re-set expectations and plan academic support.

4.2.50 In two sessions with YES in early and mid February, child F disclosed suicidal thoughts which were discussed in depth and an assurance given by child F that she had no plans to kill herself. Child F was reminded of their counsellor-client contract, and that the counsellor could decide to inform and involve other professionals if necessary.

4.2.51 Child F again stressed there was no intention to take her own life, but that her relationship with her mother was deteriorating. She was made aware she could call the agency at any time if she felt she needed an extra appointment or to talk to someone. The counsellor checked that child F had a 'keeping safe strategy' to hand i.e. a list of people, contact numbers and activities that she could utilise if needed.

4.2.52 The counsellor also discussed the case with a supervisor and agency manager. It was decided that depending on the outcome of the next appointment, a risk assessment and child F's disclosure, that more involvement from other professionals and agencies might be needed. Child F's position on CAMHS waiting list was also to be checked.

4.2.53 In the second week of February the student welfare manager spoke to CPN1 at CAMHS and it was agreed child F's appointment would be brought forward from March to later the same day. Child F confirmed she would attend. Women's Aid was also given child F's mobile number to arrange an appointment for the imminent half-term. In fact she was seen next day with two further support sessions that month

4.2.54 During her initial assessment by CPN1, child F spoke of suicidal thoughts but no intent or plans. She requested that her mother *not* be informed of the assessment though she was aware of the referral to CAMHS. No signs of depression were noted though child F 'disclosed an emotionally abusive relationship with her mother and a history of physical abuse'.

4.2.55 Next day the CAMHS CPN1 called to see child F at school. Feedback to school was that she was not considered as being at immediate risk because of low mood, but CAMHS involvement would continue.

4.2.56 Referral to Children's Social Care was raised again by the CPN1 and it was recognised that her age meant that the agency 'might not see its involvement as helpful'. CAMHS had sought advice from its child protection nurse. It was also reported that the GP had raised some concerns.

4.2.57 The advice provided by the Trust's named nurse for child protection was a summary of the conversation and what appears to be an accurate account of problems faced by child F. Significantly it included the following statement:

'We have agreed that child F is suffering emotional abuse and has a history of physical abuse

She is being controlled by her mother and her education and social life are suffering as a result

There are also concerns for her physical health and self harming behaviours'

4.2.58 The nurse also provided an extract from the Buckinghamshire Safeguarding Children Board procedures which she advised made explicit an obligation to inform Children's Social Care if a child is subject to domestic abuse.

4.2.59 The approach agreed was that CPN1 would await further information from the GP, convene a professionals' meeting and invite Children's Social Care.

4.2.60 In late February GP3 spoke with CPN1 and reported that he had met child F for an urgent consultation. She was reporting that she was staying in bed for most of the half-term, feeling hopeless and having suicidal thoughts. This doctor checked with his colleague (GP2) who had last met child F (accompanied by her mother) and he had been told of her lack of interaction.

4.2.61 Following her discussion with GP3, a later meeting with child F in school by CPN1 revealed:

Child F was struggling to concentrate on her homework

Increased sleep and lack of energy

That her YES counsellor was recommending further support

Thoughts of cutting her wrists

Use of the Samaritans helpline

An initial meeting with an Asian outreach worker from Women's Aid

4.2.62 CPN1 also learned that child F, although not shown it by mother, had had sight of the letter written to her mother by Children's Social Care confirming

that it would not become involved. CPN1, having taken advice from the Trust's 'named nurse for child protection', noted her intention to alert Children's Social Care, convene a professionals' meeting and trigger a psychiatric assessment. She also left a message for GP2 offering an update.

4.2.63 Later the same day, CPN1 received a call from the counsellor at YES who advised that it was pleased that CAMHS was now involved and that it would now close off contact with child F.

REQUEST FOR CHILDREN'S SOCIAL CARE INVOLVEMENT BY CAMHS

4.2.64 Child F had attended a follow-up dietetic appointment in late February and was seen alone. Her weight was recorded though the report supplied does not comment on its significance .e.g. was she gaining or losing weight and in relation to height was she was unduly thin? (a promise to initiate further contact in May *was* honoured though child F did not respond to a message left for her).

4.2.65 Of greater relevance was that on the same day CPN1 phoned Children's Social Care and shared concerns about child F's 'emotionally abusive' home, her mood, previous physical abuse and self harm as revealed by the assessment earlier that month. Children's Social Care was invited in the course of this phone exchange to meet with CAMHS and school for a professionals' meeting.

SECOND EPISODE OF SELF-HARM (OVERDOSE)

4.2.66 In late February child F disclosed to the 6th form student manager that she had taken 36 Paracetamol and 4 Ibuprofen tablets. The student welfare manager was alerted, and informed the deputy head. Child F's mother was called and asked to take her to the Emergency Medical Centre (EMC).

4.2.67 Child F presented to the local EMC at 09.29. After medical treatment for what the hospital recorded as a claimed ingestion of 16 Paracetamol and 2 Ibuprofen, the following social / family history was captured next day by a hospital doctor:

'One sibling at University – does not have a good relationship with
A tormentful [sic] relationship with mum
Recent parental separation
? physical abuse from mother
Currently in 6th form
Good network of friends at school.
School aware of CAMHS involvement
Non-smoker, no recreational drug use'

4.2.68 The notes of the examining doctor included a note that child F 'wishes to end her life'.

4.2.69 At 13.00 child F disclosed that she had taken a further 18 Paracetamol tablets at 07.00 that day. This disclosure necessitated further treatment and admission to hospital. A total of 34 Paracetamol had been taken.

4.2.70 The overdose was concluded to be 'high risk' due to its premeditation (the tablets were bought over two days in separate shops) and inaccurate reporting of dosage and timeframe within which they were ingested (blood tests suggested child F had consumed more than she first claimed).

4.2.71 F was moved to an (adult) medical ward and following an overnight stay was assessed by CPN1 and psych.4 and an inpatient admission to the Adolescent Unit arranged. This took place at 22.00 and child F indicated that she did not want her mother to escort her there. The move to the medical ward did not represent a formal 'admission' which meant that medical records would not have been available.

4.2.72 Information about her attendance at EMC was recorded on the patient information system (RiO) and shared with the school nurse in accordance with the '*Paediatric Liaison Protocol'*. The school nurse followed up this with contact with the student support worker who informed her of child F's admission to the Adolescent Unit. There was a failure to involve the paediatric team as required by Buckinghamshire Healthcare NHS Health Trust Policy 397.2 '*Policy for Admission of Children & Young People*'.

4.2.73 The assessment by CPN1 and CAMHS senior house officer described child F as pale and flat in affect. She provided details of how she had overdosed and the centrality of the conflict with her mother.

4.2.74 When contacted and updated mother was unable to think of any reasons why her daughter would overdose. She claimed she was 'terrified' of her daughter whom she described as closed, inhibited, selfish and isolated.

Inter agency communication

4.2.75 Later that day, the student welfare manager spoke to the CPN1; this overdose was classified as a 'very serious suicide attempt', and child F was being admitted to a CAMHS tier 4 in-patient facility i.e. a residential adolescent unit.

4.2.76 CPN1 had, on the same day followed up her phone referral to Children's Social Care with a comprehensively completed 'multi agency referral form' that included reference to an 'emotionally abusive relationship' and to 'mum regularly hitting her'.

4.2.77 The day after child F's admission CPN1 alerted a duty social worker to her serious overdose and the need to consider other options if it was inappropriate to return home. The social worker explained that a response to the earlier referral was still awaiting a manager's decision.

4.2.78 The recorded management response to CPN1's follow-up was provided *after* news was received of the overdose and was limited to ….'contact CAMHS to clarify current situation as we have been advised young person is to be admitted to hospital today [the date recorded was out by a day], as she has taken an overdose; request information around treatment plan and any professionals meetings so we can consider….'

4.2.79 The final version of the merged chronology provided to the SCR indicates that the…'referral form received via fax from CAMHS [was] added to the ICS [the agency's client information system) as a 'contact' by admin. And CAMHS referral form added on 1 Feb 13'. This suggests that this critical material had been awaiting incorporation into the electronic Children's Social Care records for almost a year.

4.2.80 The GP practice was also notified promptly by letter of child F's. Presumably because of her subsequent admission to the Adolescent Unit, child F failed to attend a GP appointment later that week.

ADMISSION TO ADOLESCENT UNIT

4.2.81 Four days after her overdose child F was admitted to an Adolescent Unit in another area where she indicated that she did not wish to die but wanted to escape the 'overwhelming ache' pervading everything.

Inter agency communication

4.2.82 In response to the request made by her manager four days earlier on, a duty social worker phoned CAMHS and recorded the information given as:

'Child F has been assessed and does not present with depression or any other mental disorder

She has been asking to go home, but CAMHS remains concerned about the risks there

An Asian Woman's Aid worker has been supporting her and been discussing use of a refuge or the YMCA (child F was not keen)

Child F will be discharged and be supported by CAMHS Crisis Team

Mother does not appear to understand her daughter's emotional needs

4.2.83 The CAMHS worker agreed to inform Children's Social Care about the planned discharge meeting. The duty social worker also spoke with the ward where staff expressed the view that, in consequence of the relationship difficulties between mother and daughter (which they described as cultural) there could be a role for Children's Social Care. The school was also in communication with her key worker, providing information about background, academic matters, and liaison about home leave for child F.

Progress at the Adolescent Unit

4.2.84 At a review in early March (attended by child F and mother, medical and psychiatric staff, and a teacher) child F's weight deficit of 18% and an iron deficiency was noted.

4.2.85 The need to further assess her mental state and risk factors while on home leave and after discharge, was agreed. No medication was prescribed. A programme of gradually extending 'day leave' and support from the Crisis Team was also agreed.

4.2.86 Children's Social Care was to be asked to 'keep the case open if in future child F needs to have support away from home for social needs'.

4.2.87 That same evening child F discussed with her primary nurse a now reduced fear of her mother, her relief that the overdose had made her distress visible and hopes about resuming school and getting on with life. Child F explained that the overdose was not impulsive but came after weeks of feeling low and seeking support via counsellor, GP and the Samaritans, none of which had provided sufficient.

4.2.88 Child F was upset that her contact with Women's Aid had been raised in the morning's meeting in front of her mother and suggested that this would negate the potential value of this agency to her in the future.

4.2.89 CPN1 sent an email in early March and invited Children's Social Care participation at the now scheduled discharge meeting. This communication referred to child F's 'moderate depression; her being keen to be discharged and a wish to return home' (a change from the previous reluctance to do so).

4.2.90 The manager within Children's Social Care (SWM1) decided that because there was adequate support for child F, no social worker would attend the meeting. This decision was relayed to CPN1 by phone who is recorded as agreeing to the proposal that she contact Children's Social Care '*if* [sic] there are any signs of emotional abuse'.

4.2.91 CPN1 maintained contact with child F during her home leave and saw her and her mother together and then separately. Records suggest mother and child had managed their time together by avoiding one another e.g. eating separately (said to be a routine anyway but one which child F had hoped might change).

4.2.92 Child F's account of the period provided later that day to her primary nurse referred to her mother's constant unhelpful comments which she found 'depressing' and 'negative' e.g. 'life will only get harder'; 'child F's difficulties have made her i.e. mother's situation worse'. Child F felt she was to blame.

4.2.93 At a planned home visit by a Crisis Team senior mental health practitioner (SMHP 1) child F was seen to be pleasant and co-operative though anxious when mother joined them. Mother's frequent interjections of critical comments was noted as was child F's ability to rise above them.

4.2.94 Child F again shared with her primary nurse, frustrations about mother's controlling and critical ways e.g. insisting her hair was cut differently to the style which child F had wanted. No signs of low mood were detected. Next day (a Friday) and noted to be lower in her mood state, child F independently travelled home for the weekend.

4.2.95 That weekend at home was difficult for child F who contacted senior mental health practitioner 2 (SMHP2) and spoke of her mother's reluctance to let her leave the house to visit a friend.

4.2.96 On the Sunday the same mental health practitioner met child F who in general terms presented well, but tended to be tearful when mother was discussed. She reported a lowering of mood since coming home on Friday and resented the fact that her mother was not making time for her. She felt unloved and that there was something fundamentally wrong with her.

4.2.97 Child F indicated that in spite of feeling less hopeful, she had no current plans for suicide. A number of techniques for coping were offered. Child F feared her mother's view would prevail amongst professionals.

4.2.98 Child F became tearful when alluding to her mother hitting her in the past and feeling unsupported by 'Social Services' [an historic label for Children's Social Care].The record offers no further detail.

Discharge meeting

4.2.99 On 09.03.12 the school had been informed of a planned return to school on 12.03.12. In fact, a 'Care Programme Approach' discharge meeting was held at the Adolescent Unit on 13.03.12 attended by child F and mother, CPN1, school's head of 6th form and student welfare manager and psych.2

4.2.100 The plan agreed was for child F to meet daily with the CAMHS Crisis Team, and weekly for individual sessions with the CPN1 who would take the lead role in co-ordinating care. Psych.1 (a consultant psychiatrist) would offer one to one to sessions to mother.

4.2.101 It was felt child F's mood was still low, and there were concerns about her relationship with her mother. The diagnosis was 'mild to moderate depression'.

4.2.102 Alternative living arrangements were to be kept under review, and child F would need medical monitoring (blood testing) so that her liver function could be assessed with a view to possible anti-depressants medication at a later date. It was noted that child F did not wish to work with Women's Aid, but was keen to return to school, which she did the same day.

FURTHER CRISES MANAGED BY SCHOOL AND CAMHS

Anxiety following return to home / school

4.2.103 On her first day back at school child F did not attend period 5 and instead asked to use the school phone to speak to the Crisis Team. After 15 minutes of conversation, the phone was passed to the 6th form student manager, who was advised that returning on a full-time basis was overwhelming and a part-time programme might be a better start. An English 'mock' exam scheduled next day should not be taken.

4.2.104 During her conversation, child F denied suicidal ideation or intent. She rang back at 16.00 to thank SMHP 1 for her support. Child F later commented that she had not wanted to talk about school, but about her relationship with her mother, who had shouted at her and blamed her when they left hospital. There was to be a meeting at her home that evening, but child F felt she would not be able to speak freely. She had tried to call the Crisis Team back to request a private meeting, but could not contact them. No record of that reported attempt has been found.

4.2.105 On the same day the GP surgery received a discharge summary from the Adolescent Unit. The record provided by psych. 2 of discharge arrangements noted 'moderate depressive episode' as opposed to the mild to moderate seen elsewhere.

4.2.106 Except when child F (occasionally) declined a visit, daily contact was maintained by the Crisis Team.

4.2.107 Two days after her return to school child F spoke to the 6th form student manager. She expressed her worry about the English mock exam. She said she had been telling people she cannot be at home, and is close to feeling how she did when she overdosed. Hospital had been a safe place, but 'she has a pain inside her'.

4.2.108 At a contact with CPN1 next day child F was told that she could always supplement her support by using Women's Aid and that Children's Social Care remained in the background and could be contacted…'if things become untenable at home'. CPN1 did subsequently ask the Asian Women's outreach worker to re-contact child F.

4.2.109 Five days later the student welfare manager emailed CPN1 to pass on child F's request to stop seeing CAMHS staff. Child F felt CAMHS' involvement was making things worse, and that her mother was constantly shouting. The previous day's Crisis Team visit had made mother angry because (child F reported) the team member had said in response to some questions mother posed, 'child F does not want us to discuss this with you'.

4.2.110 CAMHS' reply acknowledged the difficulties, but stated that follow-up after in-patient care was necessary. The following day, the head of 6th form contacted CPN1 to ask whether alternative accommodation could be found for child F during the Easter break. She then met with child F to discuss academic issues.

4.2.111 Psych.1 met with mother and observed some negative remarks and an involved yet isolated figure, who had not shared with husband or friends the facts of the difficulties between her and child F, nor the overdose.

4.2.112 The school has confirmed that child F continued to find life at home difficult, and explained that it was hard to work there because she felt sad, was struggling academically, and expected to 'stay in bed for two weeks' during the holidays. It was suggested she could use the library but child F thought her mother would not allow it.

4.2.113 At a session with CPN1 at the school a week after her return child F denied suicidal thoughts though indicated that 'things were building up again, like before'.

4.2.114 Next day CPN1 emailed to confirm CAMHS were continuing to work with child F and her mother, focusing on their relationship, and would provide support them through the holiday period. Options for child F should the situation become intolerable had been discussed, and Women's Aid remained involved.

Child F expressing suicidal thoughts

4.2.115 On a Friday in late March 2012 in response to a phone call from child F who said she was feeling suicidal and unsafe, SMHP 3 agreed to undertake an immediate visit. In consultation with the relevant teacher, arrangements about which subjects child F would continue to study, were negotiated.

4.2.116 Child F re-iterated her concern that CAMHS home visits increased the anger her mother felt and expressed toward her. It was agreed today's planned contact after school would be by phone and the next face to face would be by a member of the Crisis Team on Sunday away from the family home.

4.2.117 When SMHP1 of the Crisis Team called early that evening, child reported that she had managed to remain at school all day but was now feeling sad and had not been sleeping well. A number of ideas and techniques were offered and no suicidal ideation expressed by child F.

4.2.118 The planned Sunday visit was completed at home because mother was out. Child F reported being shouted at and blamed by her mother for the apparent theft of some flower pots the day before. Child F expressed anxiety about how she would cope in the forthcoming Easter holidays.

Changed presentation / stuttering

4.2.119 On the Monday after that weekend child F left her personal, social and health education (PSHE) lesson and spoke to her 6th form student manager, stating she did not wish to think about her future. It was noted that she spoke very softly, and was stuttering.

4.2.120 On the following day she again asked to use the school phone to contact the Crisis Team. The CAMHS staff member then spoke to the 6th form student manager to arrange a visit to school for that afternoon.

4.2.121 Child F stated she could not live at home; she was dreading the following week when her sibling would be home from university, and thinking about speaking to Women's Aid. The 6th form student manager agreed to inform CAMHS of these concerns.

4.2.122 Later, the Crisis Team worker called back to say that as she was the only available staff member that afternoon, and had not had previous contact with child F, it had been decided not to make the planned visit to school. The CPN1 would be back at work on Thursday. The 6th form student manager agreed to contact Women's Aid.

4.2.123 Child F remained adamant that she did not want to return home. The 6th form student manager rang the Crisis Team worker to express concern that no-one was available to see child F, who was stuttering (she was ordinarily a very able communicator).

4.2.124 School staff were concerned that she might be planning to take, or might even have already taken, a further overdose. CAMHS assured the 6th from student manager that the agency would continue to take the lead; the team member would speak to a manager, and call back before the end of the day.

4.2.125 Psych.3 (a consultant psychiatrist in the Community Mental Health Team) was asked for advice by MHP 1 and suggested speaking with CPN1 who might visit. It is unclear whether this doctor knew or was told that the individual in question was on annual leave until Thursday of that week. He advised MHP1 to phone child F again that afternoon and re-assess whether to visit her.

4.2.126 Child F was spoken to by phone and seen in school. The worker was satisfied that she was safe this evening, but was mainly concerned about the holidays. Child F had expressed a wish to be back in hospital, and might be low in mood. A further phone contact would be made to child F later that day from the Crisis Team.

4.2.127 Next day child F asked again to use the school phone to speak to the Crisis Team and asked the 6th form student manager to talk to the member of staff, who reiterated that child F was *not [*emphasis added*]* likely to harm herself, and she could not do anything until CPN1 returned next day.

4.2.128 She suggested that child F was not left alone during study periods, and so she remained with the 6th form student manager until break. Later that day, child F again contacted CAMHS, and SMHP2 called to meet with her at the end of the afternoon. Child F's stuttering was noted (she was repeating some words up to ten times) and she re-iterated her fear about being at home over the Easter break.

4.2.129 Child F, though denying suicidal ideation stated that if she could not get the option that suited her i.e. leaving home, she 'would rather die'.

4.2.130 Next day child F received a text message from her CPN1, saying she would be in touch the following day. Child F was noted to be withdrawn and stuttering and she tried to contact Women's Aid. A multi –disciplinary team meeting that day tasked CPN1 with discussing current concerns with Children's Social Care and raising the possibility of 'floating support'.

4.2.131 Child F stated to the head of 6th form that she did not wish to be at home; she was thinking of staying with a former school student, but would wait for the outcome of her meeting with the CPN1 tomorrow. Stuttering and tremors were judged to be worse than before.

4.2.132 On the following day the student welfare manager met with Child F, who was calm and not tearful, but still stuttering. The student welfare manager agreed to contact the CPN1, and on speaking to CAMHS was told she was off sick Another team member would call back. It was in fact, a third member of the team who called, and agreed to arrange to meet with child F that afternoon. This message was passed to child F.

4.2.133 SMHP1 of the Crisis Team spoke with child F by phone that evening at which time she was at the home of a friend, planning to stay overnight and ignoring calls from her mother. Child F was recorded as 'distressed but calm'. The worker also spoke with mother later that night and sought to allay her anxiety and anger about her daughter staying at a (known) friend's home. SMHP1 tried to maintain contact over the remainder of the weekend though child F did not respond to messages left on her mobile.

Self organised alternative residence during Easter holidays

4.2.134 On a Saturday at the end of March child F was understood to be staying with friends. After the Easter break and on the second day of Summer term the student welfare manager emailed the deputy head teacher to say that the CPN1 would meet with child F at school later the same day or tomorrow. She had been in contact with child F during the holidays, and she was fine. Long-term plans remained unclear, but an appointment for family therapy had been made.

Further attempt to engage Children's Social Care

4.2.135 Though not reflected in the earlier draft chronologies the Children's Social Care individual management review referred to an email sent by CAMHS at then end of March to confirm an earlier (undated) phone conversation. CAMHS was reportedly concerned that Children's Social Care was planning to close child F's case because in its view, the situation at home had not changed following her discharge.

4.2.136 The following account from Oxford Health NHS Trust is clearly the same exchange. It actually occurred three days later and may be summarised as:

'Further to my email of [date provided] and my subsequent telephone conversation with SW3 when she advised that Children's Social Care was closing the case, I now wish to highlight our ongoing concerns regarding child F who has now been discharged from our inpatient unit and has returned home to live with her mother

Their relationship continues to be extremely hostile and child F reports that her mother does not allow her to go out and, when she does, requests to know where she is going, who with etc

When asked what would happen if she went anyway, child F said her mother would come and collect her and it would be embarrassing

We are having input, both with child F and her mother, but so far are making little impact on the difficulties in their relationship

Mother feels strongly that children should respect their parents and reports that child F is un-cooperative and rude towards her

Dad lives in [a location some forty miles from child F's home address] and, so far, is unaware of the overdose and recent difficulties.

Child F does not want him informed and, although mother wants to tell him, she is also concerned about his reaction and that he may blame her

4.2.137 CPN1 went on to say that:

Child F continues to present as a very vulnerable young person with strong feelings of helplessness and lack of control over her situation

As you are aware, the overdose she took was very serious and she is expressing feelings of becoming overwhelmed again currently now that she is back at home

School is a protective environment for her and we have concerns for her welfare during the school holidays over the next two weeks

She remains open to our Crisis Team but it is difficult to commence any therapeutic work whilst the home environment remains at this level of hostility

Child F is currently saying she does not wish to live at home anymore

She is in contact with Women's Aid who have suggested a refuge or YMCA but we would appreciate your input and/or advice regarding this emotionally abusive situation

4.2.138 A manager (SWM2) instructed a duty social worker to ask what CAMHS felt Children's Social Care *could* offer as a number of services were already

involved with child F and her mother. ….'there may be some services at school which could support her in regards to having somebody to talk to and work around cultural issue…'.

4.2.139 Children's Social Care records indicate a phone call in early April in which CPN1 'agreed' with SW3 there was no current role for Children's Social Care. CPN1 indicated she would explore with the school the possibility of sourcing some support from a person of similar ethnic background to child F. The social worker wondered whether child F (who would be eighteen in September) might usefully be considered a 'vulnerable adult'?

4.2.140 The CAMHS record of this discussion (dated a day later) does not confirm that CPN1 *agreed* with Children's Social Care position; nor though, does it suggest she challenged it.

4.2.141 A case discussion within CAMHS the day before involved psych.1 and a discussion about whether child F needed to remain on the 'watch list'[2]**.** Her name was removed from that list when levels of concern had reduced, though the need to review if / when child F returned home was acknowledged.

4.2.142 On a date in mid April the student welfare manager emailed CPN1 to say child F had left school and would not be available at 13.30 to meet as arranged; she did not want to see CPN1, would rather be in hospital than return to live at home (a close friend expressed concern child F would 'do something silly' to make this happen), and did not want to attend CAMHS sessions with her mother.

4.2.143 The student welfare manager then stressed to child F that she would need to speak to CPN1; the school could not offer the specialist help needed. Child F agreed to phone CPN1, and the student welfare manager provided her with contact details for child F's friend.

4.2.144 These contacts to CAMHS were followed up two days later in another email requesting a meeting to discuss concerns about child F's living arrangements, whom to contact in an emergency, and the impact on child F's friend.

4.2.145 Child F had withdrawn from a modern foreign language oral exam because of her stuttering, and a request was made for a letter to pass on to the Examination Board. The school was concerned about her ability to manage 'AS' written exams, if the current situation was not resolved. Child F said she wished to leave school, and remained reluctant or unable to engage with support outside school.

[2] The 'watch list' is an alert system for the Crisis Team so that they are aware that a child / young person is on the edge of crisis.

4.2.146 CPN1 responded five days later to the email sent by the school. CAMHS remained concerned, and acknowledged it was hard to engage child F. A meeting had been fixed for child F and her mother to meet with a consultant psychiatrist that afternoon, but child F had telephoned to say she would not attend. A review meeting would be arranged, to take place in school.

4.2.147 Next day there was a call from CPN1 to inform the school she would be calling for an unannounced meeting with child F that Friday as she had not attended yesterday's meeting, and not met CPN1 for two weeks. CPN1 had spoken to the parent of the ex-pupil with whom child F was staying, and the contact details would be passed to school. On Friday, plans would be made for a meeting with the deputy head teacher and the head of 6th form in the following week.

Third episode of self harm (scratching wrists)

4.2.148 In late April the parent of the friend with whom child had been living spoke with CPN1 and expressed concerns about child F who, over the weekend had cut herself (albeit not severely). The informant thought that child F might also be staying with two other families so as to avoid returning home.

4.2.149 CPN1 was told next day of the discovery in the school medical room of a pouch of forty loose tablets thought to have been left there at the time child F had overdosed. It is unclear with whom this supposition (which reinforced the seriousness of the intention prompting the overdose) was shared.

4.2.150 Two days later when child F saw the 6th form student manager she was noted to be upset, and almost unable to speak. The student welfare manager was called to help. Child F stated she wanted to return to hospital, and showed clean and 'fairly superficial' cuts on her arm. She denied having taken any tablets that day. Given the option of returning to lessons, or attending the 'student support services', she reluctantly returned to lessons.

Further attempt to engage Children's Social Care

4.2.151 On the same day as the above events the following email (which was not available to the author of Children's Social Care individual management review) was sent to the Referral & Assessment team by CPN1:

> Further to previous correspondence about this seventeen year old girl, I am writing to advise that she left the family home approximately three weeks ago and is currently temporarily staying with two or three families of friends of her at school
>
> This is likely to break down at some point as the father of one of the girls has already contacted me with concerns about her self harm
>
> There have been no further overdoses, however, she is doing some cutting and is under some considerable stress at school with exams
>
> I am also having difficulty engaging her at CAMHS but will continue to pursue this
>
> She is currently not having any contact with either parent and I understand has no intention of returning home

I did make contact with Bucks Floating Support who confirmed that she does not meet their criteria as she is technically homeless and therefore comes under your responsibility

I look forward to hearing from you with regard to this matter. I am happy to convene a meeting for you to join with ourselves and school to discuss a way forward for this vulnerable girl.

4.2.152 In response to the email SW3 phoned and recommended contacting Connexions for housing advice.

4.2.153 CPN1 followed up with the school the suggestion of Connexions' advice and an appointment was made for the first Tuesday in May. Reports of child F's condition referred to her tearfulness, stuttering and some cutting to her arms.

4.2.154 When CPN1 and a student nurse met with child F next day she did not stutter and presented well. She acknowledged cutting again (superficial scratches to left inner forearm were seen) and denied any suicidal thoughts.

4.2.155 Child F said she was living in two locations at present and has been borrowing money and clothes from each. She was told of the imminent Connexions appointment. Child F indicated that her mother had returned her Bank card to her (though at a further meeting in early May she indicated she was still awaiting its return).

4.2.156 She felt too stressed to join the planned joint appointment at CAMHS. CPN1 sought to reduce the risk that she might self harm to prompt a return to the Adolescent Unit (where she had made a friend) by informing her it was full.

4.2.157 The student welfare manager emailed CPN1 at then end of April to set up the meeting with the deputy head teacher and head of 6th form in order to review child F's care package.

4.2.158 At the beginning of May the school contacted SIET to seek further advice, and this confirmed that CAMHS and school should meet as planned, and ensure clarity about timescales and reviews so that 'there is momentum'. School was encouraged to liaise between child F and Connexions, and advised to contact the parents of another student who was 'feeling vulnerable'.

4.2.159 CPN1 spoke with mother and learned that she was about to share the situation about child F with her husband. Mother also commented upon the impact of the temporary living arrangements in terms of its impact on the host families rather than child F.

Involvement of Connexions Service / meeting with school senior management

4.2.160 The Connexions personal adviser (PA) met child F for the first time at the beginning of May and completed a referral to access that agency's counselling service. Child F indicated that she wasn't finding CAMHS support helpful. The possibility of a referral to Children's Social Care was discussed.

4.2.161 Later that same day, an email was received by the school from CAMHS proposing to meet with the deputy head teacher and head of 6th form when child F was visited on Friday of that week. This meeting took place as planned. A professionals' meeting was envisaged, and it was confirmed that any contact with Connexions (in relation to counselling) would be managed by CAMHS.

4.2.162 CPN1 completed a phone discussion with the personal adviser PA1 from Connexions and provision of counselling from both agencies agreed. In exploring the apparent options for child F (by then 'sofa surfing') the need to 'be evicted' or to 'disclose abuse' were identified as the only routes out of the home. CAMHS mentioned its referral to Children's Social Care and that it was awaiting a response.

4.2.163 Child F was later given confirmation of the proposed counselling from Connexions. Apparently on the same day a further conversation between CPN1 and the Connexions PA1 resulted in the agreed cessation of Connexions counselling whilst CAMHS remained involved.

4.2.164 CPN1 then met child F and was told that she was sleeping and eating without difficulty. No stutter was observed and no self-harm reported. Child F reported a 'nasty' text from her elder sibling which had put her off returning home for a few days as she had been planning. CPN1 took the opportunity to explore a reference to sexual abuse reportedly put to her by her mother and sibling. Child F denied that she had even been sexually abused. She was noted to appear confused when asked, with whom might she share such information *if* she had been?

4.2.165 Later that same day both child F's parents arrived unannounced at school asking to see her. A meeting was facilitated but child F left before it finished. The parents were informed by the deputy head teacher, who had been contacted by the student welfare manager, that child F had self-harmed (superficial cutting) after leaving this meeting. This was also shared with the parent of the former student with whom child F was staying. Four days later, that parent emailed the school seeking help to set up a meeting with CPN1.

4.2.166 CAMHS records indicate that child F had cut herself (though 'not seriously') and received medical attention (presumably at school). CPN1's record also refers to the school's description of father as rational and calm in presentation. This is the only account of father in any documents supplied.

4.2.167 During the second week of May the school was copied into an email from the Connexions co-ordinator to a personal adviser (PA), confirming that CAMHS had agreed child F should see a Connexions counsellor at school (Connexions was unable to access alternative accommodation at this time). It was noted that Connexions *could* refer to Children's Social Care, and that CAMHS *had* done so. Presumably the agreement reached the week before about CAMHS exclusively providing counselling was unknown to the sender of the email.

4.2.168 In a phone conversation with CPN1 child F said she was 'overwhelmed with stress' and 'beyond self-harm'. She was not stuttering and denied feeling unsafe. CPN1 agreed she would be placed on the 'watch list' again. In a later conversation with the Connexions PA, CPN1 indicated that the link to that agency had been for *housing advice* rather than counselling as the latter need was being met by CAMHS. A return call confirmed eviction or referral to Children's Social Care for abuse, were the only clear routes to alternative accommodation.

4.2.169 Next day psych.1 spoke with mother who reported that father was back from a trip abroad and at home, Mother also indicated child F had moved to a second family because the children of the first household had become upset. Child F was reported to be staying with an ex school friend now a student at a local Further Education College. Her stay there could not, mother reported, extend beyond mid June when other teenagers in the family were due to return (from where was un-stated).

4.2.170 On the same day, child F indicated to her supporter at Women's Aid that she no longer required the involvement of that agency.

4.2.171 Next day CPN1 met child F at school and noted a tremor / twitch around the head area and that she was fidgeting. Child F was maintained on the Crisis Team watch list whilst exams were completed over the following two weeks. Child F spoke for the first time of a fear that her thoughts and beliefs represented a long term issue and might mean she was 'crazy'.

4.2.172 Later in the second week of May the deputy head teacher called a meeting with the head of 6th form and student welfare manager to review plans for child F and consider:

A 'Care Programme Approach' meeting

Referral to Children's Social Care

An email to all child F's teachers

An email from the 'host' family

The scheduled Connexions appointment (the student welfare manager was asked to advise that CPN1 did not feel that additional counselling should be offered)

An email about a Summer school place for child F

4.2.173 Later that same day, the deputy head teacher emailed child F's parents to inform them that the school had requested an urgent meeting with CAMHS to review progress and make plans. The parents were encouraged to contact CPN1 directly to expedite this.

4.2.174 SMHP5 from the Crisis Team met child F in mid May. She continued to 'feel crazy and suicidal all the time'. Child F was by then planning to return home and expressed guilt about her mother being on her own. She disclosed for the first time, visual hallucinations.

4.2.175 Child F also alluded to doubts about the usefulness of Connexions, an inability to trust her school counsellor or to share *everything* with CPN1 especially with respect to hallucinating. This individual undertook to ask CPN1 to clarify the potential value of Connexions and to seek advice from her and a doctor about the possible need for medication with respect to her reported hallucinations.

4.2.176 SMHP5's notes of this meeting indicated child F made references throughout to suicidal thoughts and feeling that ultimately it would happen one day; she said she was scared of causing damage is she were to be unsuccessful.

4.2.177 The results of tests of child F's liver function taken in late March were relayed by the GP to CPN1 at this time and were 'normal'.

Further attempt to engage Children's Social Care

4.2.178 Although not appearing in the chronology or individual management review supplied (indicating it had not been uploaded into the agency's records) the following email was sent by CAMHS to Children's Social Care in mid May:

> We have contacted you on three previous occasions regarding the above young person and continue to be concerned for her welfare
>
> Child F was previously living with her mother in an emotionally abusive environment which culminated in her taking a serious Paracetamol overdose which required an inpatient admission in our adolescent unit
>
> She then returned home but the situation continued to be difficult despite intensive input from ourselves with both F and her mother
>
> Child F then left home to live with a friend and is now living with another friend, but this will be coming to an end in the next few weeks
>
> Child F is adamant she does not want to return home despite her mother being desperate for this to happen
>
> Her father, who is separated from her mother, has returned temporarily to the family home to also try and persuade F to return but to no avail
>
> We have concerns about the dynamics between mother and child F and their impact on her mental state so feel unsure that home is the best environment for her
>
> We have been advised by yourselves to contact Buckinghamshire Floating Support and Connexions for housing support but both these agencies have redirected us to yourselves

Connexions has advised that, unless parents categorically state that they will not have her home, then there is nothing they can do unless the home environment is emotionally abusive, which we feel it is

4.2.179 The email went on to state that 'we are now left with a vulnerable girl, with no stable base who seems to be falling between the criteria for different agencies. I understand that school are making a separate referral to you to share their concerns. We have convened a review meeting to discuss the ongoing situation and feel that it is important that Children's Social Care attend in order to advise the best way forward for this case. The meeting is on [date in mid June] at 13.30.

4.2.180 No response to the above concern and the proposal it contained has been found.

4.2.181 In late afternoon of the next day, the student welfare manager emailed CAMHS seeking an urgent meeting following last week's difficult meeting with parents, the email from the father of the former student, and continuing concerns about accommodation for child F and her A/S exams. The school IMR indicates that on this date, Connexions made its own referral to Children's Social Care.

4.2.182 Connexions' chronology suggests child F agreed to such a step though the referral itself was initiated four days later as described below.

4.2.183 The response from CAMHS anticipated bringing the meeting forward, and contacting the ex-student's parents.

4.2.184 The family friend with whom child F was by now staying phoned CPN1 on and asked to attend the planned meeting. He reported that sometimes child F was absolutely fine but that she had arrived in the kitchen this morning holding a knife with blood on it [whose blood was not specified].

4.2.185 A day later child F was reporting visual hallucinations experienced since the previous night. The case was discussed in the multi-disciplinary team and the three 'referrals' to Children's Social Care noted as was the meeting CPN1 had called in the expectation of the presence of that agency.

4.2.186 It was agreed that the Community Mental Health Team (CMHT) should be approached with respect to transition to Adult Services.

FOURTH SELF-HARM EPISODE (OVERDOSE)

Threat to self harm / exploration of private psychiatric support

4.2.187 The concern about child F escalated when at 12.56 on the day of the multi-disciplinary meeting the GP phoned CPN1 to report that child F (who was with him) was reporting visual and auditory hallucinations as well as feelings of anxiety. The doctor was informed of the current support from CPN1 and the Crisis Team.

4.2.188 Child F later told a friend she was going to kill herself that evening; this was reported to CAMHS by the friend by text message and by the school which contacted CPN1 and left a comparable message.

4.2.189 At 15.00 on the same day child F spoke by phone from school to MHP2 and expressed her distress. He and a second mental health practitioner went out to meet child F. She explained she could hear three female voices or alternatively could see three people. Child F's stutter had returned.

4.2.190 She initially claimed to have been hallucinating only since the day before but then said she had heard a voice before taking her first overdose. Child F complained of not eating or sleeping well. Child F acknowledged self-harming with a knife and assured the two staff that she could keep herself safe until she saw CPN1 next day.

4.2.191 On the following day child F came to school to take an exam. CPN1 was aware that two members of the Crisis Team had been in to see her, and was coming in at 14.00 that day.

4.2.192 The school understood that parents were considering consulting a psychiatrist privately and that this would mean that CAMHS involvement would finish.

4.2.193 CPN1 noted that child was not stuttering but looked slightly unkempt and tired; her legs and hands were constantly jiggling. She reported little relief from the auditory hallucinations but was no longer having visual ones. Whilst she was convinced she had done badly in her exams that morning and was still feeling 'crazy' she denied suicidal thinking or intent.

4.2.194 Child F though tempted to spend some time at home felt unable to risk exposure to her mother and declined the offer of a mediated return. Child F agreed to her friend's father attending the scheduled meeting on 30.05.12.

4.2.195 Also on that day child F was called by GP3 following a visit by mother. The GP reassured child F that no information had been disclosed to mother but that she would need to become involved if a psychiatric consultation via BUPA was to be commissioned. The doctor confirmed that in this event, he had been advised by CPN1 that the involvement of CAMHS would cease.

Further attempt to engage Children's Social Care

4.2.196 A further opportunity for Children's Social Care involvement arose only a day later. That agency's records suggest a date two days earlier and the fax itself was only scanned and inputted on in February 2013. PA2 from Connexions phoned to inform the agency that child F was 'sofa surfing' and had very limited finances. Child F had indicated that she now welcomed a Children's Social Care referral as she was concerned about her homelessness and thought it might help make her case a priority. She had run out of friends to stay with and wanting independent housing away from her family home.

4.2.197 The team manager SWM2 advised the duty worker to contact Connexions and advise that agency of the other services already involved. The individual management review provided also indicates that Connexions was to be asked to explore with child F whether she had friends or family with whom she might stay. It would appear the call was not made for five days and a message was left.

CPN1's consultation with named nurse

4.2.198 CPN1 again consulted her 'named nurse for child protection' and actions agreed were to:

Chase Children's Social Care to ask for attendance at the Care Programme Approach review meeting for any advice / support

Be clear with child F that her chances of being offered any accommodation was extremely unlikely and that her option may be a return home

4.2.199 Late that evening of (at 23.00) child F spoke with SMHP1 to whom she described voices in her head telling her to cut herself. Child F's suicidal ideation was relayed to CPN1 next day.

4.2.200 By the afternoon of the following day child F was indicating in a phone conversation with CPN1 that the voices were telling to kill herself and that she 'felt she would go through with this'. On discussing the return home contemplated a week previously, child F thought that she was more likely to kill herself if she was at home.

4.2.201 CPN1 contacted the school to say that child F had been in touch: her exam had not gone well and she was suicidal. She understood from her first and a follow-up conversation that there was no plan to act on this today (Wednesday), but instead, Friday was planned.

4.2.202 The Crisis Team was also informed, and the CPN1 would contact child F again before the end of the day. The student welfare manager alerted the head of 6th form and 6th form student manager, then spoke to child F, who appeared calm, and was revising. She denied having taken any tablets, and was planning to take her exams the following day (Thursday). Child F felt that CPN1 does not listen to her.

4.2.203 Child F subsequently called GP3 and confirmed that she *would* like a private psychiatric referral but only after she had met with CAMHS and Children's Social Care at the end of May. The doctor agreed with child F that she would call again when ready to proceed.

Actual overdose

4.2.204 On a Monday in late May another student reported to the 6th form student manager that child F had phoned her to say she had taken another overdose and was going to the Emergency Medical Centre The head of 6th form contacted CPN1, who said she was on duty, and would be informed by the hospital when child F arrived.

4.2.205 At 10.50 that day child F self-referred to the Emergency Medical Centre following ingestion of what she said were'32 Paracetamol tablets with sips of cider.' She described feeling down and not coping.

4.2.206 It was noted that she had been living with a friend for the last two months because she did she not get on with her mother.

4.2.207 In response to the report of this overdose, the deputy head teacher rang the Emergency Medical Centre. That afternoon, the father of the former pupil phoned the school to say they were in 'A&E', and child F was on a drip. *He* had contacted CPN1 because, he reported, 'the nurses did not know who she [CPN1] was'.

Further attempt to engage Children's Social Care

4.2.208 CPN1 had made another attempt to engage Children's Social Care when she phoned seeking a response to her previous emails. Duty worker SW3 advised that a social worker SW4 had been appointed to look into the case and that he would be asked to make contact. The manager recorded the case as 'medium risk' but on what basis is unrecorded.

4.2.209 CPN1 stated that when she rang (at 15.14), the hospital had in fact told her child F was not there. The ex-pupil's father said he was not sure he could have child F back to stay, and would say this at Wednesday's meeting. He later texted the head of 6th form to confirm child F was anyway to stay in overnight. She was discharged into the care of her parents the following day.

4.2.210 At 15.47 a staff nurse alerted CPN1 to the overdose of 64 Paracetamol plus alcohol. This individual had not made earlier contact because she had only come on shift at lunchtime and was unsure of child F's arrival time. The family friend contacted CPN1 at 16.57 and explained how he understood child has acquired Paracetamol. He was unsure about the possibility of a return to his family.

Treatment and assessment in hospital

4.2.211 Medical treatment was commenced as per the treatment protocol for a Paracetamol overdose with a plan to review on completion and discharge once medically fit. Records indicate (although no time is captured) that contact was made with CPN1 to inform her of F's admission and the plan was for her to be contacted again when F was medically fit for discharge.

4.2.212 Child F was admitted overnight to the medical ward where she was visited by her family. When reviewed the following morning it was documented by the doctor that 'child F is quiet, not speaking'.

4.2.213 SMHP2 together with a family therapist completed a self-harm assessment and child F was subsequently discharged home with her mother with a meeting involving Children's Social Care and CPN1 due next day.

4.2.214 The GP Practice was promptly notified of the further EMC attendance by letter from the hospital and from CAMHS. It was not involved in the pre-discharge meeting described below.

4.2.215 Information about the overdose was (some two weeks later) recorded by the school nurse and the plan was for her to liaise with the school. There are no other entries on the electronic recording system, nor attendances at hospital prior to child F's death.

ENGAGEMENT OF CHILDREN'S SOCIAL CARE

Referral

4.2.216 On the day after child F's overdose Children's Social Care records indicate a further contact from the school and the deputy head teacher reporting serious, ongoing and increasing concerns for child F's physical, mental, emotional and academic well-being.

4.2.217 The deputy head teacher referred to child F's relationship with her parents breaking down completely and that she was technically homeless.

4.2.218 The deputy head teacher also passed on the news of child F's latest overdose. A reference in the Children's Social Care individual management review supplied refers to un-timed calls made by the duty worker to the school and to CAMHS, in an attempt to establish the extent of the overdose. The school was recorded as not having this information and the CAMHS worker being unavailable. The proximity in time with the contact initiated by the school remains unknown.

Response of Children's Social Care

4.2.219 In response to the referral, the records of SWM3 indicate that an 'initial assessment' was 'completed' and a decision made that:

The CATCH team (a non case-holding team whose role is to provide rapid and intensive support if there is a risk of family breakdown) would work with the family and look at the relationship difficulties with a view to child living with one or other of her parents

The case would transfer to the Assessment & Intervention Team but

Allocation to a social worker was unlikely due to 'pressure of work'

4.2.220 The author of Children's Social Care individual management review points out that the 'initial assessment' contained no information beyond a declared intention to provide short-term services i.e. no contact was made with family, child or other agencies.

4.2.221 In fact a social worker *was* allocated on the last day of May, kept updated about her work by the CATCH worker but took no active role between allocation and the death of child F. When interviewed the individual (SW5) indicated she had been allocated the case whilst 'not at work' and that there had been no clarity as to the level of urgency she should award to making contact with child F. There is no evidence of her former assertion which is challenged by the agency (records indicate the social worker returned from a prolonged absence in the first week of May).

4.2.222 The CATCH worker has indicated that she and the social worker had been due to meet child F together in the week that she died.

4.2.223 Toward the end of the first week in June the allocated CATCH worker contacted CAMHS and was updated about its ongoing involvement and about the return to mother's home of child F and her father respectively.

CARE PLANNING APPROACH (CPA) REVIEW MEETING

4.2.224 Psych.1 saw child F prior to the 'Care Planning Approach' meeting and reported in a letter to the GP that 'child F's auditory and visual hallucinations appear to be related to the very stressful circumstances she has been in…'

4.2.225 A meeting was held and attended by child F and her parents, psych.1, CPN1, two staff from school as well as the parents of the family with whom child F had been staying.

4.2.226 Contact from Children's Social Care was noted, and a social worker and a worker from the 'CATCH' team had both been allocated. The support plan involved the CATCH and Crisis Teams as well as CPN1 and consisted of:

Weekly individual sessions with CPN1 to provide therapeutic support

Crisis Team to provide twice weekly input for support and to monitor risk / mental state

Regular review by psych.1

Referrals to both the Adult Mental Health team (CMHT) plus the Early Intervention Service (a 14-35 years service for early intervention in psychosis) *if* current symptoms persist

Support offered by CAMHS, CATCH and school

4.2.227 In a phone conversation with CPN1 on the last day of May child F repeated her wish not to be at home but indicated no significant risk to self. The Crisis Team also contacted her and agreed a home visit for the next day.

4.2.228 In fact, child F refused the visit due next day and reported that she was feeling as though 'being dead would be better than living her life with her parents'. She said though, that she was not having specific suicidal thoughts and had no plans to self-harm. Child F confirmed ongoing tension with her mother and reported no visual, some auditory and latterly some olfactory hallucinations at times of stress e.g. if talking with her mother.

4.2.229 The Crisis Team made contact on 02.06.12 and 04.06.12. On the latter occasion, child F and her parents were away for the weekend and she indicated that she was fine. A phone discussion took place on 06.06.12 between CPN1 and the CATCH worker**.**

4.2.230 Child F was seen by psych.1 on 06.06.12 who defined her reported of voices (now three not five) as 'pseudo hallucinations' not a sign of psychosis. The author understands a pseudo hallucination to be an involuntary sensory experience vivid enough to be regarded as a hallucination, but recognised by the patient *not* to be the result of external stimuli i.e. an hallucination recognised to be an hallucination, as opposed to one perceived as real.

4.2.231 Next day, a multi-disciplinary team meeting agreed, in the light of her being out with friends etc to amend child F's care plan to being on the 'watch list' Parents were to be informed. A family therapy session was due.

4.2.232 Further to a phone conversation with her on 06.06.12, the CATCH worker undertook a home visit on 11.06.12 where she met only mother. She was told child F had been living with two other families in the preceding eight weeks. Mother's belief was that the stress child F was experiencing was of her own making and she sought to convince the worker that what was described by the worker as 'an unmade bed and a couple of items of clothing on the floor' of child F's bedroom was 'unacceptable mess'. The worker noted how controlling mother tried to be.

4.2.233 The CATCH worker met child F two days later (13.06.12) and was told by child F she would rather live elsewhere. Child F reported that she sometimes felt like 'ripping her skin of and setting herself alight' and that she does not get on with her mother or sibling. Child F was also very worried about her A/S level results which she anticipated she had failed.

4.2.234 The CATCH worker and child F agreed that they would work on making home more comfortable to be in and child F should think about this until the next meeting with the worker.

4.2.235 On 15.06.12 CPN1 met with child F as planned at school. The individual management review supplied by the school refers to the CATCH worker saying she had met child F 'several times'. This assertion is not confirmed by records. Child F had asked for these meetings to take place at school. The next meeting was booked for 19.06.12 at 09.50 and did take place though no records of its contents had been inputted prior to child F's death.

4.2.236 CPN1's observations of child F on the above occasion were of some hostility and sarcasm, an unchanged home situation (though father was 'being less annoying than mother'), fewer and less intrusive auditory hallucinations and some improvement in sleep patterns.

4.2.237 Child F did report suicidal thoughts but expressed no intent. Child F indicated meeting the worker from the CATCH team 'once'. Child F reported that her mother had declined to attend the last family therapy session. She herself did not wish to attend any further family therapy.

4.2.238 On 18.06.12 the GP Practice was belatedly notified by the hospital of child F's EMC attendance on 28.05.12.

4.2.239 On 20.06.12 there was an email exchange between CATCH and CAMHS workers. The former indicated that the allocated social worker was SW5. She also regretted she would be unable to attend the CPA review scheduled that day and asked to be kept up to date with CAMHS work so that she could feed this back to the social worker and 'we can discuss *whether* [sic] we need to arrange a Child in Need (CIN) meeting'

CPA review meeting

4.2.240 A review meeting was planned at school for 20.06.12. Neither parent nor child F attended. When phoned, mother apologised for overlooking the event and child F's mobile went to voicemail.

4.2.241 The student welfare manager who had attended mentioned that a friend of child F had informed staff that child F had been considering 'doing something silly' earlier whilst in the school library but had changed her mind. The CPA review was re-scheduled for 06.07.12 and invitees were to include the allocated social worker, CATCH worker (CAMHS records indicate she confirmed her intention to attend) and CMHT. A further invitation to family therapy was put to mother over the phone and a date of 26.06.12 offered.

4.2.242 An email sent by CPN1 to the CATCH worker and SW5 (and not reflected in the material made available by Children's Social Care) re-iterated the need to consider the options for child F to live away from home.

Alarm raised

4.2.243 On the following day CPN1 was informed that child F had phoned a friend she had met in the Adolescent Unit and indicated she was going to kill herself. Having failed to reach child F by phone, she rang the 6th form student manager to ask whether child F was in school. She was not marked present, and could not be contacted on her mobile.

4.2.244 CPN1 was concerned, as child F had said to the head of 6th form that she had made another suicide attempt. Parents were contacted by phone, and mother called back to say she had been told child F was suicidal, but had thought she was in London on a 'taster day' at university. Mother also indicated that maybe they should allow child F to live elsewhere.

4.2.245 Mother was very concerned and asked to speak to the member of staff who had informed the CPN1 that child F was suicidal. The head of 6th form called mother to confirm she believed child F to be attending a Classics 'taster day' but could not contact the students directly.

4.2.246 Mother wanted to clarify the conversation her daughter had had with the head of 6th form on 20.06.12. It was explained that she had not wanted to take her report home, or to live at home, as it 'made her suicidal', and that the second overdose was because of 'voices'.

4.2.247 Child F had then told the head of 6th form of a third attempt to self-harm. When asked whether CPN1 knew, she said no, 'it only happened very recently'. The student welfare manager had passed on this information to CPN1 at the Care Programme Approach meeting held the previous day. Mother was concerned that CPN1 had not mentioned the event to her when they had last spoke.

4.2.248 On 26.06.12 the parents attended without child F a session with the family therapist. Thoughts about her going to relatives in her country of birth were expressed. Child F failed to attend a pre-arranged session at school with CPN1 at lunchtime on 29.06.12. School staff reported no particular concerns about her presentation and a voicemail message was left for her. Later that day CPN1 asked the Crisis Team (which had queried whether child F needed to remain on its watch list) to retain child F's name on it for the moment since she had not been able to have a face-to-face since 15.06.12.

4.2.249 The referral of child F to the Adult Community Mental Health Team resulted in an assessment by the 'Early Intervention Service (EIS) being arranged.

DEATH OF CHILD F

4.2.250 On a Sunday in early July Thames Valley Police called the Children's Social Care Out of Hours Emergency Team to pass over the news that child F had been found dead at her home.

5 ANALYSIS

5.1 INTRODUCTION

5.1.1 Section 5 addresses each item of the given terms of reference. Sections 6 and 7 respectively offer findings and conclusions, and recommended organisational changes respectively.

5.2 WERE PRACTITIONERS AWARE OF, AND SENSITIVE TO, THE NEEDS OF THE CHILD IN THEIR WORK, AND KNOWLEDGEABLE OF POTENTIAL INDICATORS OF ABUSE OR NEGLECT AND ABOUT WHAT TO DO IF THEY HAD CONCERNS ABOUT A CHILD'S WELFARE?

AWARENESS / SENSITIVITY

5.2.1 The majority of professionals with whom child F had contact in the period under review showed considerable sensitivity to the distress this young woman was experiencing.

5.2.2 Though the services provided by the GP surgery were in most respects unremarkable, the initial response in October 2011 was a thorough one, i.e. relevant medical enquiries were initiated and child F was signposted to a suitable source of counselling for young people.

5.2.3 The interview with GP2 whom it was thought initially had referred child F (still only 17 years and 2 months) to an *Adult* Mental Health Service clarified that he had recently been briefed on what that service could offer, was not making a formal referral and was instead signposting a source of support that child F might want in the future to explore via its website.

5.2.4 Without regard to the potential for improved practice identified in the individual management review supplied by Thames Valley Police, the response of its 101 service and the conduct of the police officers deployed to child F's home showed a high level of sensitivity.

5.2.5 School staff and (at a later date) CPN1 and members of the Crisis Team were very responsive and attentive to the significant level of need indicated by child F's presentations. The school's commitment to providing support for the emotional needs of child F whilst still sustaining their primary role as educators was commendable.

5.2.6 Though CPN1 (and others) later failed to escalate concerns through the hierarchy of Children's Social Care, she clearly worked very hard to coordinate the CAMH services. This individual recognised and persistently articulated the perceived emotional abuse that justified enquiries under s.47 Children Act 1989 by Children's Social Care.

5.2.7 The medical care offered by the general hospital was routine in terms of its response to the drugs overdose and was in general terms sensitive to child F's distress. Hospital staff should though have referred to Children's Social Care the allegation (albeit historical) of child F about physical abuse. A failure to make early and more substantive use of the information then known to colleagues in CAMHS is commented upon elsewhere.

5.2.8 The relatively limited involvement of Women's Aid and of the Connexions service nonetheless illustrated a very clear recognition of the distress child F felt and a willingness to offer what help those agencies could.

5.2.9 The sensitivity and efforts demonstrated by the majority of agencies was *not* matched by the organisation that should have become of central importance.

5.2.10 The question of what duties and powers Children's Social Care has with respect to a young person aged seventeen plus is explored elsewhere. Setting aside what those responsibilities were, the *manner* in which invitations to engage with multi agency efforts to support child F, and formal referrals from CAMHS and Connexions were rejected was wholly unacceptable. A number of duty officers (the first being in an exchange with the school in January), were simply instructed to pass on ill-evidenced and formulaic rationales for a refusal to meet statutory obligations.

5.2.11 The author suspects that the recorded 'agreement' of other agencies to press on without Children's Social Care involvement was little more than a reluctant acceptance of the situation. For example the agreement of CPN1 in early March to contact Children's Social Care again 'if [sic] there are any signs of emotional abuse' is hard to reconcile with previous clear communications / referral from the same individual, e.g.:

…'Child F disclosed an emotionally abusive relationship with mother and a history of physical abuse' (assessment of 09.02.12 phoned through to Children's Social Care on 21.02.12)

…..A 'very serious suicide attempt', the description applied by the psychiatrist following child F's overdose in February 2012 and phoned through to a duty social worker on 24.02.12

5.2.12 Without the overview that an earlier professionals' meeting involving Children' Social Care might have provided, the growing number of agencies could not have known that their very involvement would be misused as a further excuse for the non-involvement of Children's Social Care.

WHAT TO DO IF CONCERNED ABOUT A CHILD'S WELFARE?

5.2.13 Advice offered in December 2011 when the school raised the issue of possible abuse of child F, suggested insufficient confidence within the Safeguarding in Education Team that the action required (involvement of Children's Social Care) would be effective.

5.2.14 Later events explored below i.e. the repeated refusal of Children's Social Care to respond to invitations to become involved, offer a sense of *why* the adviser to the school formed the view she did. However, to avoid making what was correctly perceived as an appropriate referral on the grounds it would be rejected was a mistake.

5.2.15 Aside from the coincidental fact it could offer an Asian outreach worker, the engagement of Women's Aid in December 2012 was curious. The primary focus of that organisation's work is on addressing abuse between intimate partners (albeit there is a high correlation between this and child abuse).

5.2.16 With the wisdom of hindsight and whilst in no way diminishing the value that child F may have placed upon this further source of sympathy and support, the significance of Women's Aid was probably marginal. Its involvement and the later consideration of Connexions and the YMCA reflected a growing sense of frustration amongst those agencies which were supporting child F at their collective inability to make a substantive difference.

5.2.17 CAMHS and other agencies clearly wished Children's Social Care would become involved so as to assess need and risk and/or offer alternative accommodation. What was lacking was sufficient confidence and/or knowledge about *how* to challenge the rejection of what originators regarded as 'referrals' and Children's Social Care (until late May 2012) defined only as 'contacts' thus justifying no further action on its part.

Was child F considered a child or an adult by agencies involved?

5.2.18 By virtue of s.8 Family Law Reform Act 1969 child F (because she was a competent minor aged sixteen or seventeen) enjoyed a right to give consent to medical treatment. Unless grounds exist for believing that such a patient is mentally incompetent, no further consent is required.

5.2.19 The dietician with whom child F met in November 2012 recognised the constraint mother's presence represented and (presumably in the knowledge of the above law) helpfully provided an appointment to see child F alone in February 2012. The dietician also honoured her promise to make follow-up contact in May, though child F chose not to respond to a phone message.

5.2.20 In December 2012 child F's request at the GP Practice that she be seen *without* her mother's presence was readily agreed. With the advantage of hindsight, it is a pity (though not a criticism of what was a reasonable judgment in the circumstances prevailing at the time) that the arrangement of such an appointment was left to child F.

5.2.21 The Safeguarding in Education Team correctly advised the school in January that the advice reportedly given child F over the preceding weekend by the Out of Office Hours Social Work Team (that her mother could *insist* on her return home if she were to be accommodated by the local authority) was incorrect. S.20(11) Children Act 1989 makes it clear that a young person of sixteen or seventeen can override what is otherwise the right of a parent to insist on resumption of care of a child accommodated under s.20 of that Act.

5.2.22 During her admission to the local hospital, child F's admission to an adult ward and a failure to involve a paediatrician in relation to allegations of hospital physical abuse or the then current overdose suggest that child F's needs were in some respects being treated as having an adult status.

5.2.23 The health overview report cites an involved professional as speaking in terms of child F 'falling down cracks between agencies' and that is a fair summary of the varying approaches within and across agencies to age-related responses.

What consideration was given to child F's capacity to make decisions about services provided to her, regarding her engagement with academic and other professionals involved?

5.2.24 Only the YES agency made an explicit reference to its contractual arrangement with child F i.e. exchanges were confidential *unless* the counsellor formed the view that a breach of confidentiality could be justified.

5.2.25 The author's view is though, that the other health-related services showed awareness of child F's capacity and sought and developed a pragmatic middle ground which navigated between the respective needs and rights of a responsible parent and those of a minor aged seventeen years of age.

5.2.26 Insofar as the school had by far and away, the most contact and involvement with child F, its staff managed very well indeed, the challenging task of maintaining a trusting relationship with both pupil and parent.

5.2.27 The *only* breach of what child F regarded as her right to limit what her mother was told, arose when the involvement of Women's Aid was revealed in the course of the meeting held in early March in the Adolescent Unit.

5.3 WHEN, AND IN WHAT WAY, WERE CHILD F'S WISHES AND FEELINGS ASCERTAINED AND TAKEN INTO ACCOUNT WHEN MAKING DECISIONS ABOUT PROVISION OF SERVICES? WAS THIS INFORMATION RECORDED?

5.3.1 As outlined above, health staff (GPs, dietician, general hospital doctors and CAMHS staff) appear to have listened to and tried to act upon their perceptions of child F's wishes and feelings.

5.3.2 The means by this was done varied. In the case of the GP2 and dietician each provided an opportunity to meet child F other than in her mother's presence. Perhaps because responsibility for arranging the appointment was left with child F in December 2011, she did not follow up this early opportunity to have a one to one consultation.

5.3.3 The police officers attending child F's home in January 2012 clearly sought and recorded what they understood child F's wishes and feelings to be. They may have underestimated the impact of mother's presence in the house and this might well account for the perception child F formed or anyway relayed to school i.e. that she had not been seen alone by officers on that occasion.

5.3.4 From the detail and clarity of the individual management review provided on behalf of the school, not only were the wishes and feelings of its pupil sought and taken into account throughout the period of review, they were also comprehensively recorded.

5.3.5 In that Children's Social Care consistently resisted acknowledging its lawful responsibilities, it failed to seek or be influenced by child F's wishes and feelings.

5.3.6 Since October 1991 when the law was implemented, s.22(4) Children Act 1989 has required the local authority to consult any child / young person 'looked after' by it. The loophole created if a child *should be*, but is not looked after was closed off when s.53 Children Act 2004 amended s.17 (assessment of need and provision of services), s.21 (provision of accommodation) and s.47 (child protection enquiries) of the Children Act 1989.

5.3.7 Thus, the Children Act 1989 *as amended*, places an obligation on the local authority to seek the wishes and feelings of each such child and (having regard to age and understanding) give them due consideration.

5.3.8 The consistent failure of Children's Social Care to accept that child F was a 'child in need' and indeed, subject to assessment, one 'in need of protection' meant that the opportunities to express her wishes and feelings to the agency were denied her.

5.3.9 Even when in late May, when a referral was finally accepted, no meaningful form of assessment was undertaken. Neither child F nor either of her parents was spoken to, nor any other action initiated by the social worker to whom the case was formally allocated. Nor was any coherent child in need process or plan put in place.

5.4 DID THE ORGANISATION INVOLVED HAVE IN PLACE POLICIES AND PROCEDURES FOR SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN AND ACTING ON CONCERNS ABOUT THEIR WELFARE?

Include, where appropriate reference, inclusion and consideration of LSCB policies and procedures.

5.4.1 The multi agency policies and procedures available on the website of Buckinghamshire's Local Safeguarding Children Board appear sufficiently clear and comprehensive for use by local professionals. Though the website is being updated to reflect the revised 2013 version of *Working Together to Safeguard Children*, it is understood that the current procedure and form for use by professionals wishing to make a referral to Children's Social Care was in place during the period under review.

5.4.2 In one minor respect only (the time limit for completion of an initial assessment) the referral form is inaccurate but it otherwise provides a clear and potentially useful means of informing an appreciation of need, risk and therefore urgency.

What is considered a contact or a referral and was this recorded?

5.4.3 What appears initially to be only a semantic difference i.e. a 'contact with' versus a 'referral to' Children's Social Care is actually of critical importance.

5.4.4 The multi agency form currently in use compounds the problem (by no means confined to this County) in that it refers throughout, to its completion as being a 'referral'. It is though received, described and recorded by Children's Social Care as only a 'contact' that may or may not be evaluated by a manager as satisfying eligibility criteria and deemed a 'referral'.

5.4.5 In practice, the way in which the then government introduced its 'Integrated Children's System (ICS) and the needs of the various companies which have sold service-user databases to local authorities has resulted in confusion, inter-agency tension and potentially heightened risk to vulnerable children.

5.4.6 If the term 'referral' is used to reflect the intention of the originator (its dictionary definition and one favoured by the author) *all* notifications and contacts are referrals. Some will require no further action, some signposting on to other sources of help and others, varying levels of formal response according to assessed need.

5.4.7 If a local authority defines the word 'referral' in a manner other than is commonly used and well understood, it creates for itself the very difficult task of promoting sufficient awareness and understanding of that position. Neither Buckinghamshire or any other local authority of which the author has any knowledge has succeeded in achieving local acceptance of such a re-definition of the term.

5.4.8 Other longer established professions e.g. Health appear to have no difficulty in making 'referrals' e.g. to a hospital and accepting that some may be rejected if the receiving agency or person concludes that they are unnecessary or require re-routing.

5.4.9 Numbers and proportions of contacts, referrals and indeed re-referrals have become examples of performance indicators, pre-occupation with which was criticised by Professor Munro in her government-commissioned report[3]

5.4.10 For as long as they remain proxy indicators of effectiveness, tampering with local definitions may result in unintended effects on comparative data sets i.e. how one local authority is compared with another and what trends are seen to be emerging from any individual area.

5.4.11 The latest *Working Together to Safeguard Children* 2013 uses the term 'referral' in its obvious sense. This may offer an opportunity for local authorities to collectively seek from the Department for Education its advice about how to avoid the problem seen often and so starkly in this case. A recommendation that the LSCB address this issue is included in section 7.

[3] The Munro Review of Child Protection: Final Report 2011

5.5 WHAT WERE THE KEY RELEVANT POINTS / OPPORTUNITIES FOR ASSESSMENT AND DECISION MAKING IN THIS CASE? DO ASSESSMENTS AND DECISIONS APPEAR TO HAVE BEEN REACHED IN AN INFORMED AND PROFESSIONAL WAY?

KEY POINTS?

5.5.1 There were many key points even in the period reviewed viz:

Consultations with GPs in October and November 2011

A consultation with the dietician in November 2011

Child F's allegation at the school in December 2011 of abuse by mother

A further consultation with a GP in December 2011

Involvement of Police and Out of Office Hours Emergency Social Work Services in late January 2012

An attempt in February by CAMHS to engage Children's Social Care

The further attempt by CAMHS to engage Children's Social Care after child F's overdose

The assessment of need and risk completed within the hospital in February and May 2012 (and non-involvement of paediatrician on both occasions)

A third attempt by CAMHS to engage Children's Social Care in April

The final apparently successful referral to Children's Social Care in May

PROFESSIONALISM OF ASSESSMENTS AND DECISIONS?

Health and other agencies

5.5.2 The responses by health professionals (GPs and dietician) during October and November 2011 were all informed and reasonable ones,

5.5.3 The school's justified wish in December 2011 to initiate a referral to Children's Social Care was diverted by the advice provided by the in-house source of expertise (SIET).

5.5.4 In December, the unforeseen result of leaving child F to initiate her requested further one to one consultation with a GP, was that no such opportunity arose for another two months.

5.5.5 Police officers (who had no specialist child protection expertise), acted professionally when they attend the family home, though *may* have under-estimated the power imbalance between child F and her mother.

5.5.6 The learning that emerges from the subsequent poor communication between Police and Children's Social Care reflects the need to have sufficient child protection expertise in those working in the Out of Office Hours Social Work Service (reportedly now in place) and for Children's Social Care to develop sufficiently robust internal communication systems that do not depend upon information flow from other agencies.

5.5.7 The efforts made by CPN1 in February to trigger the engagement of Children's Social Care were well intentioned though stopped short of using (possibly through lack of awareness of) the locally labelled 'conflict resolution' procedure i.e. to implement a previously agreed inter-agency protocol to escalate differences of professional opinion through respective management hierarchies.

5.5.8 Though the possibility of offering child F anti-depressant medication was considered whilst she was in the Adolescent Unit, the decision to first await the results of her liver function tests was standard practice and the decision (seemingly arrived at by consensus following discussions) to focus on psychological approaches entirely reasonable.

Opportunities for Children's Social Care involvement

5.5.9 The dates provided by Children's Social Care with respect to contacts / referrals sometimes differ from those indicated by other agencies. The author has formed the view that the other agencies' records are more reliable and has used them in the table below.

5.5.10 The consistently poor response of Children's Social Care is tabulated below.

Date	Other agency involved	Children's Social Care Response
January 2012	School consulted by Children's Social Care following Police attendance at home address over then weekend	Decision: 'No role for Children's Social Care'; CAMHS involvement considered sufficient
February 2012	CPN1 by phone invited attendance at a professionals' meeting with CAMHS & school & later the same day submitted the first comprehensive 'referral form'	No immediate response
February 2012	CPN1 informed Children's Social Care of child F's overdose & need to consider alternatives to home	'Manager's decision still awaited'
March 2012	CPN1 emailed an invite to attend a pre-discharge from Adolescent Unit meeting	Manager determined there was enough support in place & no social worker was required at the meeting
April 2012	Follow up email from CPN1 to highlight unresolved concerns and child F's vulnerability	Records indicate CPN1 'agreed' with a duty worker who responded that there was no current role for Children's Social Care
April 2012	CPN1 sent second email 'referral'	A social worker phoned CPN1 & advised contacting Connexions for housing advice
May 2012	CPN1 sent third email 'referral' & invitation to a Care Programme Approach review	No response given
May 2012	Connexions emailed a 'referral'	Phone response 5 days later advising Connexions explore options with child F
May 2012	CPN1 made fourth referral	Case nominally allocated to a social worker with no explicit purpose or plan – she failed to take any action

Consider if there was a shared approach to risk management ?

5.5.11 There was clearly a good deal of agreement between school and CAMHS about the level and nature of child F's needs and risks associated with those needs. Both agencies co-operated well and were very flexible in the manner in which they worked with child F.

5.5.12 The health overview report raised the possibility that, in view of child F's intermittent engagement with sources of help, some 'cold-calling' by the Crisis Team might have been preferable to responding to requests to do so from other professionals or child F herself. With hindsight, this may be so but should not detract from the fact that CAMHS staff worked hard to maintain contact.

5.5.13 There was a near total disconnect between the views of those professionals who knew or came to know child F well (school and CAMHS staff) and managers in Children's Social Care whose responses were ill-informed.

5.5.14 Those managers, even on post- mortem questioning adduced as justification for inaction, that 'several other agencies were already involved'. Whilst there is clearly some merit in an argument that too many overlapping sources of help had become involved with child F, the notion that this justified absolving the sole agency charged with statutory responsibilities for child protection and provision of alternative accommodation is wholly unacceptable.

5.5.15 If the thinking above is what informed management responses, it was naïve. If the rationale was an excuse for avoiding committing resources, it is inexcusable. Practitioners and managers are paid to recognise and articulate need (even if this means reporting insufficiency of resources or in extremis 'whistle-blowing') not to minimise it.

Were actions arising from decisions made, followed up?

5.5.16 As commented upon elsewhere, the decision by GP2 to await child's F arranging a further one-to-one appointment, whilst a reasonable one, served to delay a greater level of understanding of her distress within the Practice.

5.5.17 Though of no real consequence, the unpredicted shift pattern of the police officer who had seen child F in late January, caused there to be a slight delay in implementing her senior officer's instruction to follow up the events

5.5.18 The commitment by CPN1 in mid February 2012 to try to convene a professionals' meeting was honoured within days though achieving the required meeting proved beyond her ability at that time.

5.5.19 The most significant example of a failure to act upon a decision made is seen in the much delayed acceptance by Children's Social Care of a need to regard incoming concerns as justifying the allocation of a social worker.

5.5.20 The combined impact of poor management (no establishment of purpose or priority) and poor practice (SW5's unconvincing excuse for her inaction), coupled with an inappropriate dependence upon the unqualified CATCH worker had serious consequences. These failures denied child F the opportunity that was long overdue to have her voice heard by the agency that was positioned to and charged with assistance in such situations by virtue of s.17, s.47 and s.47 Children Act 1989 (as amended).

Was a 'Child in Need' assessment considered / conducted, comment on the decision making process if not?

5.5.21 Records within Children's Social Care offer no evidence that at any time during the first seven attempts to engage that agency's involvement was the need for a child in need assessment considered.

5.5.22 As intimated above, the responses articulated by various duty officers relaying their manager's instructions suggest a resource-driven reluctance to acknowledge and/or ignorance of child F's personal needs / risk and the agency's statutory duties.

5.5.23 Even when, according to that agency's records an initial assessment was 'completed' in late May it contained no information save for a stated intention to provide short-term services. No contact was made at that point with child F, her family or other agencies.

5.5.24 The above action is an (it is hoped rare) example of how one of the numerous Children's Social Care performance indicators (to 'complete' an initial assessment within ten working days) can be satisfied whilst in practice doing little or nothing to actually assess the level of need or risk.

Was due consideration given to the concerns of emotional abuse?

5.5.25 School staff had known child F longer than any other professional who became involved. Whilst many seemed to be aware of mother's exceptionally controlling manner, only one made a passing and informal reference to this being exceptional.

5.5.26 The GPs who saw child F and her mother together observed a lack of interaction but did not characterise the situation as one of emotional abuse.

5.5.27 The limited involvement with the YES counselling service began to reveal the centrality of the mother-daughter relationship amongst a larger number of stressors.

5.5.28 By late January, the phone call to the Out of Office Hours Children's Social Care Services referred not only to alleged physical abuse but to fear and consequent self-harming that would have justified a conclusion of potential emotional abuse and justified enquiries under s.47 Children Act 1989.

5.5.29 The initial failure to identify potential emotional abuse was compounded by the actions taken by the duty worker (on the instructions of her manager) in early February when she indicated to CAMHS that there was no role for Children's Social Care.

5.5.30 The letter written to mother later that day not only failed to raise any concern with mother about the allegations of physical, and what could have been regarded as emotional abuse, it entirely overlooked child F's needs and wishes and feelings. Child F's chance sighting of that letter some weeks later may have added to her sense that she was worthless.

5.5.31 Several clear assertions by CAMHS that child F was experiencing 'emotional abuse' and required Children's Social Care intervention and possibly alternative accommodation became diluted over time, viz:

'Child F disclosed an emotionally abusive relationship with her mother and a history of physical abuse' (CPN1's initial assessment in early February)

'We have agreed that child F is suffering emotional abuse and has a history of physical abuse' (summary of the Mental Health Trust's child protection nurse after CPN1 had consulted her in mid February 2012); curiously that adviser justified her statement with reference to domestic abuse rather than child protection procedures

CPN1 phoned Children's Social Care and shared her concerns about child F's 'emotionally abusive home' later that month following this up with a comprehensive referral form the same day

By early March (by which time child F had survived her 'very serious suicide attempt' and been discharged from the Adolescent Unit, CPN1 agreed (according to that agency's records) to re-contact Children's Social Care *if* [sic] there are any signs of emotional abuse

By early April, though her concerns about proposed case closure in this 'emotionally abuse situation' remained high, CPN1 seemed to be seeking only 'input and/or advice' from Children's Social Care

5.5.32 Given the consistently negative responses she received it is scarcely surprising that CPN1 lowered her expectations. Records indicate that her concern and level of commitment did not diminish.

5.6 WERE THERE ANY ISSUES, IN COMMUNICATION, INFORMATION SHARING OR SERVICE DELIVERY, BETWEEN THOSE WITH RESPONSIBILITIES FOR WORK DURING NORMAL OFFICE HOURS AND OTHER PROVIDING OUT OF HOURS SERVICES?

5.6.1 The first example of difficulty arising in consequence of 'office hours' and 'out of office hours' working, arose over a weekend in late January 2012. Given the allegation from child F that she had been hit in the past and clearly appeared currently fearful, a more formal strategy discussion with Police would have been justified.

5.6.2 Though the Police individual management review regrets a delay in its officer following up the event of that weekend with Children's Social Care, the

author takes the view that the responsibility for follow-up lay chiefly with Children's Social Care.

5.6.3 Information supplied provides reassurance that since May 2012 staff within the Out of Office Hours Service are sufficiently qualified and experienced and are no longer dependent upon Police for child-protective action outside of office hours.

5.6.4 There was a significant delay following child F's overdose in late May before the school nurse was informed of the incident. Had the communication between school and CAMHS not been so good, this could have had adverse consequences.

5.7 WAS PRACTICE SENSITIVE TO THE RACIAL, CULTURAL, LINGUISTIC AND RELIGIOUS IDENTITY AND ANY ISSUES OF DISABILITY OF THE CHILD & FAMILY, AND WERE THEY EXPLORED & RECORDED?

Was practice sensitive to the cultural impacts on child F individually, at home and within her academic and social environments?

5.7.1 Some agencies sought to capture child F's ethnic origin (though few recorded it correctly). Not all considered or addressed with mother or child F its consequences:

At home, with a professional mother raised in another country where their heritage posed challenges for advancement, yet determined to see her daughters succeed within the UK.

At school, where the pressure of keeping up with peers, academic targets and an older (and allegedly favoured) sibling at university would have been considerable – though the commendable efforts of school staff to provide all the support that staff could, should not be overlooked

With friends, whose levels of freedom from parental control were likely to have been significantly and obviously different to that of child F

Was consideration given to cultural pressures on child F's academic ability during the assessment process?

5.7.2 Insofar as the school will undoubtedly have had experience of other intelligent, hard working pupils of Asian origin, its staff may not have regarded the ambitions of either child F herself or her mother to have been exceptional.

5.7.3 It is not apparent from the individual management review provided to what extent staff regarded the origin of mother's need to control her daughter's appearance, friendships or movements as a function of culture (ethnicity, race and religion) as opposed to a reflection of an overly controlling personality type.

5.7.4 There is no evidence in the accounts of Police, general hospital or Adolescent Unit to indicate that these subjects were explored.

5.7.5 The issues of cultural conflicts were ones that could usefully have been (and perhaps were) being considered by CAMHS professionals. Records do not however confirm such consideration.

5.7.6 Clearly, the overall failure of Children's Social Care to recognise a role for itself denied the family any opportunity for social workers to explore the respective norms and expectations of each parent and child F.

Were cultural expectations within child F's parental relationships considered and explored?

5.7.7 As in so many serious case reviews, the significance of the father was underestimated by agencies. When latterly he was involved by CAMHS, it was beginning to become clear that he personified the possibility of a more moderate and less conflictual relationship for child F.

5.7.8 Records of those working with child F and her parents offer no evidence that the roots of the parental differences in beliefs and expectations of children were being explored e.g. the death of both maternal grandparents within a year of one another when the mother of child F was the same age as child F was known and remained unexplored.

5.7.9 In addition to their relevance to child F's psychological security and her self-esteem, the practical possibility of father being able to offer an acceptable (to mother) alternative home remained unexplored by Children's Social Care.

To what extent were child F's relationships with her parents considered and explored?

5.7.10 The relative 'invisibility' of father appears to have been accepted by involved agencies. In consequence, the family became characterised by the highly conflictual mother-daughter relationship. Mother's lack of engagement with family therapy constrained its potential value and the school was the only agency to have positively engaged with child F's father and recognised his genuine interest and potential value to his daughter.

5.7.11 There were clearly attempts made (by means of family therapy) by CAMHS staff to facilitate and inform an improvement in the mother-daughter relationship, their attempts to obtain Children's Social Care involvement was an indication of a degree of (probably well founded) pessimism that the relationship would improve whilst under the same roof and whilst child F remained an A level student.

5.8 WERE SENIOR MANAGERS OR OTHER ORGANISATIONS AND PROFESSIONALS INVOLVED AT THE POINTS IN THIS CASE WHERE THEY SHOULD HAVE BEEN?

5.8.1 Involvement of the school's senior management including those with specific responsibilities e.g. head of 6th form appear to have been exemplary. Staff also worked closely with the professionals from CAMHS and participated actively in the planning at the hospital and later the Adolescent Unit.

5.8.2 The police officers briefly involved with child F in late January appropriately involved senior officers. The presumption that the Out of Office Hours Service would alert day-time Children's Social Care was a reasonable one.

5.8.3 Whilst treated at the general hospital, there was an appropriate use of senior staff, though the paediatric team and CPN1 might usefully have been directly involved in child F's re-assessment at the time of her second overdose.

5.8.4 The CAMHS staff discussed child F's situation with one another and sought advice as required e.g. CPN1's consultations with her named nurse for child protection and a consultation with psych.3 when child F began to manifest a severe stutter in late March 2012.

5.8.5 The involvement of Women's Aid and of Connexions was well intentioned but could add little value to the significant efforts being made by all those who were actively involved with child F and her family.

5.8.6 The persistent and failed attempts by CPN1 to engage Children's Social Care is documented elsewhere. Connexions also tried and failed to gain acceptance by that agency of the contention that its involvement was vital.

Escalation of concerns – including responses for a child dis-engaging with services?

5.8.7 There seems to have been a widespread ignorance of, or insufficient willingness to employ, a locally labelled 'conflict resolution' protocol. At least one of the several opportunities to challenge via senior managers, the stance adopted by Children's Social Care's office should have been taken.

5.9 WHAT MEETINGS TOOK PLACE? WHAT WAS THE STATUS OF THESE MEETINGS AND HOW EFFECTIVE WERE THEY?

5.9.1 The following meetings were of significance in terms of the understanding of need and planning of service delivery:

A Care Planning Approach meeting in mid March

A meeting convened by the deputy head teacher in mid May

A Care Planning Approach review at the end of May

An abortive Care Planning Review scheduled for late June

5.9.2 The first Care Planning Approach meeting agreed what appears, even with hindsight, to be a clear and practical plan which enjoyed the support of all present.

5.9.3 The absence of Children's Social Care at this and all subsequent inter-agency discussions weakened the value of what was put in place. For example, an agreement made to 'keep living arrangements under review' presumably referred to the possibility of Children's Social Care involvement and/or provision of an alternative to living with mother. This option was not available to the agencies represented at this meeting.

5.9.4 The internal meeting convened by the deputy head teacher provided several clear and useful steps to be taken by members of staff and offers a further example of the collective commitment shown toward this troubled pupil by the school.

5.9.5 The further review meeting scheduled for late June was aborted when neither mother nor child F attended. For the latter anyway (and given her reported threats next day to kill herself), this failure to participate may have marked the beginning of a level of despair so great as to lead on to child F taking her own life eleven days later.

5.9.6 What was missing and in theory at least should have been triggered by the much-belated allocation of a social worker in late May was a multi-agency 'child in need' meeting. Insofar as the allocated worker initiated no action whatsoever and the CATCH worker became only another observer of child F's distress, there is little reason to assume such a meeting would (as required by internal procedures), have been convened in a timely fashion. Certainly, by the time child F died a month later, the need for such a forum had not been recognised nor steps taken to convene one.

5.10 WERE THERE ORGANISATIONAL DIFFICULTIES BEING EXPERIENCED WITHIN OR BETWEEN AGENCIES? WERE THESE DUE TO A LACK OF CAPACITY IN ONE OR MORE ORGANISATION?

BETWEEN AGENCIES

5.10.1 A challenge which confronted all involved agencies was that of child F's age and maturity. The way that each agency or professional sought to strike a balance between supporting mother in her legitimate exercise of parental responsibility whilst recognising and supporting child F's own rights as a seventeen year old of high intelligence with 'mental capacity' and an ability to articulate her needs for protection and alternative accommodation is described elsewhere.

5.10.2 Of *central* importance to the difficulties experienced between the majority of agencies in this case (the exception being the Police) and the position apparently espoused by the managers and practitioners within Children's Social Care was a different understanding of relevant law.

5.10.3 It remains unclear to what extent the perceptions of other agencies e.g. the adviser in the Education Services' SIET, or CAMHS staff was rooted in experience of similar difficulties referring those aged sixteen and over to Children's Social Care. The rejection of repeated referrals (by means of deeming them 'contacts' that did not satisfy eligibility criteria) was unjustified and arguably unlawful.

5.10.4 Notwithstanding all the practical difficulties and dilemmas that this position poses, statute law is clear. For purposes of the Children Act 1989, a child remains a child until s/he reaches eighteen years of age. The responses of Children's Social Care suggested managers were unaware of this fact or chose to ignore it.

5.10.5 Some or potentially all the following provisions of that law applied to child F:

S.47 …when a local authority has reasonable grounds to suspect that a child is suffering or is likely to suffer significant harm

S.17 …a general duty to safeguard and promote the welfare of children within its area and insofar as it is consistent with that duty, to promote their upbringing by their families by providing range of and level of services appropriate their needs (this *can* include, after an assessment help with accommodation or accommodation itself under s.20[4])

S.20 …every local authority shall provide accommodation for any child in need within there area who appears to them to require accommodation as a result of there being no person who has parental responsibility for her/him

5.10.6 Case law[5] has further clarified that the correct approach is for a local authority to determine whether a child requires accommodation or merely help with accommodation *without* having regard to the implications of her/him becoming looked after.

5.10.7 As a result of a further test case[6] it is now clear that the tests which Children's Social Care should have applied were (given that there was no dispute as to age or ordinary residence in the area) simply ….'is child F a 'child in need'?

5.10.8 Had she ever been assessed under s.17, child F's vulnerability by virtue of her mental health, her 'sofa surfing' in two or possibly more families coupled with her clearly expressed wishes would inevitably have concluded that she was 'in need' as defined in s.17(10) Children Act 1989.

WITHIN CHILDREN'S SOCIAL CARE

5.10.9 Even when Children's Social Care belatedly accepted the need for its involvement and allocated a named social worker, little changed.

5.10.10 The briefing provided about the role and status of the CATCH service makes it clear that it failed to follow its own procedures which required the registered social worker to lead on case management, with the CATCH worker completing more practical task defined by a child in need meeting and encapsulated in a child in need plan. No such meeting was convened and no such plan drafted.

HOSPITAL / CAMHS

5.10.11 What information was shared with the medical team at the local hospital following the CAMHS assessments of child F after her deliberate self-poisoning is not well documented. It is not standard practice for CAMHS practitioners to write in hospital notes and hospital staff do not have access to CAMHS records.

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[4] Local Authority Circular (2003) 13 'Guidance on Accommodating Children in Need and their Families DH
[5] R(H)v Wandsworth London Borough ; R Barhanu v Hacknet Borough [2007] EWHC (Admin)
[6] Law Lords in R(G) v Southwark LBC

5.10.12 It does not appear that discussions between the teams occurred during either hospital admission. The initial assessment by the medical team was not shared with the CAMHS team and therefore taken into account in the overall analysis of risk. There is apparently, no record of a risk assessment in the hospital notes.

5.10.13 It is not easy to access copies of previous records of admissions / attendances to EMC as these are stored off-site. A computer record of the attendance is kept though it contains minimal information and would give only a diagnosis with no details of assessments or risk e.g. it might state self-harm as a diagnosis but is unlikely to indicate significant suicide attempt or type of self-harm. In-patient records would include a copy of the EMC record card and include details of recorded assessments treatments and outcomes. These records are more readily available during working hours.

5.10.14 As child F was not formally admitted in February, an in-patient record was not created for this episode and only an EMC record was kept. This record was not available when F re-presented in May and therefore information from the first episode was not accessed to form part of the risk assessment on the second occasion. This is unlikely to have impacted on this case as child F was able to talk and was honest about her previous attempt. Had she arrived unconscious this information would not have been available. A recommendation about this issue is included in section 7.

5.10.15 It is right to acknowledge that the generally good standard of work delivered by CPN1 and members of the Crisis Team was in spite of a significant shortfall in numbers of available practitioners and managers.

5.11 ADDITIONAL ISSUES COVERED IN THE PARTNERSHIP REVIEW

5.11.1 The above material has sought to take account of the following specific questions included in the 'partnership review' that had been initiated prior to its upgrading to a serious case review:

- Was any mental health diagnosis actually formed, being formed / considered by the agencies?
- What was the view / belief held about child F's allegations and the understood status of the case
- What assessments were undertaken
- Were there gaps in recording relating to significant events – and if so why? e.g. overdose of late May
- What were the outcomes for referrals made to other agencies

5.11.2 The above questions have been addressed and the only additional responses that may add value to what is covered elsewhere are that:

- No specific diagnosis (beyond 'mild to moderate depression') had been / was being formulated, nor was necessarily required at the point of child F's discharge from the Adolescent Unit
- CAMHS and to a lesser extent school, regarded child F's observed and reported behaviours to reflect a level of 'emotional abuse' whereas Children's Social Care made an assumption (on the basis of minimal evidence) that the behaviours reflected mental health issues capable of management by CAMHS and other agencies and not requiring its involvement
- Assessments undertaken by GPs, dietician, CPN1, Crisis Team members and the Adolescent Unit were proportionate to observed need
- No assessment of need / risk was undertaken by Children's Social Care
- Standards of record keeping between agencies ranged from high (school) through good or adequate (Police and other agencies) to very poor (Children's Social Care)
- The only referrals that raise concerns are the several failed attempts to trigger action by Children's Social Care

5.12 SELF-HARMING IN THE GENERAL POPULATION

5.12.1 Deliberate self-harm is the greatest predictor of eventual suicide[7] and over 40% of completed suicides are preceded by a previous attempt[8].

5.12.2 Young people usually start to self-harm as the result of a complex combination of experiences, not one single event or experience:

- Mental health problems e.g. hopelessness and depression
- Family circumstances e.g. parental criminality and/or family poverty
- Disrupted upbringing e.g. periods of local authority care, parental marital problems such as separation or divorce
- Continuing family relationship problems[9]

5.12.3 The most frequent reasons mentioned by young people were:

- Being bullied at school
- Not getting on with parents
- Stress and worry around academic performance and examinations
- Parental divorce
- Bereavement
- Unwanted pregnancy
- Experience of earlier abuse (sexual, physical, and/or emotional)
- Difficulties associated with sexuality
- Problems to do with race, culture or religion
- Low self-esteem
- Feelings of being rejected in their lives[10]

5.12.4 Research has also shown that Asian women aged 15 to 35 are two to three times more vulnerable to self-harm than non-Asian counterparts[11] and available research suggests rates of self-harm and eating disorders are higher among adolescent Asian girls.

[7] Welch SS (2001) A review of the literature on the epidemiology of parasuicide in the general population Psychiatric Services 52 (3): 368-75
[8] Walker Z and Townsend J (1998) Promoting adolescent mental health in primary care: a review of the literature Journal of Adolescence 21 (5): 621-34
[9] Fox C and Hawton K (2004) Deliberate Self-harm in Adolescence. London Jessica Kingsley Publishers
[10] Truth Hurts, Report of the National Enquiry into self-harm among young people 2006 Mental Health Foundation
[11] Soni-Raleigh V (1996) suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales Ethnicity and Health 1 55-63

5.12.5 Newham Asian Women's Project research[12] revealed a complex range of disturbing issues with accounts of isolation and despair and many forms of abuse within families. There were reported conflicts between generations in families but also additional religious and social pressures with many reporting pressures which include rigidly defined matrimonial roles and the duty of women to maintain the family honour. Many expressed their concern at the unrealistic expectations demanded of them from their families.

5.12.6 A number of risk factors had been identified by those working with child F and included her conflictual relationship with mother, academic pressure, and moderate depression. Other issues might well have emerged if she or her family had engaged better with the services offered.

INCREASING PREVALENCE

5.12.7 In answer to a Parliamentary question on 05.12.11, the then Minister of Health revealed that over the past ten years, the number of young people under the age of twenty four who had been hospitalised because of self-harm had increased by 68%.

5.12.8 During 2010-11 three times as many girls aged between fourteen and eighteen were hospitalised due to self-harm than boys in this age group (absolute numbers 12,637 girls).These figures highlight the wider societal context and within it the greater vulnerability of girls.

5.12.9 Because the above figures reflect only those who were hospitalised the actual numbers who self-harmed was much greater.

[12] Newham Asian Women's Aid Project and Newham (1998) Growing up Young Asian and Female in Britain: A report of self-harm and suicide London: Newham Asian Women's Project and Newham Inner city Multifund

6 FINDINGS AND CONCLUSIONS

6.1 INTRODUCTION

6.1.1 This section encapsulates the learning from this case for the way in which agencies worked to safeguard and promote child F's welfare. It offers a brief summary of good and sub-optimal response (systemic and individual).

6.2 FINDINGS

GOOD PRACTICE

6.2.1 Examples of 'good' practice by professionals (i.e. *exceeding* what would be expected in comparable cases) were as follows:

- The school's persistence in offering pastoral and academic support and in its attempts to engage Children's Social Care
- The speed and thoroughness of initial Police response in January
- The dietician enabling child F to speak for herself at the follow up consultation in February 2012
- The frequency of contact with, and efforts made to support child F by CAMHS staff (CPN1 and Crisis Team members)
- The recognition by GPs of child F's right to confidentiality and the efforts made to strike a balance between that right and the overriding need to ensure her survival

SUB-OPTIMAL PRACTICE

6.2.2 There were several examples of practice which fell below the minimum standard a service user might reasonably expect:

- A widespread misunderstanding amongst local agencies (the exception being the Police) that for purposes of child protection, a child remains a child until s/he is 18 and how to ensure that the provisions of s.20 Children Act 1989 are made to work for vulnerable individuals
- A *serious* Children's Social Care management failure to understand or comply with the duties of either s.17, s.20 or s.47 Children Act 1989
- An unrecognised need across the involved agencies to *escalate* concerns through the Children's Social Care hierarchy
- A belated and ineffective involvement of the CATCH team and social worker by a Children's Social Care manager (which undermined the value of the worker's efforts)
- (Though of no consequence in this case) a systemic communication weakness between Police and Children's Social Care revealed by the 101 call in February 2012

6.3 CONCLUSIONS

6.3.1 Some agencies e.g. school and CAMHS expended a considerable amount of energy and time in commendable efforts to understand and respond to child F's high level of need and to mitigate the risks this posed.

6.3.2 Children's Social Care responses failed to assess need and risk and a need for alternative accommodation or care.

6.3.3 The consequences of the reluctance in Children's Social Care to meet its responsibilities were compounded by a number of factors:

- A shared uncertainty across the network about relevant law and about the extent to which child F could or should use adult-oriented services
- A lack of awareness of or a reluctance to use an 'escalation policy' so that the repeatedly poor responses of Children's Social Care could be challenged
- Insufficient appreciation of the fact that without regard to the nature of child F's A psychiatric / psychological symptoms, her social needs could not be met by educational or CAMHS professionals alone i.e. Children's Social Care involvement was critical not optional

7 RECOMMENDATIONS

RECOMMENDATIONS	INTENDED OUTCOME
SAFEGUARDING CHILDREN BOARD	
1.The LSCB should establish, within the County and amongst other LSCBs the ways in which the terms 'contact' and 'referrals' are applied and use the intelligence gained to inform further local or national action	Greater clarity with respect to the operational distinction of the terms and their value when used for comparative data applications
SERVICE DELIVERY: Local Agencies	
Buckinghamshire Health Care Trust	
2. The Trust should develop a policy for children and young people who present at an EMC following self-harm	Ensuring clarity and consistency of expectation across the Trust
3. The Trust should introduce and maintain a programme of specific training for EMC staff about self-harm amongst children & young people	Better informed management (responsibilities and required actions) of self-harming children and young people
4. The Trust should complete an audit of attendances at Emergency Medical Centres (EMCs) of children & young people who have a history of self-harm.	Data to inform the scale and nature of the challenge
5. The Trust should reinstate the 'EMC forum' [subject to endorsement by senior staff in that department]	An opportunity for staff to reflect on child protection cases, review management challenge and improve practice.
6. Ensure BHT are working toward one set of records available electronically within A&E (Laming 2009)	Will assist staff with risk-assessment, diagnosis, management and facilitate best practice
Oxford Health NHS Foundation Trust	
7. The Safeguarding Team should provide information to staff about the Local Safeguarding Children Board 'conflict resolution' and how to escalate a case	Improved knowledge of and greater confidence about its use
8. Review documentation of clinical supervision within the CAMHS team	Ensuring compliance with Trust policy
9. A proforma should be developed and used during CAMHS multi-disciplinary case discussions.	Clearer records of attendance, discussions and outputs
Children's Social Care	
10. If the criteria for triggering s 47 Children Act 1989 enquiries are satisfied, they must be conducted as thoroughly for those aged sixteen or seventeen as they would be younger children	Improved understanding of and responses to risk

11. If a young person is deemed Gillick / Fraser – competent s/he should be provided with information directly from Children's Social Care	Young people can then make an informed decision if they want to access Services.
12. Fathers should be involved in any assessment process	Assessments will be more holistic and 'Human Rights-compliant' and will highlight an often neglected source of potential support or risk
13. If after consideration, a request by CAMHS or other services to attend an inter-agency meeting is declined, a clear justification should be recorded	Enhanced clarity of mutual expectations and more effective information sharing
14. An audit of a sample of cases to CATCH should be undertaken to establish if there is a clear plan in place for each child / young person.	The extent to which cases open to CATCH do not have a regularly reviewed 'child in need' plan in place will be made clear
15. A clear written protocol should be developed for involvement of the CATCH Service that clarifies respective requirements of its staff and an allocated social worker in terms of roles, planning, contact with child and family, recording and case review	Clearer accountabilities
16. All relevant staff should be reminded that: All information received (including emails) should be recorded onto the 'Integrated Children's System' (ICS) Serious incidents e.g. overdoses should be flagged as significant events on ICS Information should be added to 'Livelink' within 24 hours of receipt Chronologies should be started from the first contact recorded on ICS	Facilitating and informing decision making.
17.The existing joint protocol between Children's Social Care and the District Councils should be re-launched to ensure that all staff are aware of this protocol	Compliance with the Southwark judgement and improved understanding of respective roles and responsibilities for vulnerable young people of sixteen and seventeen

Thames Valley Police	
18. The Service should implement a communication strategy to ensure that all staff understand that 'out of hours' child protection issues / updates must be made to the 'Referral Centres' and not the local 'Child Abuse & Investigation Unit' (CAIU)	Improved clarity of expectation
19. The Service should issue written clarification about the out of hours roles and responsibilities of the CAIU and Referral Centre detective sergeants to internal staff and to partner agencies	Improved clarity of expectation
Health Commissioners	
20. Commissioners should ensure there is an agreed	Enhanced clarity about

pathway across all health – providers for the management of children and young people who self-harm	expectations
GP Practice	
21. None, though the current review by commissioners of the self-harm pathway for teenagers (including the threshold for GPs to initiate referrals) should help in similar future situations	Enhanced clarity about expectations
School:	
22. Staff should be reminded that the current 'staff handbook' requires that urgent medical advice is sought if a pupil is suspected or known to have ingested an overdose of tablets	Reducing the risks associated with delayed treatment in the case of some drug overdoses e.g. Paracetamol

7.1.1 So as to ensure effective implementation of the above recommendations, each agency has developed an 'action plan' that includes allocation of responsibilities and deadlines for completion of specified tasks.

8 GLOSSARY OF ABBREVIATIONS / NAMES

Abbreviation	Meaning
CAMHS	Child and Adolescent Mental Health Service
CATCH	A non-case holding team within Children's Social Care which provides intensive support to families at risk of breakdown
Connexions	A source of vocational and personal advice for young people
EMC	Emergency Medical Centre (often referred to as A&E)
IA	Initial assessment (a standardised means used by children's Social Care of gathering and analysing information so as to identify need and potential risk)
IMR	Individual management review (a report provided by each agency to the SCR panel drafted by a suitably experienced author from within the agency who has had no supervisory or management responsibility for the case under review)
CMHT	Community Mental Health Team
CSC	Children's Social Care
PA	Personal Adviser (a role within Connexions)
PEC	Police Enquiry Centre (which process the majority of non-emergency calls from the public via use of the number 101)
PSHE	Personal Social & Health Education (an element of the National Curriculum)
OSCA	Outreach Service for Children & Adolescents (A CAMHS service referred to in this report as the Crisis Team**)**
SIET	Safeguarding in Education Team (an internal source of advice about safeguarding for local education staff)
YES	Youth Enquiry Service (YES) (a Wycombe based self-referral counselling and advice centre)
YMCA	Young Men's Christian Association

Title	Meaning
Oxfordshire Health NHS Foundation Trust CAMHS	
CPN1	Community psychiatric nurse
SMHP1	Crisis Team
SMHP2	Crisis Team
SMHP3	Crisis Team
SMHP4	Crisis Team
MHP1	Crisis Team
MHP2	Crisis Team
Family therapist	CAMHS
Psych.4	Senior House Officer (CAMHS)
Psych. 1	Consultant psychiatrist at Adolescent Unit
Psych. 2	Consultant psychiatrist
Psych. 3	Consultant psychiatrist

GP Practice	
GP1	
GP2	
GP3	
GP4	A locum GP
Children's Social Care	
SW1	Out of office hours social worker
SW2	Duty social worker)
SWM1	Social work manager
SWM2	Team manager
SWM3	Assistant team manager
SW3	Social worker
SW4	Social worker
SW5	Allocated social worker
CATCH worker	
Education	
	6th form student manager
	Head of 6th Form
	Manager Safeguarding in Education team (SIET)
	Student welfare Officer
Connexions	
PA1	Personal adviser
PA2	Personal adviser

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APPENDIX: TERMS OF REFERENCE

1. Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable of potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

    a. Was Child F considered a child or an adult by agencies involved?

    b. What consideration was given to Child F's capacity to make decisions about services provided to her, regarding her engagement with academics and other professionals involved?

2. When, and in what way, were Child F's wishes and feelings ascertained and taken into account of when making decisions about the provision of services? Was this information recorded?

3. Did the organisation involved have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

    a. Include, where appropriate reference, inclusion and consideration of LSCB policies and procedures.

    b. What is considered a contact or a referral and was this recorded?

4. What were the key relevant points/opportunities for assessment and decision making in this case in relation to Child F and her family? Do assessments and decisions appear to have been reached in an informed and professional way?

    a. Also consider if there was a shared approach to risk management in this case.

    b. Were actions arising from decisions made, followed up?

    c. Was a 'Child in Need' assessment considered/conducted, comment on the decision making process if not?

    d. Was due consideration given to the concerns of emotional abuse?

5. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and other providing out of hours services?

6. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

    a. Was practice sensitive to the cultural impacts on Child F, individually, at home and within her academic and social environments?

    b. Was consideration given to cultural pressures on Child F's academic ability during the assessment process?

c. Were cultural expectations within Child F's parental relationships considered and explored?

d. To what extent were Child F's relationships with her parents considered and explored?

7. Were senior managers or other organisations and professionals involved at the points in this case where they should have been?

a. Escalation of concerns – including responses for a child disengaging with services?

8. What meetings took place? What was the status of these meetings and how effective were they?

9. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisation?

Reports and analysis to take account of the specific terms of reference covered in the partnership review process:

1. Was any mental health diagnosis actually formed, being formed/considered by the agencies?

2. What was the view/belief held about Child F's allegations and the understood status of the case?

3. What assessments were undertaken?

4. Were there gaps in recording relating to significant events – and if so why? (e.g. overdose)

5. What were the outcomes for referrals made to other agencies/services?

APPENDIX 1: MERGED CHRONOLOGY –SUPPLIED SEPARATELY