KNOWSLEY
SAFEGUARDING CHILDREN
PARTNERSHIP

Serious Case Review

Child Y

This report is written for publication in line with statutory guidance. In order to preserve the anonymity as far as is possible, the author has:

- used letters to reflect each child and adult
- made limited reference to the gender of person, other than where not to do so would compromise the reader's understanding of the report
- restricted the use of exact dates

1. The circumstances which led to the Serious Case Review

1.1 Child Y died having attended college that morning prior to leaving at lunchtime. Directly prior to this incident, Child Y had argued by text message with their partner.

1.2 The family had experienced some challenges related to parental mental health difficulties and subsequent marital separation.

1.3 Child Y had been supported by a range of statutory and non-statutory children's services intermittently over a period of ten years. During primary school years, Child Y was identified as a young carer in relation to the health of his father. The family had accessed both family support services and Child and Adolescent Mental Health Services (CAMHS).

1.4 During senior school years, Child Y and the family were less visible to services, although in the latter years, services were provided to a sibling. During this time, Child Y had on occasion stated that he felt fearful of the sibling. Support was sought through school counselling services.

1.5 Child Y commenced college. However, within a few months Child Y made the decision to leave college to pursue an alternative career. He subsequently returned to college but began to struggle emotionally. After a period of supporting Child Y, the college made a referral to the Family First support service for additional support. During the screening of the contact, a duty worker spoke to MY, who stated she did not feel the family needed any support as she was managing the situation. The response was discussed with the school and no resource was allocated.

1.6 Over the Christmas holiday, Child Y attended hospital Accident and Emergency Department accompanied by MY. Child Y had self-harmed to both forearms overnight and stated this was the first instance of self-harm. Child Y did not wait to be seen by a mental health practitioner after a triage assessment. The hospital recorded that a referral was made to the CAMHS assessment and response team. However, CAMHS have no record of having received this referral.

1.7 Child Y later met regularly with a school pastoral support worker. MY arranged for Child Y to see a private counsellor and advised the college of this. Both professionals considered that Child Y gave every indication of secure mental health. He discussed his plans for his immediate and long-term future, and both the college and the counsellor have been entirely shocked by Child Y's actions.

1.8 The Coroner ruled that Child Y had taken his own life.

1.9 In considering the circumstances of this case, the Independent Chair of the Local Safeguarding Children Board decided that there should be further exploration of the potential for learning in relation to children at risk of self-harm and suicide. In particular, there was an evident need to understand the role of emergency services in responding to Child Y immediately prior to his death and to establish why there appeared to be a delayed response. Accordingly a Serious Case Review commenced in June 2018.

2. Methodology

2.1 Working Together 2015 requires that Serious Case Reviews are conducted in such a way that:

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

2.2 The methodology is intended to capture both the practitioner perspective and a wider systemic understanding of how effectively individual agency processes combined to best safeguard the interests of Child Y. A Detective Chief Inspector was appointed to chair the Review and an Independent Author, experienced in undertaking Serious Case Reviews and not connected to any agencies in the area, was commissioned to support the learning and write an Overview Report.

2.3 A Review Panel of senior officers from agencies who had connection with, or worked with Child Y and the family was established. This included Police, Designated Doctor, Named GP and Designated Nurse Clinical Commissioning Group, Children's Social Care and Early Help, Education, Youth Offending Service and Legal Services.

The Local Safeguarding Children Business Unit supported the panel.

2.4 The Review Panel members coordinated their agency engagement with the Review. This included providing a written timeline of significant events, an analysis of their actions and interventions, coordinating the gathering of information, and identifying and supporting the professionals involved with the family who could contribute directly to the review.

2.5 The Review was keen to involve practitioners who had direct involvement with Child Y and the family. The passage of time from some of the periods of intervention meant this was not always possible. The Author was able to have structured conversations with a range of professionals from each key agency who had a good understanding of the interventions from their agency perspective and could offer reflection how effectively they worked within the multi-agency partnership.

2.6 The information used to inform this Review has been collected through the Agency Reports, meetings with practitioners directly involved in the case and some specifically sourced documentation. The Author was also given access to a Duty of Candour Report by the Ambulance Service and a Report for the Police Professional Standards Department. In addition, the Author was able to meet with MY and undertake a conversation with the privately engaged counsellor to establish a more complete picture of Child Y in the period leading up to the incident.

3. Scope and Key Lines of Enquiry

3.1 The Review Panel determined that the Review should review all agency contact in relation to Child Y with a specific focus on the months leading up to the incident. It was noted from the outset that contacts in respect of Child Y during adolescent years were less frequent than in respect of a sibling. However, the review agreed to also consider these contacts so that a focus could be given to understanding the relationship between the siblings.

3.2 In order to stay focussed on the purpose of the Review, the review maintains an emphasis on:

- Understanding Child Y's journey through services
- Achieving an understanding of Child Y's day to day life
- An analysis of how effectively services were delivered, and whether there were missed opportunities to provide greater support to Child Y and his family
- Whether any indicators of vulnerability could have provided a better understanding of Child Y's emotional and mental health

3.3 In order to complete an appraisal of practice, the review has considered the following questions:

1. What assessments were undertaken and how were these used to safeguard and promote the welfare of Child Y
2. Were judgements with regard to the levels of vulnerability of Child Y taken responsibly and in accordance with expected standards of practice
3. What multi-agency processes were utilised and was information shared across agencies at appropriate points? If not, what prevented this from happening?

4. Overview of what was known to Agencies

4.1 At the time of death, Child Y had been in a relationship with PY, for approximately six months.

4.2 At the age of 8 years, Child Y spoke at school about worries in relation to his mum and dad who were having arguments and separating. At this young age, Child Y spoke about wanting to jump off a bridge or put something in his arm to hurt himself. He had witnessed the effects of his father's poor mental health and had an awareness of attempts at suicide. MY engaged with assessment by CAMHS where it was revealed that an elongated period of parental separation had affected emotionally on Child Y. The school provided additional support to Child Y.

4.3 In July of the same year, the school made a referral to Children's Social Care. This resulted in as assessment as young carer for Child Y and the sibling. The assessment concluded that the family did not require support from Children's Social Care directly. Two years passed with no further agency contacts.

4.4 In November and December 2012 Children's Social Care received two referrals, one from adult mental health services concerned that FY had low mood and suicidal ideation which was affecting the siblings within the family unit. A further referral was from the school advising that further assessment was needed to progress the siblings needs as young carers. In response to the referrals, Children's Social Care undertook a single assessment. A period of child in need planning was recommended, there is however, no indication that this recommendation was implemented.

4.5 The GP also made a referral to CAMHS, which outlined that Child Y's mood and feelings were triggered by FY's depression episodes that happened every 2-3 months. In December 2012, Child Y was further seen by CAMHS. It was determined that Child Y presented no risk of self-harm and was discharged on that basis. A further two years passed without agency contacts.

4.6 In June 2015, the school made a referral to Children's Social Care in respect of Child Y's sibling, who, it was alleged, had been violent to Child Y and to other peers in school. The response resulted in the Family First service becoming involved with the family from January to June 2015. The work took a whole family restorative approach to enable the family to resolve issues together. At the point of closure, no risks were identified in respect of Child Y. There was no further agency contact for a period of six months.

4.7 Some fifteen months before Child Y's death, MY advised the school that Child Y was having trouble sleeping which was impacting on his punctuality at school. There were concerns for the well-being of a sibling, who was alleged to have assaulted another family member. The sibling was also admitted to hospital as a result of self-harm.

4.8 Child Y told the school that the sibling was disruptive and attacked him and that MY was not able to deal with this. The school made a referral to a local counselling service and Children's Social Care. Children's Social Care undertook a single assessment, which identified that no further action was necessary because the issues would be resolved by CAMHS working with the sibling. MY had agreed that she was struggling and would accept further help from the Family First team.

4.9 Approximately two months prior to the death, Child Y contacted the police and alleged that the sibling had assaulted him. Upon police attendance, the allegation was retracted and police made a referral to Children's Social Care.

4.10 The school made a further referral to Children's Social Care approximately one month later, when Child Y's attendance was starting to deteriorate and he had told a counsellor that he did not feel safe due to his brother's outbursts. Children's Social Care undertook an assessment, which outlined that incidents between the boys were more likely when they were left alone as MY spent time with away from home.

4.11 Between March 16 and September 16 there was a further period of attempted engagement by Family First. This was over the period of Child Y's examinations and MY requested that no direct contact was made with Child Y during this period. Following the examinations, MY advised that the issues were no of concern and the family no longer needed support.

4.12 In April 2016, the sibling threatened another family member with a knife. Following this incident, an intensive period of work with the sibling was undertaken by CAMHS. The period of intervention was considered successful and intervention was formally closed in December 2016.

4.13 Child Y started Sixth Form College. Approximately one month into the college term the school pastoral support worker met with Child Y to discuss a dip in attendance, Child Y explained that he had suffered with anxiety and panic attacks in the past. The Pastoral Support Worker offered ongoing support meetings, and by the end of October Child Y reported to feeling better and wanting to focus academically. The Pastoral Support Worker spoke with MY, who indicated that Child Y's anxiety had been solely in relation to exams. In November, Child Y made a decision to leave college to take up a different career path.

4.14 In 2017 the police and an ambulance were called to the family home. Child Y alleged that a sibling had tried to strangle him, and had also attempted self-harm by putting a ligature around his neck. The sibling refused to go to hospital with the ambulance and a referral was made to CAMHS. A short period of follow up was undertaken with the sibling over four months. Family First was notified of the incident through a referral to the MASH from the ambulance service. MY was offered further support

which was not accessed and the service was reassured by contacting CAMHS that MY was addressing the issues with that agency.

4.15 Child Y returned to College in the autumn term, however by November his attendance was once again fluctuating. Child Y advised this was because he was upset that a close member of the extended family was terminally ill. The Pastoral Support Worker maintained regular contact with Child Y who indicated that he was pleased to be back in college. Three months prior to his death, Child Y shared with the Pastoral Support Worker and GP that he was suffering from insomnia after the death of a close member of the extended family. The GP prescribed 7 low dose diazepam to support re-adjusting sleep pattern.

4.16 Child Y told the GP that he was not low in general mood, however this is in contrast when, the following day, MY contacted the college to say that Child Y was finding things difficult. Child Y told the Pastoral Support Worker that he was having relationship problems and shortly before the end of Christmas term, confided that he had fought the previous night and did not want to go home. Child Y stated that the sibling had bullied him for about 5 years that he slept with a knife under his pillow and feared for his safety. MY spoke with the school and indicated that it was Child Y himself that was initiating the problems between the siblings.

4.17 The college made a further referral to Family First. During the screening of the contact, a duty worker spoke to MY, who stated she did not feel the family needed any support as she was managing the situation. The response was discussed with the college and the contact was closed without any consultation with Child Y.

4.18 At the end of December, the Ambulance Service received a call from a friend of Child Y at 4.26 a.m. asking that they check up on him as he had said he was going to kill himself. The operator called Child Y, who said he was sad but not suicidal. At 6.04, Child Y attended hospital Accident and Emergency with MY, having self-harmed on both forearms with a razor blade. Child Y did not wait to be seen by a mental health practitioner and MY said she would take him to the GP that day. The hospital records indicate that a referral was made to CAMHS however there is no record of this having been received. No visit was made to the GP, although the GP was notified of the attendance by the hospital in a document that was filed by the surgery without being seen by a clinician.

4.19 During the weeks prior to his death, Child Y continued to meet regularly with the pastoral support worker. Child Y advised that he was seeing a private counsellor and MY spoke with the school to advise she would ensure appointments were made so as not to clash with the school timetable.

4.20 On the morning of the incident, Child Y had attended college. Child Y left the class briefly at 10.30 a.m. and told the office that he would be attending a doctor's appointment at 3 p.m. Child Y left the college building at approximately noon and left the grounds 15 minutes later after associating with other students at a smoking shelter. No concerns were evident at the college that morning.

4.21 During the police investigation of the incident, it was established that Child Y had engaged in an argument by text during the morning with PY. During this argument, Child Y had intimated that he would take an overdose and hang himself. At 12.30 pm, PY received a telephone call from Child Y, which raised suspicions that Child Y may harm himself. PY made a 999 call which was received by the Ambulance Service where PY resided and requested an ambulance to Child Y's address. After a further phone call at 13.55, PY made a further telephone call to the ambulance service seeking an update. PY also sent texts to family members of Child Y.

4.22 The calls to the ambulance service were received in the area where PY resided, some considerable distance from Child Y. Both phone calls to the ambulance service were forwarded to the local ambulance service provider. At 14.02, the ambulance service contacted the local police to request assistance as a patient had taken an overdose and was behaving violently. A police log was created noting an update would be provided once an ambulance was dispatched. The police followed up this log with the ambulance service at 15.23 and were told an ambulance had not yet been dispatched.

4.23 PY contacted S2 at 15:15 stating that he and Child Y had been arguing over the phone, and that Child Y had stated he had taken an overdose and was threatening to hang himself. Following this S2 went to the family home.

5. Family engagement

5.1 The Review was keen to engage with the family to include a family member perspective. MY was happy to participate in the review and wished to contribute to any opportunity to help others following the tragic death of her son.

5.2 MY recalled that she accessed both CAMHS and the Family First service to seek help for her children at times. MY said that she could not fault the services they received, in particular praising the helpful manner and approachability of the Family First workers who knew her family well. MY said that if she had one criticism it would be that when she attended hospital with Child Y after he had self-harmed, they were directed to the children's services and had to wait too long when Child Y was agitated and wanted to go home. MY said they left without seeing a doctor because she could not persuade Child Y to stay any longer when he was tired and it was early hours of the morning. MY recalled that they had little information about how long the wait would be, which might have helped her to manage the wait better.

5.3 A close member of Child Y's extended family had died three months before the incident. MY advised that he was badly affected by this. She recalled how after visiting the GP shortly after he had died, Child Y lost control of himself, that he raged and threw items then cried hysterically. The morning after leaving the hospital, MY spoke with Child Y and suggested a private counsellor to talk to. Child Y agreed and MY contacted a person she sourced on line.

5.4 MY firmly believes that Child Y did not intend to take his life. She recalled how they had been to visit a family member the night before when Child Y was happy because his driving instructor had said he was ready for a driving test. Nothing about his presentation or thinking patterns would have suggested he was in danger.

Additional Information

5.5 After meeting with MY, the Independent author spoke with the private counsellor who Child Y was seeing before his death. The Counsellor was asked to provide the details of information from the sessions held with Child Y but this was refused. The panel did not agree that the information should remain confidential but had no basis from which to challenge this from an immediate safeguarding perspective.

5.6 The counsellor confirmed that this was an arrangement paid for and sourced by MY, but that she would only proceed if there was a willingness from the client themselves. The counsellor advised that it is becoming more common for parents to seek private counselling services for children that she thought was due to cuts in funding and waiting lists in health and education services.

5.7 The counsellor had seen Child Y on three occasions. She was utterly shocked when she was advised that he had taken his life. The counsellor advised that he had given absolutely no indication that he was suicidal, and in fact was making a multitude of plans for his immediate and long term future.

6. Analysis

The examination of practice is supported by brief single agency reports and chronology, the meetings with the practitioners involved in the case, consultation with MY and the private counsellor.

6.1 The UK has a relatively low rate of suicide by children and young people compared with other countries, but there has been a recent increase which reverses a decline over the previous ten years. It remains true however that in the UK, suicide is the leading cause of death in young people, accounting for 14% of deaths in 10-19 year olds and 21% of deaths in 20-34 year olds. Over half of young people who die by suicide have a history of self-harm.

6.2 In 2017, Suicide by Children and Young People, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) was published. A study was undertaken of 922 suicides by people aged under 25 in England and Wales during 2014 and 2015 to find the common themes in the lives of young people who die by suicide. The study showed that 76% of the suicides were male, 57% had previously experienced self-harm and 42% had been in recent contact with an agency.

6.3 Child Y grew up in a family where he was loved and supported. He experienced a complex parental separation and was exposed from an early age to the impact of FY's compromised mental health and the impact of both of these events on the completely family functioning. His early years were unremarkable, the contacts with universal services were without incident and the family functioned without support

until 2008. The first point of concern was at the start of an elongated period of parental separation and the deteriorating mental health of Child Y's father. At the young age of eight years, Child Y told a teacher that he wanted to hurt himself and thought of jumping off a bridge. Self-harm in primary school children is considered an increasing issue, challenging the notion that it is a behaviour associated with adolescence. In primary children, self-harm is more often expressed through impulsive behaviour such as head banging, scratching and hair pulling rather than premeditated actions. Emerging self-harm in young children can be difficult to identify and it was positive that the school were attuned to this need and sought to address the difficulties at the earliest opportunity.

6.4 In very young children who self-harm, the root of concern often lies in witnessing another member of the household self-harming. This would have been true for Child Y, who developed an awareness of self-harm and suicide from a young age, in particular in the context of a coping strategy in relation to the separation of relationships. This continued to be a theme throughout his young life, in relation to a parent and siblings. Child Y experienced periods living separately with MY and FY; in both circumstances, MY remained the emotionally available parent. The first referral to CAMHS was not taken up at a time that family life would have been somewhat chaotic.

6.5 The school remained tenacious in their efforts to support the children and a further referral was made to CAMHS within a few months when Child Y was aged 9 years. After a short period of assessment, Child Y indicated that he did not wish to continue to attend the CAMHS service as he felt he was well supported by MY. A Strengths and Difficulties Questionnaires was used to support the assessment, with risk determined as low. Information shared during this assessment suggested that FY was allowing the children to have access to adult media and was referred into Children's Social Care.

6.6 It is fair to say that the historical records in Children's Social Care are limited and do not always adequately outline how matters were addressed and who with. The matter was closed without discussion, with FY noting that 'MY had taken steps to deal with the matter'. Undeterred in their quest to seek additional support, the school made subsequent further referrals to Children's Social Care concerned that

the children's worries about their parents were affecting their behaviour in the school setting. The children did receive some services from the young carers support service with a view to helping them gain an understanding of the father's mental health difficulties.

6.7 There is good evidence during the primary school years that the emotional needs of Child Y were identified, assessed and services delivered to address need. The school were tenacious in their desire to access additional support and CAMHS provided a service in partnership with MY. It is apparent that the school were clear during Child Y's primary years that they needed to support him to understand mental health issues by adopting strategies to build his resilience and coping strategies. Child Y's thoughts of self-harm and suicidal thoughts were taken seriously and acted upon by referral into specialist services.

6.8 A period of two years followed when there was no additional agency contacts with the family with the next contact being in relation to FY, by which time Child Y was in secondary school. Within a six week period there were three different agency contacts that indicate that Child Y was struggling emotionally and that FY's mental health was deteriorating. The three referrals again demonstrate that the agencies were well attuned to the impact of parental mental health on Child Y. Two referrals were made to Children's Social Care, one from adult mental health services and one from Child Y's school. A further referral was made to CAMHS by Child Y's GP. The GP recorded that Child Y's mood and feelings were triggered by FY's episodes of depression that occurred every 2 to 3 months. The observation of continued mental health crisis and self-harm and suicide attempts within his family is likely to have affected Child Y's own problem solving skills during key adolescent stages of development.

6.9 Two years followed, with no additional agency contacts until Child Y was approaching 15 years. A six month period of intervention by the Family First Team provided the opportunity for professionals to better understand the family dynamics and assessed that the areas of risk were associated with anger management issues on the sibling. The practitioners involved reflected that the sibling could be extremely challenging and that this did have an impact on Child Y. The practitioners reported witnessing

an incident in the Children's Social Care office when BY became so out of control that others present had to leave the room when he refused to do so. They witnessed BY destroy the room and smash a glass door until the police arrived to gain control.

6.10 The professionals who worked with Child Y and BY from CAMHS and Family First all described an intense sibling rivalry between the boys and that BY's behaviour towards Child Y was at time abusive. All professionals described MY as an attentive mother, but considered that she minimised the aggression shown and therefore may not have recognised the extent of the impact on Child Y. Two months before his death Child Y told a school counsellor that he feared his sibling and kept a knife under his pillow. Although the college referred the information to Family First, this information was not taken as seriously as it should have been and the potential risks arising from this were neither assessed not addressed.

6.11 Other than one incident between siblings, domestic abuse was not formally considered as a feature in this family home. Most likely this is because abuse in a domestic setting is generally thought of as an adult issue rather one which can be perpetrated across all family members. If aggression is perceived as a two-way issue between peers or as in this case siblings, the focus on protecting children can become more complex to systemise and resolve. The delineation between seeing a child as a perpetrator and/or a victim can result in children being in left in vulnerable situations. The experience of Child Y left him feeling fearful and trapped, akin to the feelings of a victim of domestic abuse. In this instance, the abuse originated from a peer who was a sibling.

6.12 The severity and frequency of the incidents indicate that the level of risk in the family home was significant and likely to impact on the welfare of those living in the household. A research review by UK psychologists Wolke and Skew concluded that about half of children are involved in sibling rivalry every month, with one in every five children involved in sibling bullying several times a week. In a research paper by Lucy Bowes, a study group of UK children were asked about sibling bullying at the age of 12, and then assessed for mental health aged 18. This revealed that those children who reported sibling bullying several times a week were twice as likely to report depression and self-harm at the age of 18.

Learning Point

The impact of peer-to-peer abusive behaviour on children in a family setting requires assessment to uncover the complexity of risk in order to respond in the most supportive manner.

6.13 The standard definition of bullying is 'severe, repeated, and deliberate efforts to harm someone'. When children experience severe bullying from a sibling, there is no place of escape. There is clearly a danger of labelling usual family dynamics as abuse, and caution is needed to prevent overreaction and over labelling. There is however a need to recognise when abuse is occurring, and to take action to protect children from the effects of this. It is common for adolescents exposed to domestic abuse to experience depression, sleep problems, risk taking behaviour, academic decline and self-destructive behaviour. The experience of living with fear will have affected Child Y's level of resilience and sense of security.

6.14 Child Y contacted the police to report violence from a sibling on two occasions. On the first occasion, the police referred the incident to Children's Social Care but the referral was not actioned when it was established that CAMHS were working with the sibling. There was an acceptance that the CAMHS work would successfully address the issues of concern and that the aggressive behaviour would be controlled. Whilst CAMHS may have addressed the sibling's anger and helped him to regulate this better, the closure meant that Child Y's needs were not considered and he was not given a voice through the process of assessment. An Initial assessment would have revealed that he had recently shared with the GP that he was not sleeping and feeling anxious and this, coupled with listening to how he felt, could have offered him an opportunity to express his fears and how he could be supported to feel safe. Further intervention was offered from Family First to MY, but on the basis that she requested that no further work took place until the exams were finalised, Child Y was not directly spoken with.

6.15 Within the following two months, Child Y told a counsellor at school that he did not feel safe at home, and only weeks later, he intervened following an incident at the family home when the sibling was seen in possession of a 'Stanley knife'. On this

occasion, the situation was assessed by the police within the protocol for domestic abuse and risk was identified at a bronze level. The referral made to Multi Agency Safeguarding Hub was actioned as a standard response to the assessed level of risk by sending a letter to the family home advising of support from domestic abuse services. The response to this referral was made without any analysis of what was happening within Child Y's life or home; within a two month period two referrals were received from the police which, if further probed, would have revealed information about Child Y's stated unhappiness in the family home because he felt unsafe and unsupported to change this by MY. Child Y was assessed to establish where he was in need of support or protection.

Learning Point

Invoking 'standard responses' to interagency information sharing about children detracts from consideration of individual assessment of need and risks need remaining unidentified and potentially escalating.

6.16 It is notable that Child Y at 16 years old was not offered services directly when he was the subject of referrals to Children's Social Care. This same principle was also applied when the last referral into Children's Social Care was made 18 months later. This raises two issues that require further consideration. Firstly, the approach lacked a focus on the child, and accepted MY's assessment of his needs without seeking out his wishes and feelings. On one level, this approach overlooked Child Y's capacity to advocate for himself and did not take his age into account yet conversely his age may have been a reason not to consider him as a child in need. Children between the ages of 16 – 18 years can generate different responses influenced by the extent to which the young person is seen as a child. The Children Act 1989 and the UN Convention on the Rights of the Child are clear that a child is anyone that has not reached their 18th birthday, yet the Sexual Offences Act 2003 states the age of consent as 16 and the Code of Practice Mental Capacity Act 2005 refers to children as below the age of 16 years.

Learning Point

The principles of the Children Act with regard the duty to assess the welfare of a child should be applied equally to children up to the age of 18 years.

6.17 Child Y described himself as becoming 'lost in study', study provided an escape and he excelled. Ironically, the fact that he did excel perhaps became a reason why he was considered to be coping with life pressures and able to make safe judgements. Those who knew him best did however recognise his vulnerability. This is evidenced by the continued referral for additional support through school and college. The pastoral support in school and college offered a good level of support to Child Y: Whilst the college supported Child Y to reach his potential educationally, this was not at the expense of supporting his emotional vulnerability, which they continually identified and sought to respond to.

6.18 Child Y's struggle with his dedication to study was perhaps an indicator that his coping strategy was no longer working for him. After leaving before the first term of college, he tried again at the next academic year but two weeks before his death, he told the pastoral support worker that he was struggling to get back on track. His academic ability was not in question, but his emotional ability to focus continued to be problematic. The college gave Child Y continued messages that they would support him educationally and emotionally and he continued to access their support.

6.19 MY believes that the death of a close member of the extended family had a profound effect on Child Y him, that his absence caused him to consider questions of life and death. Approximately 25% of young people who commit suicide have recently experienced a death (National Confidential Enquiry into Suicide and Homicide 2016). Child Y attended the GP surgery who noted that he had experienced insomnia for more than a year but does not reference any problems with his mood.

6.20 The last referral to Children's Social Care made when Child Y was 17 years was when he stated that he slept with a knife under his bed. Child Y stated at this point that he did not wish to return home. The college and Family First spoke with MY who indicated that neither Child Y nor herself needed further support. Once again, Child Y was not spoken with directly. Given the severity of how he stated he needed to protect himself in his home, the history of family functioning and other incidents

involving a knife, without doubt a referral to CSC should have been made if not by the college then by Family First where an Initial Assessment should have been completed within which Child Y's wishes and feelings should have been formally considered. The Local Authority had a duty to listen to Child Y's fears and concerns and in such circumstances should have assessed Child Y's needs, including those related to accommodation. The Ofsted thematic report The Voice of the Child: Learning from Serious Case Reviews was published in 2010. It reported themes found across too many cases which included the following:

- Children not being seen by professionals, and not asked about their wishes and feelings
- Parents and practitioners prevented practitioners from seeing and listening to the child
- Practitioners focussed too much on the needs of parents, especially vulnerable parents, and overlooked the implications for the child

All of which have been contributory factors in this case. Despite the intervening years and focus on the children's voice agenda, it will be disappointing to the LCSB to find this issue of concern is present.

Learning Point

The child's voice should be paramount in all decisions to assess or not undertake an assessment of their needs. Where a child's voice has resulted in the need to share information across the multi-agency partnership, any decision not to assess the child's needs should include the rationale for not doing so and that due regard has been given to the voice of the child.

6.21 Ten days later Child Y attended the hospital because he had self-harmed. MY described this as a difficult experience because Child Y was unwilling to wait and was becoming more agitated. Records show that Child Y arrived at 6.04 am and left at 7.45. MY considered that Child Y's state of anxiety was not taken into account and a better customer approach would have helped to manage the situation. MY stated she was focussed on keeping Child Y calm and because there was no information

about when they could be seen agreed to leave with him. The hospital information states that a referral was made to CAMHS, however, upon checking the detail of this, a completed CAMHS referral is available but there is no confirmation to confirm it was faxed. CAMHS stated the referral was never received. The process of faxing has been now been changed and all referrals from hospital to CAMHS are now emailed which is practically easier to track.

Learning Point

Self-harm or suicidal ideation in children should be treated as a wider safeguarding issue with focus beyond the immediate presenting mental health problem. No child should exit services without an assessment of risk.

6.22 Although it is apparent that Child Y had some factors that reduced his resilience and affected his problem solving skills, everyone who knew him has been astounded by the actions, which resulted in his death. Despite some missed opportunities to get a clear picture of his wishes and feelings he did have a support network that he used and trusted. He had witnessed mental health difficulties throughout his childhood, self-harm and suicide discussion became part of his normalised experience. Whether he intended the outcome that arose from his action cannot be known. MY is strongly of the view that this was not what he intended. Child Y suffered from an underlying anxiety but there was no indication that he did not see himself as having a future. The study referred to in 6.1 noted that that a small number of suicides are 'out of the blue'. Although Child Y did have factors that increased his vulnerability, this specific act was not expected by the people who knew him including those who were concerned for his welfare.

6.23 Directly prior to the incident, Child Y had an argument with a partner. A specific meeting was held with representatives of the ambulance service to understand the events between PY calling for an ambulance at 12.30 pm, then again at 13.52 to one arriving at 15.48 after a third call from S2 at 15.40. the contacts in relation to emergency services are outlined below:

Time	Agency	Event
12.30	Ambulance Service	PY contacted Ambulance Service stating that Child Y may harm himself and had threatened to take an overdose.
13.52pm	Ambulance Service	PY re-contacted Ambulance Service. PY stated that he had just had a telephone conversation with Child Y who had told him that he had taken a number of sleeping tablets and was planning on hanging himself. He stated during the call that that Child Y was not violent and that towards the end of the call had made a choking noise.
13.55pm	Ambulance Service	Contacted neighbouring Ambulance Service, where child Y resided to advise of the incident.
13.57pm	Ambulance Service	Allocate an ambulance to attend
14.00 pm	Ambulance Service	Ambulance reallocated due to another incident taking higher priority
14.01pm	Ambulance Service Police	Advise police of the incident and that assistance was required due to a concern for safety because the patient was violent. Police advised that an ambulance had not yet been deployed. Police grade the request as priority, to be dispatched within one hour. 15.35 record was added that that they had failed to have someone dispatched within the target time.
15.39	Ambulance Service	Call received from sibling who reported that she had found Child Y not breathing.
15.41	Ambulance Service	Two first response vehicles deployed to the address and informed police of information, arrived at 15.48
15.46	Police	Despatched a Response Patrol, arrived 15.49
15.51pm	Ambulance Service	Child Y life pronounced extinct.

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6.24 The Ambulance Service gave very detailed information about the Emergency Medical Dispatch System (EMDR), which is used in relation to calls into the service, to determine the urgency of an incident and the corresponding speed of response. Using this system, the call handler/emergency medical dispatcher (EMD) will input information to an electronic system that creates an algorithm response. This is a system that is used nationally and internationally. The first call made by PY at 12.30 pm was received by the Ambulance Service however he was in a different physical location to Child Y. The EMDR created a coding of '23 (protocol) Bravo (condition of patient) 01.The first figure related to the protocol pathway followed, in this instance, protocol 23 refers to self-harm and there is a separate protocol for suicide attempts. Each input is based on a series of predesigned questions which once inputted create the dispatch code. The response was category 3, which requires a response time of within two hours. This information was shared verbally between the respective Ambulance Service call centres.

6.25 FY made a second call to the ambulance service at 13.52pm. During this conversation, PY stated that he had just had a telephone conversation with Child Y who had told him he had taken a number of sleeping tablets and was planning on hanging himself On this occasion the dispatch code was '23 Charlie 07 V I' . This meant that self-harm remained the underpinning pathway, Charlie indicated that the patient was in better condition than bravo, but two errors were made in the recording and verbal handover of information between respective Ambulance Service call centres . This related to the erroneous inclusion of the letter V which indicated violence, and the EMD at the call centre receiving the information did not include the letter' 'I' which indicated significant intent to harm. It is believed that the letter 'I' was missed because of a difficulty in clearly understanding the accent of the EMD providing the information. This error in recording was significant because the letter 'I' would have automatically led to a category 2 dispatch code, which would have required a response within 40 minutes. Arguably, at this point, the underpinning pathway could have been changed to one of suicide which would have resulted in a category 1 emergency response. It should be noted that the ambulance service is currently working towards complete electronic transfers of incidents

between ambulance trusts which will prevent any room for error through verbal communication.

6.26 At 13:57 hours, the Ambulance Service call centre, which covered the area where Child Y resided, allocated an ambulance to attend Child Y's address but this was stood down at 1400. Due to a further unrelated incident being graded as a higher priority. At 14:01 Police were contacted by the Ambulance Service Call Centre to advise that they required their assistance due to a concern for safety whereby the male involved had taken an overdose and was violent. Police were advised that the incident was graded as a 'three' and no ambulance had been deployed. The police created an incident log and graded the incident as a priority (to be despatched within one hour). At 15:35 hours a record was added to the police log that they had failed to have someone despatched within the target time. The police patrol dispatcher contacted the Ambulance Service at 15:23 to establish whether assistance was still required and was advised an ambulance had not yet been dispatched, the police dispatcher was awaiting further contact from the Ambulance Service before allocation because the threat was understood to be to the ambulance staff.

6.27 It was 15:39 when S2 contacted the Ambulance Service and stated that she had found Child Y not breathing. The Ambulance Service arrived at the scene at 15:48 and the police at 15:49.

6.28 Through discussion with the representatives with the Ambulance Service, a number of significant points were established. Firstly, when receiving information, the Ambulance Service Call Centre made two inputting errors, the second being significant to the category of response. An additional error was made when verbal information was shared between the respective Ambulance Service Call Centres, which resulted in a further alteration to the category of response. This clearly posed the question as to if help had arrived sooner, could Child Y's life have been saved. Secondly, each receipt of information was recorded with a self-harm pathway and not a suicide pathway. A suicide pathway would have resulted in a category 1 response (within 7 minutes), this was particularly relevant after the information provided in the second call by PY. The third significant point from a child safeguarding

perspective is that age is not a factor within the EMDS suicide pathway, this is because it is not considered to be a determining factor on the medical consequences.

6.29 The Ambulance Service, which covers the area where Child Y resided, does have a Safeguarding Vulnerable Persons Procedure which gives additional guidance that can be accessed by call handlers. This guidance does not however specifically address adolescent mental health. Given the particular vulnerabilities of adolescents to impulsive acts, it would be prudent to include specific guidance in this area, particularly for staff assessing risk at the first point of contact.

Learning Point

The combined vulnerability of poor mental health and the impulsivity of young people needs to be reflected through all safeguarding systems so children and young people are supported without delay at points of crisis.

6.30 The Ambulance Service wished it to be noted that at the time in question, had ambulances not been backed up in a hospital queueing system, the service would have been able to achieve category 2 responses for all those allocated as category 3.

7. Learning Outcomes

7.1 The review evidences that successive educations settings were responsive to Child Y's emotional needs. Child Y received good support within the settings through the use of pastoral services which liaised as appropriate with MY. Both schools and college advocated for additional services at relevant points of interventions and made referrals into the multi-agency safeguarding hub when safeguarding concerns were identified. This demonstrated a good understanding of safeguarding procedures and a willingness to manage lower level risk in accordance with threshold criteria.

7.2 In the latter years of child Y's life, in particular from age sixteen onwards, there are points of missed opportunity to assess referrals which indicated a safeguarding risk was present. This is because responses tended to consider Child Y's presenting difficulties as a whole family issue, the consequence of which lacked a focus on Child

Y's perspective and enabled others to speak for him. These opportunities could have given Child Y an outlet to express his feelings and articulate his fears through a process that could have offered a structured response. Child Y needed to be actively heard and listened to when he articulated his fears in order to achieve a greater understanding of his day to day life and what supports he needed to alleviate the pressures he was feeling and mitigate the risks to his safety and welfare.

7.3 The decision for Child Y to see a private counsellor was made the morning after his last attendance at hospital by MY in consultation with Child Y. Given that MY indicated that she had been happy with CAMHS service previously, there is no suggestion that she would have been unhappy to assist Child Y to attend this service again, however, MY indicated that Child Y did not want to be perceived as a child within the health services. The propensity of parents to refer children for private counselling is unknown, but, it is important to consider that this is a service that is not subject to statutory safeguarding regulation and not connected to wider safeguarding systems. In the UK, the British Association of Counsellors and Psychotherapists (BACP) registers and accredits counsellors who achieve a certain level of training and practice. The main purpose is to help people to find counsellors they can trust, the organisation is accountable to the Charities Commission. The organisation sets and monitors standards and will investigate complaints about members. Whilst the organisation does have good practice guidance on Working with children and young people, it remains that within a private capacity, a counsellor has a high level of professional autonomy and can operate outside of the multi-agency partnership.

7.4 This review has raised questions about whether Child Y could have been helped sooner at the point of crisis. It is simply not possible to answer this question with any degree of confidence, but that fact that we cannot conclude it could not leads to consider what systems within the multiagency partnership can be improved to reduce the likelihood of re-occurrence.

7.5 The review following specific learning is identified within this report:

7.5.1 ***The impact of peer on peer domestic behaviour on children in a family setting requires assessment to uncover the complexity of risk in order to respond in the most supportive manner***

The chronology of referrals to police and Children's Social Care both for immediate assistance in relation to violence within the home and the risks that Child Y felt from this would have justified an assessment of Child Y under section 17 Children Act 1989. The factor most likely to have mitigated against this happening was that each referral into the multi-agency safeguarding hub was responded to in isolation and the totality of what this indicated for Child Y was not thoroughly considered. There was an ease by Family First responding to check with MY how the family was, but this approach side-lined Child Y and offered him no voice in a process that was about his needs. Family First have accepted that this approach was consistent with general practice at this time but offer assurance that this has no changed and that the child's voice is central to their assessment methodology.

The perception of need and risk may well have been influenced by a professional tendency to the view advancing age as an automatic factor of resilience, a view which would have led to greater levels of reassurance than was actually present for Child Y. This review is an important reminder to professionals not to assume that age in itself will be a resilient and positive safeguarding factor.

Abusive behaviour in a family setting, wherever originated, has a profound impact upon the welfare of those affected by it. Living with a person who instils fear leaves family members at best feeling anxious and at worst feeling trapped and unable to find a coping mechanism. Multi-agency safeguarding systems in relation to domestic abuse are designed to respond to risk posed by adults, but perhaps less attuned to responding when such risks originate from children themselves.

Recommendation:

1. **The Board should ensure that the local definitions and threshold criteria in relation to domestic abuse encompasses the impact of abuse from any household member which threatens the welfare of children under 18 years.**

7.5.2 ***The principles of the Children Act with regard the duty to assess the welfare of a child should be applied equally to children up to the age of 18 years.***

The extent to which the age of Child Y impacted on decision making with regard to threshold application is not specifically established through this review. It does however raise the question as to whether some of the indicators of risk would have been actioned with greater consideration if Child Y had been a younger adolescent. The 16-18 year old age group is recognised as a particularly vulnerable group, both through the challenges they face developmentally and the perception of professionals as to their levels of resilience.

Recommendation:

2. **For thematic audit to address the response of 16-18 years olds in respect of domestic abuse and seek reassurance about the consistent application of threshold criteria.**

7.5.3 ***Assessments of children's needs, and decisions not to assess children's needs, should wherever possible include the wishes and feelings as determined directly by the child.***

Successive reviews, research and academic studies have shown that both children and professionals believe that better decisions will be made for children if they are actively involved in assessment and decision making processes. The decision making in respect of Child Y at potential points of assessment are startling in the extent to which they do not include the views of Child Y who was an articulate and engaging young person. Potentially, if Child Y had been consulted about his concerns and needs at key points, Child Y could have been offered other services and choices which may have helped him manage his worries. The work of Family First in particular took a whole family focus, and this was indeed necessary at the first point of intervention. The service did however miss the need to adapt their approach to consult with Child Y directly when later referrals were about his sole welfare and how he was experiencing family life. It is noticeable that in the response to the last referral from the college, they were given

no further direction or advice about any further consultation with Child Y with regard to his entitlements to support and assessment.

Recommendation:

3. **Within the audit to address response to 16-18 years olds, to establish the extent to which children are given a direct opportunity to express their views through the multi-agency partnership and that they are explicitly taken into account in decision making**

7.5.4 ***Self-harm or suicidal ideation in children should always be treated as a safeguarding concern. No assessment should be considered complete without the children views and no presentation to services should be closed to agencies without an assessment of risk.***

The report identifies two points at which Child Y own views were not sought because it was accepted that MY could speak on his behalf. Child Y was 16 and 17 years old at these times and fully able to articulate his views and wishes. The prevention of self-harm and suicidal ideation requires practitioners to have a good understanding of the child's world and how they manage internal challenges. For Child Y, the risk became fatality when there were clearly points at which he could have been offered support directly. Child Y's last presentation at medical services did not result in a completed assessment, once he left the hospital the only community agency who received the safeguarding information was the GP. Had the letter been considered by a clinician, in particular with regard to a history of insomnia presentation, Child Y should have been offered an appointment to discuss his emotional health. The Review identified that although the hospital believed they had made a referral for CAMHS, this was not received. It is known now that Child Y was highly vulnerable when he commenced seeing a private counsellor, and this review led to a concern that such a resource, which may be used by children more commonly, is not anchored into safeguarding partnerships nor is it regulated in respect of services to children.

Recommendation

3. **For GP practices to be required to review and report how important letters about children's mental health is processed with clinician oversight assured**

4. **For the Hospital Trust to undertake an assurance exercise with regard to children's mental health presentations in Accident and Emergency and evidence confidence that the mental health pathway for children is being followed routinely**

5. **For the LSCB with local NHS commissioners to consider the particular vulnerability of children accessing private counsellors and whether further engagement with the registering body is required to consider safeguarding risks**

7.5.5 Young people are at greater risk of suicide than the wider population, and public health Reponses need to reflect this in planning for services. This review has established that the ambulance service does not have vulnerability through age built into the pathway of responses, nor is this reflected adequately in the Trust Safeguarding Policy. The EMDR is a national and internationally adopted system, how information is inputted is based on human accuracy and judgement. It is known that Child Y was alive when PY made the first and second phone call to WAS, this being 12.30 pm to 13.52pm, but was deceased by the third call by S2 to the Ambulance Service Call Centre at 15.39. In these circumstances it is reasonable to conclude that whilst Child Y's death was not predictable to those closest to him, a timelier response should have been facilitated.

Recommendation

6. **The Board to engage in discussion with the Ambulance Service to achieve the following outcomes:**
    - that the Safeguarding Policy provides specific guidance with regard to children and mental health/suicide risk
    - that emergency responses to children with mental health presentations at all times explicitly consider risk of suicide when determining response pathways