Safeguarding Children Board

CORNWALL & ISLES OF SCILLY

SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

OVERVIEW REPORT OF A FEMALE CHILD

D.O.B 16 September 1996

D.O.D. 30 September 2012 AGED 16 years

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1. Introduction

1.1 This document is intended to provide a summary of the deliberations of a multi-agency review group, established by the Local Safeguarding Children Board, relating to a young person who died after deliberately taking a large quantity of her mother's prescribed tablets. When paramedics arrived to the home, on 30 September 2012, the young person had suffered a cardiac arrest and could not be revived.

1.2 A Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and to identify and understand the issues that influenced how professionals worked together and individually. The decision on whether or not to initiate a Serious Case Review was not an easy one and was not unanimous. Evidence before the Local Safeguarding Children Board indicated that the young person had taken deliberate action to harm herself but the evidence suggested that she may not have intended to kill herself. Information indicated that the young person met the definition of a 'child in need' and that agencies beyond universal services were involved with her and her family. The Board heard that the young person may have been brought up by parents affected by …… and that the young person's mental well-being was causing sufficient concern that the Child and Adolescent Mental Health Service (CAMHS) was involved, in the last year of the young person's life. The Serious Case Review was therefore commissioned to understand more about the young person's life, within her family, and to examine how professionals engaged with them to ensure the young person's developmental needs were appropriately assessed and met (specified as an outcome for children in "Working Together to Safeguard Children", DCSF, March 2010). Additionally, the Serious Case Review was thought necessary to examine whether there had been progress since Serious Case Reviews were completed in 2009/ 2010 in co-ordinating early interventions for children in need and to improve services to children and their families where there are parental mental health issues.

1.3 This Serious Case Review has been undertaken in line with 'Working Together to Safeguard Children' guidance (Department for Children, Schools and Families (DCSF), 2010) and the Serious Case Review Policy guidance of the Cornwall & Isles of Scilly Local Safeguarding Children Board. However, as the County had recently taken part in a National pilot project, developing a 'systems' model for case reviews ("Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews", Social Care Institute for Excellence (SCIE), 2009) so dispensations were obtained. Individual Management Reports have not therefore been requested and a multi-agency Review Team was established, led by an Independent, trained consultant (a Lead Reviewer), instead of a Serious Case Review Panel. In line with the 'systems' model, the key professionals who worked with the young person and her family were invited to tell the story of their involvement, most of them together, as a Case Group. The Case Group also played a part in the analysis. The Local Safeguarding Children Board were concerned that using the 'systems' model, as piloted, may be a disproportionate response, in terms of resources and time, so the analysis phase was based more closely on Root Cause Analysis ("Root Cause Analysis Toolkit" National Patient Safety Agency, 2004), a methodology the Lead Reviewer was also trained in.

1.4 The report brings together the findings of the Review Team (in consultation with the Case Group) and after presenting them to the Local Childrens' Safeguarding Board a plan to address these was agreed and is presented at section 8 of the report. There is an ongoing Police investigation into the young person's death for the Coroner, but no report is available and a date for the Inquest has not been set. The Coroner is aware that a Serious Case Review is being undertaken and this report will be shared with the Coroner's Office, to reduce duplication in gathering information.

1.5 The parents of the young person and her half sister have been visited by the lead reviewers to enable them to participate in this review.

2. THE CIRCUMSTANCES THAT LED TO A SERIOUS CASE REVIEW BEING UNDERTAKEN

2.1 This serious case review was instigated because:

- the young person's deliberate actions led to her death on 30 September 2012; and
- the young person was being supported by services provided to children in need ……..

2.2 The terms of reference have not required an in depth historical review of agencies working with the young person and her family but to provide a context for her life, some factors that have emerged, during the recent involvement of professionals, are set out. The young person was the only child of her parents although both have adult children from previous relationships. The young person only became aware of her father's other adult children recently. The young person has grown up with her adopted sister aged 22 years, and has contact with her two half brothers, who live locally. The half siblings have the same mother as the young person.

2.3 ……What has emerged, as professionals revealed their involvement with the young person is that, at times, the parents have struggled to place the young person's needs ahead of their own and that in the year before her death her emotional and mental well-being showed signs of being adversely affected by her experiences. It is not suggested that the parents deliberately neglected the young person's needs but that their own difficulties, at times, left them unable to provide adequately for them.

2.4 Within the timeframe of this review, the young person's family experienced a troubled time…….. The family pet dog found and ingested tablets and had to be 'put down'. The young person was troubled by these events, desperately wanting a united family. She was upset by family tensions and worried about the well-being of the significant adults in her life.

2.5 The young person had a poor school attendance record with absences mainly explained by her parents as due to the ill-health of the young person or the emotional impact of her worrying about family events. Although not understood at the time, information from the young person's doctor indicates that not all her absences for ill-health were likely either necessary or as explained by her parents. The school took a supportive rather than punitive approach to her poor attendance.

2.6 Whilst the young person had several professionals in contact with her during the school term in the summer of 2012, for various reasons, these contacts ended either by or very soon after the school holidays began. The Parent Support Advisor was available, until the end of August 2012 but neither the young person nor her parents made contact, once the young person broke up from school. The young person's contacts with professionals, in the month she died, was limited so it is difficult to gain an understanding of what life was like for her, at that point, independent of her family.

2.7 The family suggested that the young person experienced bullying at school and the referral to the mentoring scheme in December 2010 made reference to some possible school based bullying. However, during the young person's contacts with professionals, during 2011 and 2012, she never raised the issue of bullying. In the week prior to the young person's death she went on a school trip to a theatre in a city out of County and whilst teaching staff reported the young person appearing a little upset, on the return journey to school, the young person stated she was "ok". The weekend of the young person's death, her family report that she went to the city she had visited with the school, by train with friends. Professionals found this to be outside of the young person's normal pattern of socialisation. After the young person's death the parents reported to the Police that they believed the young person had been sexually assaulted during her day out with friends the previous day. This was investigated, by the Police but no evidence of inappropriate behaviour found.

2.8 ……

3. TERMS OF REFERENCE AND METHODOLOGY

3.1 The terms of reference were agreed between the Lead Reviewer and the Manager to the Cornwall and Isles of Scilly Safeguarding Children Board, in terms of aims, objectives and a timeframe.

3.2 Aims:

- To gain some understanding of what life was like for this young person as a child in this family and their wider community
- To obtain an understanding of how agencies were working together to ensure they understood what life was like for this young person and what support she needed.

3.3 Objectives:

- To explore critical decision-making and communication in the context of a multi-agency approach
- To establish the lessons to be learned about how individuals and agencies are working together to safeguard children and disseminate those lessons
- To highlight examples of good practice which can be adopted across agencies as part of the learning process
- To identify gaps in meeting the support needs of this young person and their family
- To summarise the findings of the review for consideration by the Local Safeguarding Children Board
- To gain an understanding of whether agencies had the necessary information / understanding of the impact of parental mental health on the young person when assessing risk and planning responses.

3.4 Timeframe:

- The review will consider the two years prior to death of the young person. The last 10 months being considered through a detailed chronology of agency involvement. The earlier period will identify significant events.

3.5 The Review Team set up was led by an independent person and supported by the Manager to the Local Safeguarding Children Board. Other members represented the key agencies working with the young person and her family: the Designated Doctor for Child Protection, Head

Teacher for the school attended by the young person, the Youth Lead for Quality Standards and Services (working for Youth Improvement Team as part of Children, Schools and Families), a Youth Work Co-ordinator and a Clinical Team Manager for the Health Foundation Trust responsible for Mental Health and Learning Disability Services. During the review process, the role of the Police, was recognised as more significant that had initially been thought and it is regrettable that a manager was not invited to be part of the Review Team. As a consequence, limited data has been available from the Police.

3.6 The Review Team met twice although the Clinical Team Manager for the Health Foundation Trust did not attend the 2nd meeting. The initial meeting established the process and the 2nd checked the accuracy of the data and began the analysis. Between meetings they led in the gathering of information to develop the chronology and were provided with the notes of meetings with the family and professionals, who formed a Case Group. They also received and commented on the report, as it was drafted.

3.7 The Case Group consisted of the professionals involved with the young person from December 2011 until her death on 30 September 2012. Attending the Case Group meeting were the young person's General Practitioner, a volunteer mentor along with their supervisor, a Parent Support Advisor employed through the school, a Learning Support Worker from the young person's school and a Social Worker from the Child and Adolescent Mental Health Team (part of the relevant Foundation Trust). ……. The Lead Reviewer and Manager from the Local Safeguarding Children Board with the consent of the adopted sister made separate arrangements to gather information from the Police.. The parents gave consent for professionals they had contact with to be spoken to, General Practitioner's and staff from an independent agency.,……...

3.8 The Lead Reviewer and the Manager of the Local Safeguarding Children Board met, as required, throughout the process to progress data collection and to analyse information and patterns. They also worked together to seek to understand why events unfolded as they did and to begin to identify the issues for the Local Safeguarding Children Board to address to improve multi-agency safeguarding. Both the Case Group and the Review Team were engaged in activities to improve understanding and find where systems needed attention to increase the prospect of professionals making good rather than poorer safeguarding decisions, with families.

4. ACCOUNT OF AGENCIES INVOLVEMENT WITH YOUNG PERSON AND FAMILY

4.1 An integrated chronology, using the ChronoLator to merge individual chronologies, is appended to this report (appendix 2).

4.2 As a context, the young person lived and attended school in a part of the County that many indicators define as 'severely deprived'. In recognition of this, additional funding was in place, for several years, to provide a multi-agency 'Learning Partnership' team to work with children and their families showing the early signs of distress. The team consisted of educational professionals such as Educational Psychologists and Parent Support Advisors, as well as Police Officers and Social Workers. Funding was withdrawn during 2011, leading to the dismantling of the team by August 2011. After a gap, the school attended by the young person found its own funding for a Parent Support Advisor but this could not be sustained beyond one academic year. The Head Teacher describes going from having a 'first class' multi-agency early intervention team to a situation where each agency does the best it can. Each agency has funding pressures.

Pre December 2011

4.3 Until 2009, the family (young person, both parents and her adopted sister) all attended the same General Practice. For reasons unknown, the father and young person (then aged 13 years) moved to a different practice, creating an illusion of family separation to the mother's doctor (based on a conversation with mother's doctor).

4.4 During 2010 and 2011, the young person's school were noting high levels of absences, predominantly explained by her parents as due to 'ill health'. This led the school to involve the services of a Parent Support Advisor, to work with the young person and her family to seek to remove barriers to her attendance. There was early recognition that the young person was sometimes not fit for school because she was worrying about ……..other family members and that she found the tensions within her family difficult to cope with. The Parent Support Advisor, in December 2010, referred the young person to a service to be considered for a volunteer mentor but staff sickness meant that this referral could not immediately be considered.

4.5 ……..

4.6 In April 2011 the young person's doctor made an urgent referral to the Child and Adolescent Mental Health Service due to concerns that the young person was 'having problems at home and school' and 'avoids confrontation and often hides'. The Parent Support Advisor at that time was reporting concern that the young person was socially isolated and spending significant amounts of time in her bedroom. The Child and Adolescent Mental Health Service, after an initial screening by a clinical psychologist, downgraded the response required to 'routine' and following the procedures for 'routine' referrals, the young person's family was invited to make contact for an appointment and this led to an assessment in July 2011. During the assessment, the young person's parents disclosed …… that there were stresses between family members that the young person struggled with. The young person reported re-establishing contact with her adult half brothers (mother's sons and half sister's full brothers), estranged from the family for some time. The young person's mother said she had no contact with her sons. During this initial meeting the Social Worker from the Child and Adolescent Mental Health Service was also told of an incident…(concerning her father).and that this event had had a significant effect on the young person (likely 2009). Although further work was agreed, the young person and her family did not take up this offer.

4.7 When seen during the Serious Case Review process, the young person's mother and adopted sister spoke of the young person as always wanting the family to get along and tending to take the role of 'go-between' and 'peacemaker'.

4.8 In May 2011, the young person was assigned a volunteer mentor, an adult able to give dedicated attention to the young person and provide opportunities for her to engage in activities away from the home. The young person was introduced to the mentor on 3 June 2011.

4.9 In May 2011 the young person had an unauthorised absence from school of 14 days which led to a visit to the family from Education Welfare. This had followed the young person being challenged at school due to a facial piercing she had had, in contravention of school rules. The Education Welfare officer reported that the young person was ready to return to school but had been kept home by her mother who disagreed with the school's stance on the piercing.

4.10 ……. The mother was also contacting the young person's mentor to discuss her own personal issues, which was outside the remit of the scheme. The young person told her mentor and the mother told her doctor that the father had signed the family tenancy over to the young person's adopted and her boyfriend without the mother's knowledge. The young person told the mentor that her mother had left the family home for a few days and was only keeping in contact with the young person. The young person also said that, when her mother returned, she stayed in her room. The family then moved house, leaving the young person's adopted sister and her boyfriend in what was the family home.

4.11 In September 2011 the volunteer mentor, in supervision raised concern that the young person's mother was still trying to use the mentor's time to discuss her own problems. It was also reported that the young person was making good use of the mentoring sessions, talking about her worries but also taking part in some activities, including joining the school drama group, at the beginning of the school term.

4.12 On 12 September 2011, the young person was taken to see her doctor as the family were concerned she was not sleeping or eating properly. The doctor was made aware that the young person's mother had moved out and that there were 'problems' with the young person's adopted sister. The doctor did not take any action, believing the Child and Adolescent Mental Health Service was actively involved. Independently, on the same day Child and Adolescent Mental Health contacted the family via telephone offering a further appointment. The family did not follow this up and the case was closed one month later, in line with procedures at that time. The young person's doctor was not informed until that point of ending contact. About this time the young person was expressing concern to her mentor that her mother did not want her to talk with her adopted sister.

4.13 At the start of the school term the young person was still having occasional days off, explained by her parents as illness. The funding for the Parent Support Advisor Service had ended so attendance was initially being monitored by the Attendance Officer and Education Welfare but in November 2011, following an absence of one week, a request was made for a Parent Support Advisor, now funded by the school. In a mentoring session during October or November 2011, the young person told the mentor that her father came in her room at 5a.m., before he goes to work, and that this was making her tired and grumpy. The mentor reported to her supervisor that the young person had then tackled her parents on this, when they returned to her home. The young person is reported to have asked her father to stop coming in her room at 5a.m. and her father responded that he was disturbing her so she woke up in time for school. The mentor reported to her supervisor that as the parents made light of the matter, the young person withdrew from the discussion. It was also about this time that the young person showed the mentor that she had tried cutting herself, to see how it made her ….. feel but that she did not see the point of it.

December 2011 – March 2012

4.14 On 19 December 2011, the young person's adopted sister went to the Police…….. This was reported to Children's Social Work, in relation to the young person, by telephone and for information only……..

4.15 Just before Christmas, the volunteer mentor took the young person Christmas shopping, an activity she seemed to enjoy but the mentor reported an almost immediate drop in her mood as she re-entered the family home. The mentor reported to her supervisor that the mother appeared agitated and had been drinking. ……..The mother explained to the young person that they had had to have the dog 'put down'. .

……The young person is reported to have said "its mum that needs help, not me". When the young person's father arrived, the mentor left. The mentor's supervisor advised the mentor to monitor the situation and report any further concerns. The mentor was advised to discuss initiating a Common Assessment but when this was subsequently discussed the young person rejected the idea saying she did not need any further help.

4.16 In January 2012, the young person failed to return to school so the Parent Support Advisor made a home visit. The family related the events that had happened just before Christmas. To support the young person in returning to school, the Parent Support Advisor began seeing the young person twice weekly, a higher than usual level of contact, and arrangements were made for the young person to attend the school's Learning Support Unit, as she felt necessary. This unit is slightly detached from the main school and provides a place where students struggling with the classroom situation, for a variety of reasons, can attend and work in a relaxed environment. The young person used this facility frequently, during the early part of the year. The Parent Support Advisor was keeping the Deputy Child Protection Officer and the Pastoral Support Manager, at the school informed and took their advice. On 13 January 2012, following a home visit, the Parent Support Advisor was so concerned for the welfare of the young person that she telephoned Children's Social Work Single Referral Unit and followed this up with a written referral for the young person and her family to be assessed.

4.17 On 6 January 2012, the young person's mother attended her doctor's surgery with her husband. On the same day, the young person's father attended his doctor's surgery, accompanied by his wife. Records would not suggest that either doctor was aware of the accompanying partner's consultation with their own doctor, in another practice. The recent family events were reported to each doctor. The mother was described by her doctor as low of mood……. The outcome for the father was that his doctor referred him for a screening appointment with an organisation commissioned to work with adults experiencing stress in their lives.

4.18 The mother was assessed …….. the opinion . (was) that her mood was linked to current life events ……....

4.19 …….

4.20 On 20 January 2012, the young person's father was sent a letter by Outlook South West inviting him to make contact to arrange an appointment. The referral to Outlook South West ……as he had been experiencing family stress since September 2011. An appointment was agreed with a Wellbeing Practitioner on 7 March 2012, by which time the father reported that his family situation had improved and he did not attend further sessions offered.

4.21 On 19 January 2012 …….. Parent Support Advisor noticed an immediate and dramatic improvement in the parents' demeanour. The Parent Support Advisor was also contacted by the Social Worker from the Single Referral Unit and told that it was more appropriate for the young person to be referred to the Child and Adolescent Mental Health Service and that they would take no further action. When the young person was seen by the Parent Support Advisor, the next day, she was more positive about her mother's situation but her worries had turned to her adopted sister's …….. The young person expressed the view that there was one drama after another in her family. The Parent Support Advisor suggested to the parents that they ask the young person's doctor to refer her to the Child and Adolescent Mental Health Service and her father took her to the doctor on 25 January 2012. The doctor agreed to make the referral.

4.22 On 30 January 2012, the young person showed the Parent Support Advisor superficial marks she had inflicted on herself with scissors, at the weekend. The Parent Support Advisor established that a referral had not been received by the Child and Adolescent Mental Health Service so she encouraged the father to chase this up with the General Practitioner. A referral was received by Child and Adolescent Mental Health Service on 2 February.

4.23 By the end of January 2012, the young person's attendance at school had dropped below 70% and when she was in school, she continued to prefer to be in the Learning Support Unit rather than the normal classroom situation, for a number of lessons. She was showing signs of disengaging from the mentoring service telling them that she had made new friends and was able to socialise more. The young person continued to worry over her …….facing an interview with the Police and was absent from school on 6 February as she had been unable to sleep over the weekend.

4.24 The Child and Adolescent Mental Health Service Social Worker, who had previously met the young person, saw her on 7 February 2012. The Social Worker had established contact with the Parent Support Advisor before this meeting so was aware of what had been happening in the family since she last saw her in July 2011. Although the young person arrived with her parents she asked to speak alone. The young person spoke of many of the family difficulties that had troubled her, both recent and historical, her recent self harming and thoughts of being dead. She described herself as fed up with the constant dramas and arguments at home and felt that no-one cared about her. The young person spoke positively about school and told the Social Worker that the Parent Support Advisor checked her lunch box as she sometimes did not eat.

4.25 Based on the assessment of the Child and Adolescent Mental Health Service an agreement was reached that the young person would be offered appointments on her own. The focus of work was to help her to learn to deal with her past. Arrangements were made that the Parent Support Advisor would bring her to her appointments and that her father would collect her. Records indicate that the Social Worker and Parent Support Advisor kept in contact with each other.

4.26 The young person did not return to school after the February half term holiday. Her father explained to the Parent Support Advisor that she had had a good half term but all the family had a 'bug'. When the young person returned to school she told the Parent Support Advisor that she continued to worry about her half brother……. Her next appointment with the Social Worker from the Child and Adolescent Mental Health Service was on 28 February when she engaged in discussing the complexities of family relationships, including her contacts with her half brothers. The young person was continuing to use the Learning Support Unit at school, during some lessons.

4.27 During March 2012 the young person had several absences, including some that were recorded as unauthorised. One absence from school on the 23rd March 2012 led to the cancellation of an appointment with the Child and Adolescent Mental Health Service by the parent support advisor. The volunteer mentor reported very limited contact but that the young person was seeming happier at home and back in contact with her adopted sister. The young person and mentor agreed to end contact in June.

April – June 2012

4.28 In May the young person had a further appointment with the Social Worker from the Child and Adolescent Mental Health Service. The young person identified 5 big things she needed help with and began talking about her father, mother and adopted sister …….and what she knew of her adopted sister's past experiences.

4.29 On 11 May 2012, the young person went to see the Parent Support Advisor at school and was upset. She described herself as being 'like piggy in the middle' and that she was 'tired' of dealing with her family's squabbles. The young person was then absent from school the following week, during which she saw her doctor. The young person had her 3rd session with the Social Worker from the Child and Adolescent Mental Health Service on 29 May 2012. Like the Parent Support Advisor, the volunteer mentor reported to her supervisor that the young person was struggling with tensions at home. The young person was saying that she could move in with her adopted sister when she was 16, in September but that her mother did not want her having any contact with her. The mentor quoted the young person as saying that whenever "she makes a break for independence they (parents) try to pull her back in like they don't want to lose control".

4.30 Despite several attempts by the volunteer mentor, the young person did not respond to invites to arrange a last appointment for June. During June and July 2012 the young person was integrated back into her lessons although she called into the Learning Support Unit, during breaks occasionally, to update the Parent Support Advisor on her progress. She still had absences from school, including 1 week in June when she attended her doctor's surgery.

July – September 2012

4.31 On 11 July the young person had her 4th appointment with the Social Worker from the Child and Adolescent Mental Health Service. She was reported to be more relaxed and looking forward to the school holidays. She described being the listening ear for friends at school and that this was a problem as she had enough of her own worries. The Social Worker did not work during the school holidays so there was an agreement to continue the sessions in September. The discussions between the Social Worker and the Parent Support Advisor had stopped.

4.32 During the school summer holidays, no professionals had contact with the young person. The Parent Support Advisor remained available to the family, until the end of August, but they did not make any contact with her. Funding ended for the Parent Support Advisor post by the time the young person returned to school in the September and she chose not to attend the Learning Support Unit, being fully integrated back into her lessons.

4.33 On 12 September 2012 the young person was taken to her General Practitioner complaining of numbness to her right hand and arm. She was admitted to hospital overnight for tests but nothing was found. The young person was absent from school until the 24 September (which included her 16th birthday on 16 September). Her parents informed the school that the young person had had an operation to remove a toe nail. This is not supported by her doctor but the school were unaware of that at the time. The young person's appointment with the Child and Adolescent Mental Health Service was cancelled on 14 September. Her father told the Social Worker she was undergoing investigations in hospital.

4.34 On 26 September 2012 the Social Worker from the Child and Adolescent Mental Health Service established contact with the young person's father and was told the tests were all clear and that the young person had returned to school and was doing well. Her next appointment was agreed for 11 October.

4.35 On Thursday 27 September 2012, the young person attended a school trip to the theatre in a city in a neighbouring County. The young person had some unsupervised time, within the theatre. She seemed in good spirits and chatted to staff about the play. On the way back to school staff noted she seemed a little upset but she told staff she was fine.

4.36 On Friday 28 September 2012 the young person was absent from school. The young person's father contacted the Social Worker from the Child and Adolescent Mental Health Service saying that the young person was not doing well and asking for the appointment to be brought forward. An earlier appointment of 2 October was agreed. Later, her father took her to her doctor. The father did most of the talking, describing his daughter as generally unwell, tearful, not eating and losing weight. The young person said she had been 'dragged' to the doctor by her father and he was also dragging her to the Child and Adolescent Mental Health Service. She did not feel there was anything wrong with her, just under pressure due to school exams. The doctor offered to see the young person alone but she declined. A physical examination did not reveal anything. Her father told the doctor of the appointment with the Social Worker from the Child and Adolescent Mental Health Service and the doctor decided to wait for their opinion. Finally, that day, the father went into the young person's school to see the Pastoral Support Manager to request that the young person be allowed to access the Learning Support Unit during breaks and lunch time so that she could study. Her father stated that the young person wanted to be an actress so wanted to get good grades in her exams.

4.37 On Sunday 30 September 2012 the South West Ambulance Service was called to the young person's home after the young person reported taking her mother's medication for irritable bowel syndrome. The young person had a cardio-respiratory arrest and neither the ambulance crew nor the hospital emergency staff could revive her. Resuscitation was continued for 2 hours.

From the Family Perspective

4.38 From speaking with the parents and adopted sister of the young person and discussions with professionals in contact with the young person the family perspective emerges as:

- The Parent Support Advisor, employed through the school, went 'above and beyond' her role and was appreciated by the young person and her family;
- The volunteer mentor and the worker from CAMHS were also mentioned by the family as being helpful to the young person;
- ……..
- In response to providing an explanation of the potential benefits of the Common Assessment and Team Around the Child processes, the family spoke of being unclear over the roles of professionals involved and did express the view that there was a lack of coordination of effort or any focus on helping them as a family;
- The family did express the view that the young person suffered from school based bullying which was not taken seriously by the school;

- ……..;
- The family described themselves as unable to reach out or describe their own needs when most vulnerable and troubled but that they were more able to describe and seek help for each other (in other words, the person most in need of help, at any one time, is going to be least able to express that need and seek help);
- The young person described her life at home to professionals as being a series of dramas, 'like Eastenders'. The family account of their life, over many years, was of their lurching from one crisis to another and their account would suggest that they lacked the capacity to avoid or be emotionally resilient to those situations.

5. ANALYSIS OF AGENCIES INVOLVEMENT

5.1 To structure the analysis, to improve rigour, root cause analysis was used. Firstly some key practice areas were identified, as a means to scrutinise and understand why things happened as they did compared to good practice expectations and ideals. Five practice areas were agreed, with the Review Team, as the most significant to understanding the multi-agency approach with the young person and her family and to address the agreed Terms of Reference. These were:

1. Progress in adopting the 'Think Child, Think Parents, Think Family' approach to families affected by mental health problems (SCIE, 2009 – see extract in appendix 3)
2. Understanding the reason the Common Assessment and Team Around the Child processes were not initiated
3. Understanding referral processes to access specialised services (Adult Mental Health for the mother and Children's Social Work for the young person)
4. Understanding multi-agency approach to safeguarding and promoting the welfare of the young person, as described in 'Working Together' (DCSF, 2010)
5. Understanding the family disengagement from services in the summer of 2012.

5.2 To understand why professionals worked as they did with the young person and her family, all the data was examined. For each practice area the contributory factors, factors to explain why things happened as they did, were categorised under nine headings of:

- The child/ family
- Tasks
- Individual Staff Responses
- Team and Social Influences on Multi-Agency Working
- Education and Training
- Equipment and Resources
- Communication
- Working Conditions
- Organisational/ Strategic

5.3 The final step in the analysis, to allow the patterns and learning to emerge, was to group together from across all the practice areas the contributory factors under their respective nine headings. The outcome of the analysis is set out in full with the numbers, in brackets, after each contributory factor denoting the practice area(s) they relate to, based on the numbering at 5.1.

5.4 CONTRIBUTORY FACTORS RELATING TO THE CHILD/ FAMILY

5.4.1 In this family, the family member most in need is least likely to ask for help (from comments of family members) (1) (3).

5.4.2 Mother and young person capable of demonstrating insight, convincing professional's of their resilience. (1) (5)

5.4.3 When the volunteer mentor discussed the completion of a Common Assessment the young person declined, expressing a view that she did not want to see any more professionals. The young person also held the view that her mother needed help more than her. (2)

5.4.4 Mother convinced Children's Social Work (for young person) that although they were going through a difficult time (January 2012) they were managing. Other family members did not get the opportunity to contribute and in particular, neither agency spoke to the young person to get her perspective. Neither agency gathered information to understand the history or frequency of family stress events nor the mother's or young person's reaction to them. (3) (4)

5.4.5 Young person, when harming herself, did not cause herself any injuries that required medical attention (described as scratches by professionals) and she reassured them that she knew it was a silly thing to do and that she would not do it again. These were not assessed as life threatening events.

5.4.6 Self harming was a behaviour that the young person witnessed.

5.4.7 ……..

5.4.8 …….

5.4.9 The young person told professionals or demonstrated by her mood / reaction to events that she was troubled by 'dramas' at home and that she wanted a 'normal' childhood. She was able to articulate her feelings and was willing to engage with professionals.

5.4.10 The parents of the young person had both experienced ……. anxiety (evidence suggests this has been throughout the young person's life) making them less able to consistently place the young person's needs above their own. There was no evidence that either parent was deliberately harming the young person.

5.4.11 The young person, leading up to the school summer holidays (July 2012), was more positive and described herself as having more friends and being more able to socialise.

5.4.12 Young person did not initiate contacts with professionals, off school premises, this was controlled by her parents ringing for or taking her to appointments. Her parents began cancelling some mentoring sessions from May 2012. When the mother made contact with the mentor she expressed concern that the adopted sister was manipulating the young person. The young person, at this time, told the mentor she felt positive about her relationship with her adopted sister and wanted to leave home to live with her when she (the young person) became 16, in September. This was becoming a tension between the young person and her parents and the young person told the mentor that she thought her parents did not want to lose control.

5.4.13 Towards the end of the school term (June and July 2012) the young person was no longer going to the Learning Support Unit instead of her normal lessons. She did however continue to visit at break times to update the Parent Support Advisor, who reported the young person being more positive about home.

5.4.14 ……..

5.4.15 Between 13 and 24 September the young person was kept home from school and the parents told the school she was recovering after the removal of a toe nail. Medical evidence (only revealed through this review) does not confirm this although the young person did spend one night in hospital, 12 September, for precautionary tests due to numbness in her right hand and arm.

5.5 EMERGENT PATTERNS RELATING TO THE CHILD/ FAMILY

5.5.1 **Family members were reluctant to seek help / engage with professionals regarding their own individual needs but were more capable of requesting help for other struggling family members. The young person did not initiate contacts with professionals that were based away from the school.**

5.5.2 **The mother and young person were described as showing insight, normally regarded as a protective factor when considering whether a person is a risk to themselves.**

5.5.3 **The numbers of professionals involved with the young person and her family peaked from December 2011 through to June 2012 when an uncoordinated process of disengagement occurred, leaving no professionals seeing the young person during the school summer holidays in 2012.**

5.6 CONTRIBUTORY FACTORS TO THE UNDERTAKING OF TASKS WITH CHILDREN WITH ADDITIONAL OR COMPLEX NEEDS (Tier 2/3 of the County's Integrated Children's Services Framework)

5.6.1 The key messages of 'Think Child, Think Parent, Think Family' (SCIE, 2009 and 2012), an approach to safeguarding children affected by parental mental health by building the resilience of all family members, was not evident in this review. (1)

5.6.2 In January 2012, when the young person was distressed over events within her family and struggling to attend school, the Parent Support Advisor encouraged the young person to make use of the school's Learning Support Unit, a safe place provided for children to study out of a class situation. The young person accessed this between January and June 2012 and evidence would suggest it was a positive resource for the young person who felt troubled and in need of additional support.

5.6.3 Individual professionals described specific concerns about the young person's development and well-being but none consciously decided the young person met the threshold of having additional needs. Professionals in the Case Group and Review Team lacked a clear view, based on the County's Integrated Children's Service Framework, when each threshold of need was reached so there was no clear view on when the Common Assessment should be initiated.

5.6.4 From the Case Group it emerged that there was also a lack of clarity regarding the issue of consent to initiate a Common Assessment/ Team Around the Child and what to do if a young person declines, where professionals believe it would be helpful. Guidance from the Department of Education states that consent is regarding information sharing rather than to the initiation of the process but the process is dependent on information sharing.

5.6.5 There was a belief, amongst professionals working with the young person, that it was 'easier' for another agency to initiate the Common Assessment and that it was difficult for their own, with specific barriers identified.

5.6.6 In January 2012……. For Children's Social Work, the task was to decide whether the young person was at imminent risk of harm. Neither agency considered it to be their task to consider whether the young person's health or development was likely to be impaired (Tier 3 of the Integrated Children's Framework) by the on-going stresses of growing up in a family…….

5.6.7 None of the individual family troubles that professionals became aware of, that caused them to be concerned about the young person, indicated that she had experienced or was at risk of significant harm. The 'Safeguarding task' was difficult for individual workers, engaged with individual family members for specific pieces of work, to understand or recognise at the time. They were not considering the cumulative effects of the young person's situation. Troublesome events were regarded in isolation. If the event primarily affected the adults of the family, the impact on the young person was not considered by professionals working with them.

5.6.8 For each individual agency ending contact, suspending contact or losing contact by the 2012 summer school holidays, there was not an issue at the time. At the Case Group meeting it was realised, amongst the professionals that the young person went from having many opportunities to meet with professionals to none. This was at a time when the young person was not in school so not in a situation where she could initiate contacts with adults she had a relationship with. Contact between the mother and Outlook South West also reduced, due the mother failing to attend 2 appointments, during the school holidays.

5.6.9 In September 2012, there was a delay in getting contact re-established with the Child and Adolescent Mental Health Service after a planned break for the school holidays. The young person was not taken to an appointment on 5 September (no explanation given by the family) and then on 14 September the mother contacted the team to state the young person was in hospital undergoing tests (this was not the case as she was only in hospital on the night of 12th and nothing was found but this was not known to agency staff at the time). The young person was not seen again by the Child and Adolescent Mental Health Social Worker although an appointment was agreed for 2nd October.

5.7 EMERGENT PATTERNS RELATING TO TASKS WITH CHILDREN WITH ADDITIONAL OR COMPLEX NEEDS

5.7.1 **Each agency focused on its own task with a particular family member so there was less attention paid to the needs of the family collectively and how family troubles and their responses to them were affecting the young person's safety and development. Agencies share a duty to promote the health and welfare of children and to Safeguarding but forming multi-agency teams around the young person when she was showing early signs of distress was not the natural response of the professionals involved.**

5.7.2 **There was ambiguity, amongst professionals and their managers over the definitions and thresholds to identify a child as having universal, additional or complex needs (this includes children defined as 'in need' within the Children Act, 1989).**

5.7.3 **The Learning Support Unit, at the young person's school, was a supportive environment that helped the young person attend school when feeling troubled by events at home.**

5.8 CONTRIBUTORY FACTORS TO INDIVIDUAL STAFF RESPONSES

5.8.1 Mother and father of the young person attended separate doctor's surgeries. …….

5.8.2 In March 2012, Outlook South West saw both the young person's parents but neither worker allocated knew the other parent had been referred or seen. The professionals described their work as dealing with what was presented to them by the client, in the room.

5.8.3 None of the professionals involved had significant experience in initiating the Common Assessment or Team Around the Child processes and some had fairly limited experience in taking part in them. For most professionals working with the young person, starting a Common Assessment did not enter their thinking as part of their work with the young person. The only professional in contact with the young person that discussed a Common Assessment with her was a volunteer mentor and in describing the process it was

suggested that it could provide 'additional support for her and possibly the rest the family' and the young person felt that she did not want anyone else involved. It was not described in terms of coordinating the way that professionals worked with the family.

5.8.4 The supervisor to the volunteer mentor, believing that a Local Authority Social Worker was involved with the young person, (the Social Worker mentioned by the young person would have been the one employed by the Child and Adolescent Mental Health Service) thought a Common Assessment was no longer relevant. The supervisor also held the belief that a Common Assessment would bring in additional workers, something the young person specifically said she did not want.

5.8.5 There was anxiety among some individual professionals that initiating the Common Assessment/ Team Around the Child processes would mean they became the lead professional and a fear they could not manage the perceived additional workload. (2)

5.8.6 ……

5.8.7 ……..

5.8.8 In January 2012 the Social Worker for Children's Social Work reached a decision that the young person did not need a social work assessment based on a telephone conversation with the young person's mother. The Social Worker did not take into account a record of a telephone contact from the Police.

5.8.9 The volunteer mentor and their supervisor believed a Children's Social Worker was already involved so did not pass on information to Children's Social Work about the young person. This was a misconception based on the young person saying she was seeing a Social Worker but this professional was employed by Child and Adolescent Mental Health.

5.8.10 The volunteer mentor did not know that the young person had a high level of absences from school, recorded as primarily for health reasons. The mother did collect the young person from home because she had not been to school when she did not appear unwell.

5.8.11 Individual professionals, working with the young person, went to considerable lengths to improve the quality of the young person's life and to support her in achieving her potential.

5.8.12 Professionals in contact with the parents did not consider the impact …….. their parenting capacity or the impact of their resultant behaviours on the young person.

5.8.13 ……

5.8.14 ……

5.8.15 The Social Worker from the Child and Adolescent Mental Health Service, in contact with the young person, was aware that she had contact with her …….. and was aware that the young person was worried about a Police investigation. There were no discussions between the Social Worker and the Police or with Children's Social Work.

5.8.16 From May 2012, the volunteer mentor was encouraged (by supervisor) to only respond to contacts from the parents which were about the young person. The volunteer mentor lost contact with the young person in June 2012 despite many attempts to have a final meeting to ensure that all goals had been achieved and that closure was appropriate. The mentor could not establish any direct communication with the young person.

5.8.17 Parent Support Advisor was available for the young person to contact during the school holidays but had not arranged contacts. Neither the young person nor her parents made any contact.

5.8.18 The Social Worker from the Child and Adolescent Mental Health Service works during term time only so was not available to meet with the young person during the school summer holiday in 2012. No alternative service was offered but the young person and her parents agreed to no sessions during the holidays.

5.9 EMERGENT PATTERNS RELATING TO INDIVIDUAL STAFF RESPONSES

5.9.1 **The professionals engaged directly with the young person strove to improve the quality of the young person's life.**

5.9.2 **Professionals involved with the young person and her family largely worked in isolation from each other with a particular family member. Forming as a multi-agency/ multi-disciplinary team was not considered as an approach although professionals had been trained in completing a Common Assessment and forming a Team Around the Child for children with additional needs. Professionals did not use the language of the County's Integrated Children's Service Framework so there was no evidence that any had identified her to be a child with additional needs, at the time.**

5.9.3 **The way that professionals worked in isolation meant there was no sharing of information relating to potential risks to the young person …….. This was either because professionals lacked clarity or from the belief that the Police and a Social Worker would make the appropriate checks and ensure she was protected.**

5.9.4 …….

5.10 CONTRIBUTORY FACTORS TO TEAM and SOCIAL INFLUENCES ON MULTI-AGENCY WORKING

5.10.1 No multi-agency team was formed either as a Team Around the Child, a process advocated in the County for children with additional needs, or as a Team Around the Family, (an extension to the arrangements which has been adopted in some areas of the country) (Department of Education website 2012). (1)

5.10.2 When the young person was referred to Children's Social Work and the mother ……, in January/ February 2012 neither individually reached the respective agency's thresholds for a more in depth assessment or intervention.

5.10.3 The Parent Support Advisor stated that during January and February 2012 she was feeling 'out of her depth' and that she lacked access to clear support and guidance.

5.10.4 The Parent Support Advisor was not prompted to commence a Common Assessment and no other staff at the school took the initiative. The volunteer mentor discussed the Common Assessment with her supervisor but once the young person declined there was concern that she would disengage from the service, if they proceeded with it, so the mentor was not encouraged to continue with this task. During the referral process to the Child and Adolescent Mental Health Service there was no discussion of whether a Common Assessment had been done and again, the professional in that agency was not prompted, through supervision, to initiate one. When Children's Social Work received a referral from the Parent Support Advisor no enquiry was made about whether a Common Assessment was in place and when the referral was declined, no advice was given on initiating the process.

5.10.5 The loss of the Learning Partnership, during 2011, left a multi-agency vacuum for children needing early intervention services, coordinated from the school.

5.10.6 From January to June 2012, when the young person was distressed over events within her family and struggling to attend school, the young person's school having a safe, relaxed place where she had easy access to understanding adults, was a positive support for the young person.

5.10.7 Thresholds to access specialist services were higher than professionals in universal and early intervention services felt able to continue manage alone. The Parent Support Advisor felt that the young person's welfare was being adversely affected by her family situation and her needs were beyond the scope of what she could provide (aimed at improving her attendance at school).

5.10.8 Supervisory processes did not support professionals working with the young person to reflect on the young person's health and development, over time, or to consider forming a multi-agency team around the child or her family. Supervisory processes did not challenge professionals to consider the potential risks to the young person.

5.11 EMERGENT PATTERNS RELATING TO TEAM and SOCIAL INFLUENCES ON MULTI-AGENCY WORKING

5.11.1 **Whilst there were excellent early support services in place for the young person the professionals involved operated in isolation within their own agency team. There was a lack of communication between the individual professionals (explored further in other sections) which undermined the coordination of the overall provision to the young person and her family.**

5.11.2 **The review found a lack of evidence that management / supervision systems, within agencies, prompted or supported the professionals to consider**

- **whether or not the young person was a child with additional or complex needs so their approach remained that provided to children with universal needs where services are provided through individual agencies;**
- **the impact, for the young person, of growing up in a family ……..**
- **fully the potential risks to the young person (and other extended family members) …….**

5.12 CONTRIBUTORY FACTORS RELATING TO THE EDUCATION AND TRAINING OF MULTI-AGENCY STAFF

5.12.1 Common Assessment / Team Around the Child training is in place for professionals working with children and young people but professionals described barriers to putting their learning in practice. From the comments of professionals involved, it is possible to undertake the training and then not be involved in the process so the learning is not embedded into practice.

5.13 EMERGENT PATTERNS RELATING TO THE EDUCATION AND TRAINING OF MULTI-AGENCY STAFF

5.13.1 **Multi-agency training has not translated into multi-agency arrangements to work with children and families showing the early signs of distress.**

5.14 CONTRIBUTORY FACTORS RELATING TO EQUIPMENT AND RESOURCES

5.14.1 The supervisor for the Mentoring Service reported difficult experiences using the computer based Common Assessment forms which had become a barrier, in her mind, to initiating the process. In the past she had found she had to complete it in her own time and she had difficulties with losing her work.

5.14.2 There was anxiety among some individual professionals that initiating the process would mean they became the lead professional and a fear they could not manage the workload.

5.14.3 The head teacher stated that over 100 pupils attending the young person's school could come into the category that might lead to a child to be considered as child with additional needs, if the category should include pupils accessing services off the school premises. The head teacher also stated that the school was unlikely to be atypical for the area. In terms of capacity, they have 6 staff who lead the Common Assessment/ Team Around the Child processes and guidance states each should hold no more than 6 children so a capacity of 36 pupils. This is a significant resource barrier when the school has the primary task of delivering a universal education service.

5.15 EMERGENT PATTERNS RELATING TO EQUIPMENT AND RESOURCES

5.15.1 **Individuals and agencies fear that initiating the Common Assessment and Team Around the Child will demand more resources, in terms of staff time, than they have available. A computer based form was regarded as a barrier rather than a support to completing the Common Assessment.**

5.16 CONTRIBUTORY FACTORS TO MULTI-AGENCY COMMUNICATION

5.16.1 Regular, ongoing communication between professionals was limited to being between the Parent Support Advisor and other professionals at the young person's school and, for a brief period, between the Social Worker from the Child and Adolescent Mental Health Service and Parent Support Advisor. The only other contact between professionals was when specific referrals were being made e.g. Parent Support Advisor ……..over a specific concern for the wellbeing of the mother and with Children's Social Work to request an assessment. There was no communication between professionals with involvement with the parents or adopted sister and the professionals involved with the young person. (1)

5.16.2 The Common Assessment/ Team Around the Child processes facilitate communication between professionals so without them being initiated there was a lack of discussion about starting it.

5.16.3 The school were monitoring the young person's low levels of attendance at school (it did dip below 70%), which included the involvement of a Parent Support Advisor, Education Welfare and Pastoral Care. Parental authorisation for school absences, on the grounds of ill health, continued to be accepted. There was no communication between the school and the young person's doctor, or with the school nurse but if there had been it would have cast doubt on the authorisation and would have challenged the young person's absence between 13 and 24 September.

5.16.4 Decisions by specialist agencies, when they received referrals, were made without consulting other agencies/ professionals involved with the family, who held more information. The Parent Support Advisor and volunteer mentor, who had a good understanding of the young person and her family, were not contacted, before reaching a decision on whether referrals to them met their thresholds and therefore accepted.

5.16.5 The Parent Support Advisor prompted the young person's doctor to refer her to the Child and Adolescent Mental Health Service (February 2012). The mother and young person were with doctors at different practices so the young person's doctor was unaware of the mothers situation.

5.16.6 There was a lack of communication between professionals, meaning they each had a partial picture of each of the events that troubled or affected the young person and they were not working together to maximise safeguarding opportunities. Even within agencies, there

was a lack of communication between professionals in contact with different family members or sharing of information despite one some agencies having a common computer based record system

5.16.7 The volunteer mentor was told, by the young person that a Social Worker and the Police were involved so the mentor believed that those professionals would ensure the young person was safe. The mentor did not realise the Social Worker was employed by Child and Adolescent Mental Health rather than the Local Authority.

5.16.8 The lack of communication between professionals meant that they were unaware of the drift towards no professionals being in active contact with the young person during the school summer holidays in 2012 or that she had largely disengaged from services. This may have been appropriate but the lack of communication meant that this was not a planned response to the needs of the young person between June and August.

5.16.9 In addition, the mother reduced her contact with Outlook South West during the school summer holidays in 2012 but that agency was totally unaware of the young person's situation.

5.16.10 The lack of communication / disengagement of the family from professionals, between June and September 2012, led to no checks on the situation when the young person was absent from school between 13 and 24 September. The parents gave different accounts of the young person being unwell to the Social Worker from the Child and Adolescent Mental Health Service and to the school. The young person's doctor held the facts but was not in communication with any professionals. The discrepancy was not revealed at the time but became clear during this review process.

5.17 EMERGENT PATTERNS RELATING TO MULTI-AGENCY COMMUNICATION

5.17.1 **Professionals working with the adults and young person in the family did not communicate with each other effectively so each held a partial story of the life of the family and decisions were not driven by the 'Working Together' principles as the way to ensure that the young person was healthy, safe and was able to enjoy and achieve (DCSF, 2010). The child was invisible to those professionals involved with the parents and adopted sister (DCSF, 2009).**

5.17.2 **The lack of communication made it difficult to coordinate responses to the young person and her family and led to periods where many professionals were involved and periods where no professionals were involved, without there being clarity that this was the correct response to need. It also meant that when some professionals had fragments of information that had the potential to reveal, if joined, that the young person was exposed to risk, this was not recognised and acted upon.**

5.17.3 **In terms of communication, those making decisions regarding the family's access to more specialised resources had least knowledge of the family situation and those professionals, with the most knowledge over the life of the young person, had least influence over the deployment of those specialist resources.**

5.17.4 **Some barriers to effective communication were within health. Family members chose to attend different doctor's surgeries so the fact that several members of the family were being affected by problems, at the same time, went unnoticed. ……..**

5.17.5 **The school taking a supportive rather than punitive approach to the young person's poor attendance was appropriate. However, evidence has emerged that at times the parents were authorising the young person's absences, due to ill health, that may not have been supported medically had communication between the school and health professionals been in place. This was particularly concerning for the absence between 13 and 24 September 2012 as evidence suggests this may not have**

been justified and there is no independent evidence of what was happening in her life and whether events had any bearing on her death.

5.18 CONTRIBUTORY FACTORS RELATING TO WORKING CONDITIONS OF PROFESSIONALS

5.18.1 There was no secure funding for the Parent Support Advisor role which led to a sudden ending of involvement July/August 2011, a gap between then and November 2011 and then a sudden ending again July/August 2012. The volunteer mentor ended contact in June 2012 as the young person withdrew from the service. The Parent Support Advisor and volunteer mentor were professionals that held significant knowledge about the functioning of the family and how events were impacting on the welfare of the young person. They were the professionals who saw her with her parents at home. Working conditions did not lead to their knowledge being explored by more specialist staff ……..and information gathering by Child and Adolescent Mental Health Services was limited.

5.18.2 The professionals involved with the young person had narrow roles – to improve the young person's attendance at school, to provide activities and one-to-one time. The professionals with contact with the adults in the family did not consider it to be within their role to consider the young person - the young person was invisible to them - the "enduring problem of the child being 'lost'" (DCSF, 2009).

5.18.3 Several agencies were involved with the family but there was no coordinated plan.

5.19 EMERGENT PATTERNS RELATING TO THE WORKING CONDITIONS OF PROFESSIONALS

5.19.1 **Universal and early intervention services do not normally have safeguarding and child protection as a primary task so the staff can be less experienced/ skilled in this area. It was professionals providing such services that saw the young person in her family context by visiting the home. Their concerns were not fully explored by other more specialised professionals who may have had the skills/ power / access to resources to bring about change.**

5.20 CONTRIBUTORY FACTORS RELATING TO THE ORGANISATIONAL/ STRATEGIC IMPLEMENTION OF MULTI-AGENCY WORKING ARRANGEMENTS

5.20.1 The culture of 'Think Child, Think Parent, Think Family', where a child or young person are within a family affected by sustained parental health issues, was not evident between adult and children's services.

5.20.2 Initiating the Common Assessment and establishing a Team Around the Child was not evident as embedded within practice and in this case there was a lack of clarity over if and when the young person became a child with 'additional' or 'complex' needs and how to deal with the lack of consent by the young person.

5.20.3 The young person's school strove to manage the education of children, with a range of needs, within their universal provision. As a school, they struggled to decide which should receive a coordinated multi-agency rather than single agency approach. Depending whether the school was using the 'right' (no objective means of knowing) threshold for regarding a child as having universal or additional needs would affect judgements over whether the long school summer holiday, in 2012, was an appropriate period for the young person to have no additional services.

5.20.4 There was a culture among professionals of dealing with current events as they affected a particular family member, rather than a holistic view of the life of the child or life of the family, to understand ongoing needs and future risks.

5.20.5 For the young person there were no significant or imminent risks identified although several professionals were noting concerns to suggest a low level of sustained risk to the young person's safety, health and development. The situation of the young person did not trigger a multi-agency response to her needs and risks.

5.21 **EMERGENT PATTERNS RELATING TO ORGANISATIONAL/ STRATEGIC IMPLEMENTION OF MULTI-AGENCY WORKING ARRANGEMENTS**

5.21.1 **The contributory factors in this section have echoes of issues identified to the LSCB through previous Serious Case Reviews in the County.**

- **The good practice to improve the resilience of families affected by parental health, 'Think Child, Think Parent, Think Family' (SCIE 2009 and 2012) was not evident.**

- **There were barriers, creating resistance amongst professionals across agencies, to initiating a Common Assessment and Team Around the Child, the process described by 'Working Together' (DCSF, 2010) to facilitate multi-agency working for children in need of early intervention services.**

- **Professionals across agencies reacted to events as they affected individual family members rather than looking more holistically at the family, over time, so missed the signs of low level of sustained risk to the young person's safety, health and development. This left the young person "bump(ing) along the bottom" (DCSF, 2009). By the summer of 2012, because there were no child protection issues to demand immediate or urgent action, the young person lost the attention of professionals providing additional services but the lack of a coordinated approach means it is difficult to know whether this was appropriate and based on the needs of the young person or not.**

6. CONCLUSIONS

6.1 Whilst this review has identified barriers to the effective coordination of early intervention services there has been no evidence that any action or omission directly led to the death of the young person. It is harder to assess whether, if the coordination of services to the young person and her family had been better whether it would have had a significant impact on the young person's life to the point that she would not have committed the deliberate self harming act that did directly lead to her death. The young person's death deeply saddened her family and the professionals who worked with her and has been a motivator to their participation in this review to ensure that any lessons to be learned are identified and acted on.

6.2 After the death of a young person, when reviewing how agencies worked together, it is easy to dwell on the negatives but there was evidence of good early intervention services for the young person. During the review period, the young person benefitted from a Parent Support Advisor able to work closely with the family, in a supportive way, to assist the young person in attending school more regularly. This service, alongside

the Learning Support Unit, provided at the young person's school, were acknowledged by the family and other professionals to have been a positive influence in the young person's life. Both services, which could be at risk of loss in a climate of funding pressures, should be considered as examples of good provision for children showing the early signs of distress where it is affecting school attendance. Both services enabled the school to manage the needs of the young person, for some time, before more specialised services had to be introduced through the Child and Adolescent Mental Health Service.

6.3 The provision of a volunteer mentor enriched the opportunities for the young person and provided her with an adult to listen and support her aspirations when her parents were struggling with their own difficulties. The scheme, with this young person, operated in isolation and if it could have been integrated better in the provision to the family, the young person's voice may have been stronger thus enabling other professionals to recognise that the young person's difficulties grew out of long term unmet needs of her wider family.

6.4 The five practice areas examined in this review can be regarded as interlinked systems and the analysis identifies some patterns that, if tackled, could improve the effectiveness of early intervention services which in turn may reduce the numbers of children that go on to have complex and acute needs. The view of the Review Team was that if barriers to completing a Common Assessment and forming a Team Around the Family could be removed then improvements to all the other practice areas would follow. The Team Around the Family rather than Child was preferred as this would assist agencies to work together across, Adult and Children's Services to adopt the key messages advocated within the Think Child, Think Parent, Think Family approach (SCIE, 2009 and 2012 and Cabinet Office, 2007). The findings for the Local Safeguarding Board to consider will be based on these barriers but will also invite the Board to consider the 8 key messages contained in the publication At a Glance 9: Think Child, Think Parent, Think Family (SCIE, 2012). These key messages have the potential to assist Adult and Children's Services (including between adult and children's mental health provision) to coordinate provision to families affected by parental health and address issues identified in this review. Had the young person's family benefitted from such a joined up approach, over her lifetime, her development and mental well-being may have been less affected.

6.5 …….

7. FINDINGS FOR CONSIDERATION OF THE LOCAL SAFEGUARDING CHILDREN BOARD

7.1 The first five findings for the Board are to address the barriers to initiating the Common Assessment and forming a Team Around the Family as the means to improving the coordination of early intervention services.

- 7.1.1 Professionals and the agencies they work within need help to recognise when a child's needs have risen from universal to additional, in language that is simple and unambiguous and can be easily recognised within the context of each agency.
- 7.1.2 The resources necessary to initiate the Common Assessment and form a Team Around the Family need to be explored and balanced with potential savings from a coordinated approach.
- 7.1.3 Professionals need help to maximise the prospect of gaining consent to the information sharing necessary to initiate a Common Assessment and alternative responses explored when consent is withheld.
- 7.1.4 Good practice examples, in initiating Common Assessments and working as part of a Team Around the Family, need to be shared to improve the perception of the benefits.

7.1.5 To further understand the barriers to initiating a Common Assessment more fully staff that have attended training but not initiated one should be consulted and involved in developing improvements.

7.2 Next, the Board needs to address the issues that affected the family's needs being addressed more holistically, in particular ensuring that when making decisions over access to specialist resources (involving thresholds) both Children's Services and Adult Services work together to improve the outcomes for children/ young people and their parents. Additionally, it is important that all professionals in contact with parents with …….health problems consider and take actions to promote the welfare and safety of children in the family and that professionals working with children know how to recognise parental health as a factor with the potential to affect the child. To assist the Board, the 8 key messages SCIE (2012) has identified to reduce the exclusion of parents with health problems and their families from health and social care provision (Cabinet Office, 2007) are reproduced below.

7.2.1 Think child, think parent, think family in order to develop new solutions to improve outcomes for parents with ……. health problems and their families.
7.2.2 Take a multi-agency approach, with senior level commitment to implement a think family strategy.
7.2.3 Review whether criteria for access to adult health and to children's services take into account the individual and combined needs of children, parents and carers.
7.2.4 Ensure screening systems in adult health and to children's services routinely and reliably identify and record information about adults with health problems who are also parents.
7.2.5 Listen to parents and children – most want support that is flexible, based on a relationship with a key worker and takes account of their practical priorities.
7.2.6 Build resilience and manage risk – ensure ready access to specialist mental health and children's safeguarding services when needed and that staff know who makes what decisions in what circumstances.
7.2.7 Be creative – consider allocating an individual budget to provide flexibility and tackle stigma by developing non-traditional ways of providing services.
7.2.8 Increase every family member's understanding of a parent's mental health problem – this can strengthen their ability to cope.

7.3 ……...

7.4 It is now for the Board to consider these findings and decide what, if any actions it is going to take to address them, explaining their rationale. It is therefore for the Board to agree and own the action plan arising from this review, which must be documented in section 8.

References:

Cabinet Office (2007) Social Exclusion Task Force: Reaching Out: Think Family Analysis and themes from the Families At Risk Review

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