Bath and North East Somerset

Local Safeguarding Children Board

Serious case review overview report in respect of David A

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CONTENTS

1. INTRODUCTION

1.1 When children die or are harmed whilst in contact with child care agencies, the Local Safeguarding Children Board (LSCB) (a committee made up of senior representatives from health, police, social care etc.) has the responsibility to investigate the circumstances in order that any learning for professionals can be identified and acted upon. This is called a serious case review. The overview report is a summary of that serious case review.

1.2 The chair of Bath and North East Somerset' Safeguarding Children Board, Jim Gould, agreed that a serious case review should be convened, following the death of a young person who this report calls David A. The serious case review was conducted in accordance with government guidance *Working Together*[1] (2010). The review happened between November 2012 and July 2013.

1.3 A serious case review involves a series of meetings between independent people and senior representatives from all of the services, including voluntary agencies, who work with children. The independent people do not have working links with the local area or agencies. The result is a series of single agency reports called individual management reviews, (IMRs) a health overview report, and this report.

1.4 The whole process was overseen by a panel of senior managers, called a serious case review panel, who scrutinised and discussed all of the IMRs, ensuring that each author had thoroughly examined the role of their agency and identified where lessons could be learned and things done differently in future. The panel was chaired by another independent person Dr. Louise Goll. This report was written by Barry Raynes who is the chief executive of Reconstruct, a company which provides services to child care agencies, families and children. This report will be published on the LSCB web-site and sent to the Department for Education.

1.5 Each agency identified a senior manager, who was not involved with the family or with the management of the case, who wrote an IMR about their agency's involvement.

1.6 The family have been involved throughout this serious case review. David A's parents and sister were seen twice each and have contributed questions and suggestions which have informed the review.

1.7 During the course of this review, revised guidance: 'Working Together to Safeguard Children (2013)' has been published, which states that a Serious Case Review (SCR) *'should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.'* This report has therefore been prepared with a view to publication in line with that requirement.

Terms of reference

1.8 Terms of reference were drawn up and are included in their entirety in appendix one of this report.

[1] Government guidance relating to child protection

1.9 The terms of reference included the following key questions for the individual management reviews (reports provided by each individual agency regarding their involvement with the family):

1. Were David A and his family offered appropriate services to help meet their needs throughout the time period?
2. Was information clearly and appropriately shared between organisations?
3. Was there appropriate shared assessment of the level of risk between relevant agencies throughout the time period?
4. Were actions taken by individual agencies appropriate to address the assessed risks?
5. Was there a well-informed, robust multi-agency assessment of the risks of significant harm that informed the decision to end the child protection plan in March 2010?
6. Was the decision to end the child protection plan consistent with the assessment of risk?
7. Was appropriate support offered to David A as a child in need following the end of the child protection plan?
8. Did the strategy discussion in February 2012 take appropriate account of David A's history?
9. Following the strategy discussion in February 2012 was there appropriate information sharing between agencies?
10. In particular was there a shared assessment of the level of risk of suicide in April 2012?
11. Were there effective strategies to manage differing levels of parental engagement with services?
12. Were there effective strategies to manage differing levels of engagement from David A?
13. Did agencies work effectively across the boundaries of Bath & North East Somerset and Wiltshire?

1.10 Whilst this report does not address these questions separately all are covered in the analysis section in this report apart from questions 2 and 13. It is this report author's view that, after careful consideration of the facts, there were no significant learning points regarding information sharing and cross boundary working as these had been well managed.

Summary

1.11 David A died by his own hands in 2012. He came to the attention of Child and Adolescent Mental Health Services, (CAMHS) in 2007 and children's social care in 2008 and there are multiple recordings of him talking about suicide and self-harm to his family and professionals.

1.12 Between July 2009 and March 2010 David was made subject to a child protection plan due to concerns about his well-being.

1.13 David A was unsettled at his first senior school but settled well into School2, attended well and achieved good GCSE results.

1.14 In early 2012 David A was arrested by police because he had bought chemicals off the internet which could be used to make explosives. He was released without any charges and no further action was taken.

1.15 David A often talked about his unhappiness and how things weren't changing for the better. He took his own life at a time when the circumstances of his own life appeared to be improving.

Race, religion, language and culture

1.16 All members of the family are English speaking White British. It is not known whether religion is a feature in their lives as this has not been noted in records.

1.17 Both parents have been in continuous employment and have been devastated by the death of their son.

2. METHODOLOGY

Independence

2.1 Dr. Louise Goll, was appointed by the safeguarding children board to chair the serious case review panel. Louise has worked as an independent consultant in children's services since 2012 following a career as a senior leader in education and children's services in Somerset, Buckinghamshire, Leicester and Oxfordshire local authorities. Her most recent substantive appointments were as Director of Children's Services in Somerset and Divisional Director of Learning and Achievement in Buckinghamshire.

2.2 Louise has over 30 years' experience working to promote the wellbeing of children and young people as an educational psychologist, teacher, adult educator and trainer, manager and leader of services. She has a first degree in psychology, a PGCE, a Master of Applied Science in Educational Psychology and a PhD in Education which focused on the inclusion of children with disabilities in mainstream schools. She has led and managed a wide range of children's services including educational psychology, specialist teaching, youth, children's centres, school improvement, and in her final role in Somerset was responsible for the delivery and quality of all children's services.

2.3 The overview author was Barry Raynes. Barry is the Chief Executive of Reconstruct, a company providing child care training and consultancy to managers and staff throughout the United Kingdom. Reconstruct also supplies advocacy, independent visiting and participation services to children in south west England.

2.4 Barry has thirty years' experience of child protection social work. He has been involved in over 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports. He has written web-based child protection and child care procedures for more than 50 LSCBs and local authorities in England, Wales and Scotland.

2.5 Barry has a Masters degree in public sector management and is currently researching a PhD into common language in child protection.

2.6 Jim Gould is the independent chair of Bath & North East Somerset (B&NES) safeguarding children board. Jim Gould has professional qualifications in teaching and social work and a Masters Degree in Business Administration. He has worked in Social Care since 1975 working in Devon, Derbyshire and Cornwall before being appointed as Director of Social Services and Housing at the Royal Borough of Windsor and Maidenhead in 2003.In 2006 he was appointed by the Royal Borough to the combined role of Director of Children's Services and Director of Adult Social Services and Housing. He held this post until his retirement in 2009.

2.7 Following retirement Jim was appointed as Independent Chair of Plymouth LSCB and still holds that position. He was also appointed as a Non Executive Director of Cornwall and Isles of Scilly Primary Care Trust. In 2010 he was asked to become the Independent Chair of Bath & North East Somerset LSCB and also took on the role of Independent Chair of Plymouth Safeguarding Adults Board.

Serious Case Review Panel

2.8 The serious case review panel met on nine occasions for either a half or full day between 17th December 2012 and 24th June 2013. The overview report was ratified at the Local Safeguarding Children Board meeting on 17th July 2013.

2.9 The panel comprised of:

Head of Safeguarding, Assurance and Quality – Children and Young People	Bath and North East Somerset Council
Deputy Director for Children and Young People	Bath and North East Somerset Children's Services
Deputy Designated Nurse Safeguarding Children - Nursing & Quality Directorate	NHS Wiltshire Clinical Commissioning Group & NHS B&NES Clinical Commissioning Group (CCG)
Detective Chief Inspector	Avon and Somerset Police
Children's Services Manager	Barnardos
Serious Case Review Project Lead	Wiltshire safeguarding children board

Parallel processes

2.10 There was a Coroner's Hearing in respect of David A during the time of this serious case review; the Coroner recorded an open verdict. This parallel process did not affect the timescale of this serious case review.

Dissemination of learning

2.11 The learning from this review will be disseminated throughout safeguarding children board professionals via a series of workshops.

Timescales

2.12 The serious case review took 8 months between being commissioned and presented to the Board. This is one month beyond the timescale suggested in Working Together to Safeguard Children, 2010.

Production of individual management reviews (IMRs)

2.13 IMRs were received from:

Bath and North East Somerset Children's Services (CSC)	Avon and Somerset police
Wiltshire Education Welfare Service	Sirona Care and Health
School 1	School 2
Great Western Hospital (GWH) NHS Foundation Trust	General Practice
Relate Mid Wiltshire	Child & Adolescent Mental Health Service (CAMHS): Oxford Health NHS Foundation Trust and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)

2.14 A health overview report was produced by Sophia Swatton drawing together the issues and findings from the health IMRs.

2.15 Sophia is a qualified nurse, health visitor and practice educator. She holds a BSc in community health studies and a post graduate certificate in higher education (PGCHE). Sophia has worked in the field of safeguarding children since 1993 and has specialised in this field since 2010. She commenced employment with NHS B&NES and Wiltshire cluster primary care trust (PCT) as deputy designated nurse for safeguarding children in June 2012. On 1st April 2013, as part of the NHS reforms NHS B&NES CCG replaced NHS B&NES (PCT) as part of the NHS reforms and is no longer clustered with NHS Wiltshire. The designated nurse function continues to be provided to B&NES CCG via a service level agreement with Wiltshire CCG. Sophia also sits on the B&NES LSCB.

Expert guidance

2.16 Expert guidance was sought from a consultant nurse for self-harm from South London and Maudsley NHS Foundation Trust. The panel used material produced by this person to formulate the guidance included in this report at appendix three which forms part of recommendation one.

3 NARRATIVE OF EVENTS

3.1 The terms of reference for this review covered 2007-2012.

3.2 This narrative is in chronological order but some dates have been removed to protect the anonymity of the family.

Year 7 2007-2008

3.3 On October 17th 2007 Mrs A, David A and Susan A attended an appointment with CAMHS. At that appointment David A saw CAMHS Practitioner 1 and spoke of his fears about his parents arguing and his view that nothing would change. CAMHS decided that they would offer him support as well as the rest of his family.

3.4 Mrs A, Susan A and David A met with CAMHS Practitioner 1 and CAMHS Practitioner 2 for a family therapy session. Mr A had said he didn't feel the need to come. It was recorded about David A that he "*does not believe that things are ever going to change…..wanting to commit suicide,*" Oxford Health NHS Foundation Trust (page 5).

3.5 Mrs A arrived at CAMHS one morning hoping to speak to someone; she was distressed. Mrs A agreed to a referral to children's social care as she said that she wanted help. The referral was made a week later.

3.6 On 28th April 2008 social worker 1 visited the family home to complete an initial assessment[2] and talked to David A who said that he was depressed and that he had tried to kill himself by putting up a rope but that it didn't hold. Referrals were made by the social worker to:

- A family support project
- Support services for parents
- Alcohol services.

3.7 Social worker 2 (from the family support project) said that Mr and Mrs A needed to sort things out between themselves and concluded that further work with David A was not appropriate because the main problem was the relationship between the parents.

Year 8 2008 - 2009

3.8 In January 2009 David A's attendance at School1 started to deteriorate. He became increasingly depressed and as a result was finding it difficult to get into school. The school allocated a key worker for David A and tried various techniques for helping him to stay at school.

3.9 Mrs A and David A went to an appointment with CAMHS Psychiatrist 1. As a result a further referral was made to children's social care in which it was noted that there had been no change in the home circumstances since the last referral made in May the previous year, that David A was still saying that he wanted to kill himself, and that he had written a number of suicide notes.

3.10 On 27th February 2009 General Practitioner 1 saw David A and recorded:-"*Pretty despondent about situation, came with mum, went to school but could not face going so mum brought him here. Situation with father seems worse, no longer on speaking terms. Does not believe anyone can help or is even trying*," B&NES General Practice IMR.

[2] This is a short assessment, usually completed within 7 days.

3.11 School1 completed a CAF[3] and made referrals to children's social care and the educational welfare service as David A's attendance at school had dropped significantly.

3.12 On 13th March 2009 social worker 3 visited the family home to complete a 2nd initial assessment. The issues identified were:

- David A's continued suicidal thoughts,
- low self-esteem and social confidence which was causing
- poor school attendance.

3.13 Mrs A phoned CAMHS to say that David A was desperate and needed someone to talk to. CAMHS psychiatrist 2 wrote to children's social care with the view that David A was at risk of harming himself.

3.14 On 1st May 2009 social worker 4 visited David A at home, as social worker 3 was no longer allocated. David A said that he was feeling down. He said he heard voices arguing in his head. Children's social care decided that they needed to allocate a social worker to the A family.

3.15 On 13th May 2009 social worker 5 became David A's allocated social worker.

3.16 CAMHS psychiatrist 2 wrote to social care to say that one to one work with David A had been inappropriate because the cause of his distress was due to his parents' relationship. She also said that David A was at significant risk of self-harm.

3.17 Mr and Mrs A attended an appointment with CAMHS Psychiatrist 2. It was agreed that there would be more work with them in order to change in ways which would be beneficial to the children. Later that day GP1 rang social worker 5 saying that David A was at risk of self-harm and said that David A wanted to die and that his emotional health had deteriorated and he was significantly depressed.

3.18 On 26th June 2009 social worker 5 completed a core assessment. The main issues identified included the escalation of David A's suicidal thoughts.

3.19 The recommendations of the core assessment were couple counselling for his parents , long term therapy for David A[4] and that a multi-agency approach should commence. CAMHS were to continue to work with Mrs A and Mr A.

3.20 On 17th July 2009 an initial child protection conference decided that David A would be subject to a child protection plan under the category of emotional abuse, and that Susan A would be categorised as a child in need (CIN).

3.21 The plan detailed who should do what and what the timescales were. Social work assistant 1 was assigned to offer David A 1:1 support in order to give him the opportunity to talk about any worries he might have. Social worker 5's role was to look at Mrs A's use of alcohol and whether there was a need for her to be referred for further support.

[3] Common assessment form – for children with "additional needs".
[4] This recommendation did not appear on the plan formulated after the child protection conference on 17/07/09

Year 9 2009 -2010

3.22 On 3rd September 2009 social worker 5 telephoned School1, and said that although David A had had a good summer he had "*stood by the car on the first day of school and said, 'nobody understands, I can't do it*'" joint chronology (03/09/09). A meeting was held at School 1, with education welfare officer 1 and social worker 5. They decided that they would ask CAMHS to become involved again to check if David A was medically fit to attend school.

3.23 Social work assistant 1 made a home visit during which David A talked about telling his father that he was going to kill himself. Social work assistant 1 recorded that David A was angry and frustrated because nothing had really changed in his life and he still had the same worries and problems.

3.24 David A met with CAMHS Psychiatrist 2 and said he didn't want help in school because he didn't want to be abnormal; by which he meant that he didn't want it to be known that he was having learning support.

3.25 Social worker 5 was told by Mrs A that she and Mr A had started a trial separation and Mr A had left the family home.

3.26 On 16th October 2009 the first child protection conference review took place. It was reported that there were no significant changes identified since the last conference. The parents' trial separation was still in its early days. David A was at the conference and he was able to contribute with help from the local advocacy service. He submitted a statement of two pages which included "*I still have the feeling that I want to die (but) I won't try to kill myself*". David A again said he felt that nothing in his situation had changed.

3.27 David A was referred to a young people's support service for an online learning package.

3.28 In January 2010 a core group meeting took place. Mr A wrote a letter to be read out saying that he was unable to attend due to a lack of notice and the potential loss of a day's pay. In the letter he asked: "*All in all any report puts me as the root of the problem. Now that I have been pushed out of the family I regret to inform you that nothing has changed for the better*".

3.29 David A started attending a sports academy; he continued to do this until the end of his life.

3.30 Mr A spoke to social work assistant 1, and said that David A would be willing to try another school and they were considering School2; Mr A wrote to this school to that effect. He told education welfare officer 1 that he wished to apply for David A to transfer with a view to him making a 'fresh start'. Education welfare officer 1 liaised with the family and School2 to facilitate this and David A's new school was confirmed.

3.31 A meeting was held at school2 with David A, Mrs A and social worker 5. School2 staff were made aware of David A's poor attendance at School1, his low self- esteem and emotional ill-health. They were also informed that things were improving now that Mr and Mrs A had separated, and that whilst David A was still on a child protection plan he was likely to be de-registered soon. David A said he wanted to be back in school full time and did not want any support.

3.32 It was agreed that David A would remain on School Action Plus[5] for the time being. School employed school nurse 1 at school2 was allocated as a support person, he was given an experienced male tutor and a student buddy.

3.33 On 26th March 2010 the second child protection conference review took place. Mr A again sent his apologies and another letter. This letter pointed out that Mr A, David A, education welfare officer 1 and her manager had been the people responsible for getting David A to School2. The letter said that this has been achieved through "*giving discipline and guidance a teenage boy needs without third party interference and 'pie in the sky' ideas".*

3.34 The letter ended with: "*One of the conditions David A asked me to make, regarding school, is that everyone involved in this case leave him alone. And, whilst I know it's early days, may I ask you all to help me keep that promise and keep a back seat, or at least watch from a distance, and let him find his own feet in the world".*

3.35 The conference took the decision that David A no longer needed a child protection plan.

3.36 CAMHS psychiatrist 2 wrote a letter to Mrs A setting down the details of the progress made and saying that David A's case would be closed, with the ability to reopen if needed.

3.37 David A was soon doing very well at school; his attendance was 100% and he was achieving higher grades.

3.38 On 30th June 2010 at a home visit, social worker 5 met with Mrs A and Susan A. Both reported much improvement. Mrs A was confident about coping on her own. The case was then closed by children's social care despite the fact that David A had not been present at this meeting.

3.39 David A's year 9 school report showed good progress and positive behaviour points. In his own personal statement for this report David A stated that he had made good friends and his time had been quite enjoyable. He felt respected. He said that his favourite subjects were History and PE. He commented that his self- confidence had increased. He put this down to joining the sports academy where he had been going for the last 5-6 months. He said his life was on the right track.

Year 10 2010 – 2011

3.40 On 10th August 2010 Mr A phoned social worker 5 to say that David A was staying with him twice a week because of problems at home.

3.41 On 8th November 2010 an advocate made a referral to children's social care because Susan A was expressing concern to her counsellor about her mother.

3.42 Social worker 6 visited the home and completed a further initial assessment. David A was said to be very unhappy. The decision was that social worker 7 would be allocated to the family for long term support.

3.43 Social worker 7 saw David A alone. He said that Mrs A was in a new relationship and he would kill himself if he had to move in with her and her new boyfriend. He felt that school was a safe place and said he wanted to live with his father but understood that his house was too small.

[5] A system designed to provide extra support to pupils who are finding school difficult.

3.44 On 18th March 2011 social worker 7 discussed David A in supervision and said that David A didn't want a social worker anymore as nothing had changed his situation. She and her manager (social work manager 1) agreed to make a referral to the family support project and close the case.

3.45 On 21st July 2011 Mrs A rang social work manager 1, (social worker 7's manager), to say that David A had told his sister that he was going to kill himself that night or the next day. Susan A said David A had tried this four times previously. Mrs A was advised to take David A to the GP and request a referral to CAMHS.

3.46 Later that day Susan A phoned the GP practice about David A's anger and his talk about killing himself. On reflection, during an interview with the B&NES General Practice IMR author, General practitioner 2 said that Susan A mentioned knives in this conversation. The discussion about knives was her reason for not visiting. She suggested a referral to a counselling service, and advised that the police should be notified if necessary. General Practitioner 2 telephoned Susan A back later that day; Susan A was upset that doctors were not prepared to visit and it was explained to her that this was because knives had been mentioned.

3.47 The following day social worker 7 telephoned Mrs A and reiterated the importance of supervising David A closely in the light of his suicide threats. Mrs A hadn't taken David A to his GP as she didn't think he would go to CAMHS. Social worker 7 stressed the importance of this referral being made.

3.48 One month later, 22nd August 2011, the case was closed by children's social care on the basis that David A had said that that he didn't want social work support. The closing summary said there were indications that David A was less socially isolated.

Year 11 2011 – 2012

3.49 David A was reported by the school as starting year 11 in a positive frame of mind.

3.50 On 24th November 2011 Mrs A rang the school to say that she was concerned about David A who was buying chemicals over the internet. School senior staff 1 telephoned the police for advice; staff at the school discussed the matter; they decided that David A presented a low risk at school and therefore they did not take the option of a fixed term exclusion.

3.51 Intelligence was received by the police that David A was expressing a desire to kill people and was researching this on the internet.

3.52 Police officers went to see David A at his father's address. The officers explained their concerns around David A's experimenting with explosives and Mr A said that he would supervise any such use in woods on open land nearby. He said the quantities were too low to do any harm.

3.53 Police sergeant 1 recorded this visit and his observations as intelligence, which was disseminated to the police public protection unit, special branch and children's social care. The intelligence was allocated to police constable 1 for further enquiries and he subsequently spoke with Mrs A on several occasions. She told him she was extremely worried about David A's mental health and felt let down by various agencies.

3.54 On 6th January 2012 a strategy meeting took place attended by police officers, social work manager 1 and social worker 7 but no representatives from School 2, CAMHS or the GP Practice.

3.55 Decisions of this meeting included:

- Social worker 7 to complete an assessment.
- Refer to CAMHS.
- Child protection inquiries to be made.
- A new strategy meeting to be held in 6 weeks' time.

3.56 Another strategy meeting was held five weeks later attended by police, children's social care, Youth Offending Team, School 2 and representatives from Health. The focus of this strategy meeting was on the risk posed by David A's access to bomb-making materials. It was agreed that this was a police matter and not a case for social work because David A had refused to engage with social workers, or agree to a referral to CAMHS. The outcome was no further action in relation to child protection matters and that David A would be dealt with by the police.

3.57 On 24th February 2012 Mr A and David A were arrested from their respective homes by police officers for the offence of possessing explosives with intent to cause criminal damage. Chemicals and fuse wire were seized.

3.58 They were both taken to a police station and a risk assessment was carried out as part of the booking in procedure. It recorded that David A was fit to be detained, was lucid, orientated and able to process questions and answer appropriately. He disclosed a history of past depression, self-harming a "couple of months" previously, and "attempted suicide a few years ago". He said that at the current time he had "not thought about self-harming". He was visited in his cell every 30 minutes.

3.59 Detective constable 2 interviewed David A in the presence of a solicitor and an appropriate adult for 90 minutes. David A admitted ordering the chemicals from the internet and said he had ensured that it was not illegal. As his mother was unhappy about having the materials at her house he took them to his father's. They attempted to make a flare but this was not very successful so he had not used the chemicals again. David A said it was a phase that had passed. He said that at no time did he have any intention to cause explosions that would harm people or damage property. Detective constable 2 asked David A about his reluctance to engage with social workers, and David A said this was because of the way they had handled things during the separation of his parents; he did say that he would consider working with other agencies.

3.60 David A and Mr A were released on police bail. The examination of David A's computers was fast tracked to enable him to continue his school studies. They were subsequently advised that their bail was cancelled and there would be no further action taken.

3.61 On March 29th 2012 social work manager 1 telephoned CAMHS Practitioner 1. She told her about the Police intervention and that David A's mother had voiced concern as she had found part of a note on which David A had written the names of the people he wanted to come to his funeral. Susan A had apparently reported that she had found his dressing gown cord tied into a ligature on two occasions. David A had told Susan A that he had used it on one occasion and she did say that there was a mark on his neck.

3.62 CAMHS Practitioner 1 discussed a safety plan with social work manager 1 for her to pass on to Mrs A; they also agreed that social work manager 1 would make a joint visit with CAMHS Psychiatrist 2 and CAMHS Psychiatrist 3 to David A at the beginning of the following week.

3.63 On Friday March 30th 2012 social work manager 1 telephoned and spoke to Susan A as her mother was unavailable. Susan A said she had told her mother to take David A's dressing gown and cord away, which she had done. Susan A did not believe that David A would go to his GP even if his mother tried to make him. There were superficial cuts on his legs and a small mark on his neck – and David A admitted that he had tried to kill himself. Social work manager 1 made phone calls to Mrs A, police, school 2, CAMHS and Mr A. A safety plan was put in place for the weekend, involving contacting out of hours, CAMHS, or taking David A to A&E. David A was also to be supervised and kept occupied. Mrs A said that she wasn't concerned about David A's attempt to kill himself, feeling he was attention-seeking. Mr A was having David A stay with him for the weekend; he said there was nothing wrong with David A.

3.64 The following week Mrs A telephoned social work manager 1 to say that neither she nor David A would be available for the CAMHS appointment that morning, which was therefore cancelled. She said that he wasn't about to kill himself.

3.65 David A's last school report was very positive, he had a place to study at College1.

Year 12 2012

3.66 In August 2012 Mr A married his new partner, David A was his best man. In the photos he appeared to be happy because he was smiling a lot, which Mrs A said, in interview with this report's author and the chair of the panel, was unusual.

3.67 According to Mrs A, in an interview with the overview author of this report and the Panel Chair, David A found the lack of structure at college difficult. School senior staff 1, recalled in her interview with her IMR author that she had received a phone call from Mr A asking if David A could return to school which he did shortly afterwards.

3.68 A few days after the beginning of term Mrs A found David A's body.

4. ANALYSIS

4.1 The terms of reference listed thirteen questions for IMR authors to address; the answers to which provided most of the material for this part of the report.

4.2 To capture of the learning from this review they have been collated under the following themes

- National context
- Assessment and analysis of risk
- Working with Mr and Mrs A
- Working with David A

NATIONAL CONTEXT

4.3 Identifying the prevalence of self-harm and suicide in society will never be exact; many factors inhibit accurate recording, including the reluctance of coroners to label a death as suicide, Durkheim et al (1897) Madge and Harvey (1999) and young people's reluctance to admit to self-harm, NSPCC (2009).

4.4 The child and adolescent self-harm in Europe seven year study (2005) used anonymous questionnaires completed by 30,000 15-16 year olds and found that 70% admitted to self-harming. Fox and Hawton (2004) and Hawton and Harris (2008) found that girls were more than likely to self-harm than boys, by ratios between 4:1 and 6.5:1.

4.5 There are two varying approaches to links between self-harm and suicide. "*While some would argue that self-harm is in fact the opposite of suicide, i.e. a way of coping with life rather than giving up on it, there is an equally compelling argument that they are part of the same continuum, both being a response to distress,*" NSPCC (2009) page 6.

4.6 This report is taking the latter view; that there are links between self-harm and suicide.

4.7 Causal factors of self-harming and suicide include: alcoholism in the family, experiences of neglect, depression and low self-esteem, Makhija and Sher (2007), Colquhoun (2009).

4.8 Oxfordshire and Buckinghamshire Mental Health NHS Trust, (now known as Oxford Health NHS Foundation Trust) found in 2010 that family relationship difficulties were the most common trigger for younger adolescents to self-harm.

4.9 David A experienced his parents' relationship difficulties as abuse despite the fact that neither of them meant him any harm. Whilst "*CAMHS Psychiatrist 2 was clear that neither parent intended to be harmful to their children….clearly their arguments were having a harmful effect on him*," Oxford Health NHS Foundation Trust IMR, (page 7).

4.10 Research by Makhija and Sher found that: "*Depressed individuals with a family history of alcoholism have….more suicide attempts, and a greater intent to die….than individuals without a family history of alcoholism*" QJM: An International Journal of Medicine, Volume 100, Issue 5 (page 307).

4.11 Factors like this were present in David A's life which provides further evidence that he may have been at higher risk of suicide compared to other young people of his age.

ASSESSMENTS

What were the key opportunities for assessment and decision making?

4.12 The following were key moments where opportunities existed to produce in-depth and multi-agency assessments of David A's needs. An * represents opportunities where concerted action did not take place.

May 2008	CAMHS refer to Children's Social Care
19th June 2008	First visit by a social worker
13th March 2009	Second visit by social worker
17th July 2009	Initial child protection conference
16th October 2009	1st review child protection conference
26th March 2010	2nd review child protection conference
*8th November 2010	Referral from the advocacy service
*14th January 2011	David A's insistence to a social worker that he would kill himself if Mrs A moved in with her new partner
*21st July 2011	Contact between GPs, social workers, Mrs A and Susan A
Jan & Feb 2012	Strategy meetings regarding explosives
*30th March 2012	Phone call from neighbour to say David A had written a suicide note
*June – Sept 2012	David A leaves (and returns to) school

CAMHS refer to children's social care

4.13 CAMHS practitioner 1 and CAMHS practitioner 3 spoke to Mrs A and gained her permission for them to make a referral to children's social care *"noting that it would not be helpful for CAMHS to see David A anymore as it implies to him that he is seen as a problem"* Oxford Health NHS Foundation Trust IMR (page 6).

4.14 This was an appropriate referral because CAMHS had attempted to work with Mrs A and Mr A but had been unsuccessful and they were aware that the situation for David A had not changed.

4.15 Other than notification of a proposed social work visit to the family, there was no contact between social care and CAMHS following their referral letter, it is regrettable that an opportunity for a thorough discussion, between CAMHS staff and social worker, was not taken; CAMHS staff knew the family well and would have been able to clarify and expand their concerns more than was possible in their letter.

First visit by social worker

4.16 Social worker 1 visited and completed an initial assessment. *"This was a good quality assessment identifying the key issues for the family and for David A, who she described as a sensitive child*," Children's Social Care IMR (paragraph 4.4.2).

4.17 However she failed to speak to Mr A so did not get his views.

4.18 Referrals were made to a family project, an alcohol service and a couples therapy service. None of these actions directly addressed David A's needs; all were reliant on Mr and Mrs A's desire and ability to change.

4.19 CAMHS had said that they were not prepared to continue to work with the family; they should nevertheless have been more involved in the assessment as they not only knew the situation within the family but had a high level of expertise in working with troubled teenagers.

4.20 Had the social worker's recommendation been for a core assessment then there would have been an opportunity for a thorough, multi-agency approach which would have involved CAMHS.

Second visit by social worker

4.21 This visit occurred following a referral to children's social care from CAMHS psychiatrist 1 who had seen David A and Mrs A following a referral from their GP. The referral requested a core assessment because of child protection concerns.

4.22 Although described by the children's social care IMR author as a "good assessment" the social worker again failed to speak to Mr A and did not speak to David A's school teachers. CAMHS Psychiatrist 1 was also not contacted despite statutory guidance[6] which then stated that referrers of child protection concerns should be contacted to be told the outcome of the referral.

4.23 The social worker recommended a core assessment, an appropriate recommendation given that little change had been noted within the family or in David A's distress.

Initial child protection conference

4.24 The core assessment recommended that the risks to David A and Susan A be considered at a child protection conference.

4.25 By definition[7] this was a key opportunity for multi-agency decision making in relation to David A. *"The social work report for conference is an excellent report. She* (social worker) *takes into consideration, how the family and environmental factors are affecting David A directly, estimates the level of risk presented to David A and the probability of future harm. She states on two occasions that David A does not want to live"* Children's Social Care IMR, (paragraph 4.4.6).

4.26 However the risk factors identified at the conference focused more upon the relationship between Mr and Mrs A rather than upon the need to support David A. The lack of a thread from report to action plan regarding David A's suicidal thoughts was a missed opportunity to help David A and reinforced the focus upon his parents and away from himself. *"The risk of suicide to David A is not stated in the conference minutes under risks and this is a serious omission."* Children's Social Care IMR, (paragraph 4.4.6).

1st review child protection conference

4.27 The first review conference took place shortly after Mrs A and Mr A had separated. The decision was to keep David A on a child protection plan because of the following risk indicators.

a. *"David A's situation is still very stuck.*
b. *David A has very low self-esteem; he talks about and has admitted self-harming.*
c. *The situation has not markedly changed since the initial conference.*
d. *Mr and Mrs A have not been able to work together and have failed to give common boundaries to manage David A's behaviour and give support to him.*
e. *No one is in control.*

[6] Working Together to Safeguard Children (2006) (paragraph 5.35)
[7] Working Together to Safeguard Children (2006) (paragraph 5.80)

f. *The lack of confidence about whether Mr and Mrs A have really separated and given Mrs A's financial situation she may feel that she needs Mr A back in the home.*
g. *David A is not accessing any form of education at the moment and the situation regarding his future education has ground to a halt".* (Minutes of meeting).

4.28 The minutes of the meeting noted the following positives.

a. *"Mr and Mrs A have separated.*
b. *The basic physical care of David A is good and there have never been any significant concerns in relation to this.*
d. *Mrs A has used advice and support from people in the past and now".* (Minutes of meeting).

4.29 There was still no mention of David A's suicide attempts despite the fact that he submitted a statement of two pages which included "*I still have the feeling that I want to die (but) I won't try to kill myself.*"

4.30 He also said that nothing in his situation had changed.

2nd review child protection conference

4.31 This time the conference took the decision that David A no longer needed a child protection plan presumably because the positives:

Positives

a) *"There is a marked improvement in Mrs A's confidence…*
b) *The separation in October has continued and appears to be final for Mrs A and the children.*
c) *David A has self-esteem issues but he has grown in confidence enough to be able to make a decision about his future.*
d) *David A is back in education on a full time basis.*
e) *The support for Mrs A, David A and Susan A has been taken up and used by them"* (Minutes of meeting)

outweighed the risks:

Risks

a) *"Chair stated that there are a lot of "what ifs" such as:*
    a. *Concern about the way Mrs A talks about the separation and if Mr A accepts it is permanent.*
    c. *David A could have issues at school and not be able to cope".* (Minutes of meeting).

4.32 There is again an emphasis upon the importance of the separation of the parents.

4.33 The conference ended with a child in need plan which still failed to mention David A's thoughts about suicide. It was to be reviewed in three months but there is no evidence that this took place. "*A review was particularly important as the CIN Plan replaced the Child Protection Plan and therefore formal consideration of the level of David A's needs and any evidence of on-going risk should have been considered before the case was closed…*" Children's Social Care IMR (paragraph 4.3.7).

4.34 There had been no members of staff present from the GP practice or CAMHS despite the fact that they had been key payers in David A's care. "*GP's perceive* (conferences) *as being at short notice during busy working days, when a full surgery may have to be cancelled to attend, thus affecting care to other patients. Those convening such conferences need to ensure that the GP practice is contacted as early as possible to ascertain dates and times when key personnel would be able to attend. Generally this does not occur"* B&NES General Practice IMR, (paragraph 5).

Referral from the advocacy service

4.35 Counselling practitioner 1 made a referral to children's social care because Susan A was saying that things at home were still problematic. This resulted in a further initial assessment conducted on 16th November 2010.

4.36 In this assessment the social worker painted a picture of the family struggling. She described David A as unhappy and wanting to live with Mr A. She described an incident in which Mrs A physically and verbally attacked Susan A. The assessment made no mention of previous assessments and made no reference to previous suicide attempts. It concluded by saying that further information should be sought from Mr A and David A's school in order to make a decision about whether a core assessment was needed. It appears though that no further enquiries were made. The children's social care IMR author states *"It is my opinion that this initial assessment should not have concluded with a recommendation that further information be sought. The information should have been acquired and added to the assessment in order to make a concrete recommendation…..It was another missed opportunity to further assess David A's risks and needs".* Children's Social Care IMR, (paragraph 4.4.5).

4.37 This intervention is poor. David A is so distressed that he wished to leave home and Mrs A has physically assaulted Susan A. The assessment is incomplete as family members and other professionals were not contacted.

4.38 This was a missed opportunity for a core assessment which may have led to a further child protection conference.

David A's insistence that he would kill himself if Mrs A moved in with her new partner

4.39 David A talked to social worker 7 and made threats about harming himself and Mrs A at the same time as telling her that he had bought a gun. Although social worker 7 dealt with the issue of the gun well by checking the situation with the police and advising David A and Mrs A accordingly she took no action regarding the threats. The children's social care IMR author wrote that social work manager 1 said, *"…she believes that this information should have triggered a strategy discussion, which would have been her decision. However, her supervision notes indicate she was not aware of all the facts and therefore did not convene a strategy discussion. Good practice would suggest that managers read case notes, so they are aware of the facts and able to make informed decisions"* children's social care IMR, (paragraph 4.18).

Contact between GPs, social workers, Mrs A and Susan A

4.40 Contact was made by Mrs A and Susan A to two different GPs (in the same practice) expressing their concerns. These included the threat that David A would kill himself. *"A home visit was requested but not carried out. General practitioner 2 felt that as knives had been mentioned, this would not be safe and the police should be called if necessary…..There is no record of follow up by the GP team. No strategy for dealing with this problem is mentioned"* B&NES General Practice IMR (paragraph 4.20).

4.41 General practitioner 3 explored the possibility of offering an appointment but felt it unlikely that David A would attend as he had seen him two days earlier.

4.42 This was the last occasion on which concerns were brought to the primary care team until David A's death. Both Susan A and Mrs A said to the author of this report and the chair of the panel that they were disappointed that a doctor did not visit the home.

Strategy meetings regarding explosives

4.43 The two strategy meetings had to deal with two issues; David A's risk to himself and his risk to others. According to the police IMR author the searches of the parents' homes were appropriately carried out and a good assessment was made of David A's threat to the public. There was no criticism in the police IMR about the conduct of the public safety investigations or of the decision to take no further action.

4.44 However the two meetings were not so thorough in considering David A's risk to himself. The first meeting provided *"an excellent summary of David A's history and risk. An assessment and Section 47 enquires were requested,"* children's social care IMR (paragraph 4.4.9). This meeting also suggested that school 2 should make a referral to CAMHS. The focus shifted at the second strategy meeting to *"guns and gunpowder and the conclusion was that it was a police matter and there would be no further involvement from CSC"* children's social care IMR (paragraph 4.4.9).

4.45 No representatives from School 2, CAMHS or GPs were present at the first strategy meeting. CAMHS and GPs were not invited, nor did they attend the second meeting. The reason for there being no member from school 2 may have been because it was held just after the Christmas holidays. A representative from the school was present at the second strategy meeting but was only given the minutes of the first meeting as she arrived. She was therefore *"unaware of David A's risk of suicide, as presented at the first strategy"* children's social care IMR (paragraph 4.16.4).

4.46 Furthermore the school "*was not aware until then of the request for the school to make a CAMHS referral"* school 2 IMR. Consequently no referral was made to CAMHS.

4.47 The second meeting focused more upon the threats that David A may pose to others as opposed to himself and the decision was that this was a matter for the police to follow up. There appeared to be a lack of a thread from one meeting to the other, "*at the first strategy discussion… the summary of CSC involvement…..was of good quality. However in the reconvened Strategy Discussion… the summary was not shared with people who had not attended the initial discussion*" children's social care IMR (paragraph 4.6.7).

4.48 This was unfortunate given the extensive information that children's social care held on David A and his family. The disconnect between the two meetings may have been further strengthened by the fact that social worker 7 *"had a conversation* (on the way to the second meeting) *with her manager* (social work manager 1) *who said We're not going to get involved'"* children's social care IMR (paragraph 4.16.7).

4.49 This was probably based upon a belief that the problem was public safety rather than David A's well-being. It is unfortunate that professionals often see problems as a single issue rather than multi –layered; the meetings should have considered both public safety and David A's well-being.

4.50 There was no reason to not undertake Section 47 enquiries, as agreed in the first strategy meeting, and this is a significant omission as it was an opportunity to raise the risks that David A presented to himself.

4.51 David A had also stated in interview with a police officer that he would accept help from professionals providing that they were not from children's social care. He said *"Maybe you can get a counsellor or whatever but can I ask you just don't get the social workers involved"* police IMR, (page 26).

4.52 The Police IMR author wrote that following the strategy discussion and subsequent arrest *"there was very little information sharing with or from the Police. The cause of this is the absence of a mechanism, such as a strategy meeting, to ensure that it happened. Specific information that should have been shared was further detail around:*

> *David A's mood that the police established through their enquiries*
> *The outcome of the investigation, …*
> *David A's suggestion that he would engage with someone not from CYPS"* Police IMR, (paragraph 4.17).

4.53 This was a missed opportunity to re-assess David A and plan a multi-agency approach to his needs.

Phone call from neighbour to say David A had written a suicide note

4.54 Concerns were again raised by Mrs A and Susan A (following contact with them by social work manager 1 following a referral from a neighbour) about David A. He had written a list of the people who he wanted to come to his funeral and he had tied his dressing gown cord into a noose. He had superficial cuts to his legs and a mark on his neck and he had confirmed to Susan A that he was self-harming and had tried to kill himself.

4.55 The urgency of this situation was responded to by social work manager 1 who made a number of telephone calls including to Mrs A, Mr A and school 2 to inform them of these concerns. She put a safety plan in place which did not involve a social worker visiting David A. The reason given for this was that Mrs A had said that she thought David A was attention seeking and that he didn't want to see a social worker. Mr A also said that there was nothing wrong with his son.

4.56 An appointment was made for social work manager 1, CAMHS Psychiatrist 2 and a trainee psychiatrist to visit David A at home. Mrs A phoned on the day of the appointment to cancel it saying that it was not required because David A wasn't about to kill himself.

4.57 The decision made by social work manager 1 to cancel the visit was not challenged by CAMHS staff which was unfortunate as "*it appears that the assessment of David A's mental health and the risk that this carried was made by the social worker (sic) and not challenged by those with mental health expertise*" SCR Health Overview Report, page 30.

4.58 The children's social care IMR author identified in an interview with social work manager 1 that she had contacted school 2 to ensure that they "kept an eye" on David A but that the decision to not visit *"was based on an opinion of the family's non engagement rather than on the level of risk to David A,"* children's social care IMR, (paragraph 4.18.4).

4.59 A strategy meeting should have been convened at this point.

David A leaves (and returns to) school

4.60 Two further key moments for assessment were when David A left school 2, in June 2012, to go to College and his return to school. School 2 carried out assessments on both occasions and supported David A with his application to college; they acted with speed to welcome him back when it was clear that the college course wasn't working.

4.61 It could be that this was a key moment for David A. His mother told the author of this report and the panel chair, in their meeting with her, that David A liked the structure of school, hated the relaxed atmosphere of college and found free periods difficult to deal with in the 6th form when back at school 2.

4.62 It is very much in hindsight, and no criticism of the professionals or family members intended, but the break down in college could well have been a time of high risk for David A.

Were assessments thorough and were decisions made reasonable given what was known at the time?

4.63 David A and his family received help from many professionals from a range of agencies. The IMRs describe practitioners who are, in the main, committed, caring and thorough. There are though areas of concern.

4.64 The first is the view that David A should not be seen alone as this "*would be to locate the problem with him*," Oxford Health NHS Foundation Trust, (page 5).

4.65 This view was first expressed by CAMHS Practitioner 1 on October 17th 2007. It was repeated again on May 15th 2008 in a letter to Mrs A from CAMHS and a referral to Children's Social Care.

4.66 It was reasonable to deduce that David A's distress was exacerbated by his parents' relationship and focusing work upon the parental relationship made sense. But this should not have been at the exclusion of work with David A. Counselling for David A could have been on the basis of helping him to cope with the situation. A further problem with this approach was that *"the therapy did not sit effectively within a wider system of case or family management, so when the parents did not effectively engage, there was not an active response, particularly in a multi agency context, to the continuing dysfunction in the family,"* Oxford Health NHS Foundation Trust, (page 15).

4.67 This location of the problem with his parents rather than with David A himself remained a dominant theme throughout much of the work carried out by professionals in the child protection process. The main issue focused upon was the relationship between Mr and Mrs A. This focusing in on one issue was particularly apparent during the child protection process.

4.68 The first conference made David A subject to a child protection plan because of the following risks.

a) *"Mr and Mrs A cannot agree about the way forward.*
b) *The chronic situation with little change despite the plans and support.*
c) *Inappropriate discussions around the children.*
d) *Both Mr and Mrs A's alcohol use and the children's concerns about the effect of this.*
e) *The couple have admitted to a high degree of domestic abuse and arguments.*
f) *David A's negative relationship with his father.*
g) *David A has very low self-esteem, is isolated and has no positive relationships.*
h) *David A is a young person exhibiting issues of frustration, self-harm and futility about the situation he is in.*
i) *David A is not achieving educationally and he has no positive experiences at school.*
j) *Susan A's role and her feelings that she can't take it anymore".* (Conference minutes).

4.69 By the first review conference three months later it was clear that the professionals placed considerable emphasis on Mr and Mrs A separating because a listed strength is "*Mr and Mrs A have separated*" (Conference minutes), although David A was left subject to a child protection plan because *"the parents' trial separation was still in its early days,"* - Children's Social Care narrative (paragraph 2.3.24).

4.70 It was not until the next conference, six months later that the plan was ended when it became clear that *"the separation in October has continued and appears to be final for Mrs A and the children,"* Children's Social Care Narrative (paragraph 2.3.24).

4.71 This is not to say that other problems were not being discussed but it may be that they were not given the same level of importance.

4.72 School 2 completed a "general risk assessment" when considering whether to allow David A to remain at school during the police investigation. This was a series of questions relating to

- What sort of harm?
- Who to?
- How likely?
- What can be done to reduce the risks?

4.73 This was a thorough piece of work and resulted in a good and supportive decision being made to support David A.

Were David A and his family offered appropriate services to help meet their needs throughout the time period?

4.74 David A and his family were offered a range of services from different agencies. These were:

a) Family therapy for all four members from CAMHS and 117
b) Couple counselling for Mr A and Mrs A from CAMHS and Southside Family Project
c) Mentoring Plus for David A
d) Advocacy for David A and Susan A

e) Compass project which aims to engage with young people at risk of offending for David A
f) BADAS, (New Highway and DHI) alcohol support for Mrs A
g) Focus Counselling
h) Strengthening families, Strengthening Communities, parenting support for Mrs A
i) Cognitive Behaviour Therapy for David A
j) Young Carers for Susan A
k) Relateen for David A
l) Allocation of a social work Assistant for David A

4.75 In addition there was a range of other professionals: GPs, teachers, police officers and social workers who were involved with the family.

4.76 Most IMR authors expressed the view that these services were appropriate though it is unclear how many of them were for David A and were focused upon his suicide ideation. The Children's Social Care IMR author noted that "*Mr A was not offered any additional specialist services"* Children's Social Care IMR, (paragraph 4.9.9) indicating that there may have been some omissions.

4.77 It is difficult to discover how effective these services were and how long some of them remained working with the family. Many are confidential counselling services who had nothing of import to pass onto the review.

4.78 Although there were services available and made use of by all members of the family at certain points there appeared to be no coordination or measurement of the effectiveness of the services. The primary aim of these interventions should have been to improve David A's and Susan A's emotional well-being, any other objectives should have been secondary.

4.79 The main opportunity for this co-ordination to have taken place was during the child protection conference process. It failed in this regard because the objectives set in the protection plan did not focus heavily enough upon David A's well-being.

4.80 One activity not mentioned as a service in the IMRs, but according to David A an effective intervention, because it increased his self-confidence, was his membership of the sports club.

4.81 Professionals can often fail to see the value of community and universal services and this, along with the counselling services at School 2 should have formed an integral part of any child protection or child in need plans developed for David A.

4.82 CAMHS involvement with David A took place between January 2007 and October 2009. It has been well documented in this report and their IMR that their view was that David A should not be seen alone because that located the problem with him rather than with the family discord. Consequently *"…there were no systematic arrangements for the assessment of David A's mental and physical health and social care needs and the degree of risk regarding self harm and vulnerability to exploitation or accidental harm,"* Oxford Health NHS Foundation Trust, (page 12).

4.83 CAMHS attempted to improve the relationship between the parents but *"when this failed to reduce the risks to David A, he was felt* (sic) *disconnected from further systematic re-assessment and support from CAMHS,"* Oxford Health NHS Foundation Trust, (paragraph 4.9).

4.84 CAMHS staff saw David A alone on four occasions and with family members a further 18 times. CAMHS staff were available for consultation with parents and professionals and were responsive when called. It was unfortunate that their expertise was not harnessed more thoughtfully as part of a multi-disciplinary approach to David A.

4.85 CAMHS Psychiatrist 2's recording: *"Concern that if we continue to see parents this will be seen as a solution and could prevent appropriate protective action being taken by SSD*[8]*"* joint chronology (19/08/09) does imply a narrow view about responsibility for safeguarding issues.

WORKING WITH MR AND MRS A

4.86 Both parents engaged with services; Mrs A was the person who most often attended meetings and sustained her involvement in parenting classes; Mr A's involvement with specialist services was more sporadic although he consistently stayed in contact with School 2.

Mrs A

4.87 It appears some services (in particular the parenting classes) may have been provided to Mrs A because they were available rather than as part of a planned and co-ordinated approach to meeting the identified needs of David A and Susan A. For example there is little evidence in the Social Care records of contact with services like BADAS, Southside Family Project and Strengthening Families, Strengthening Communities. It appears therefore that there was a lack of objective setting and monitoring of these services and it is consequently difficult to see how these services were helping Mrs A and whether, as a consequence this was helping David A and Susan A.

4.88 The Children's Social Care IMR author considers that Mrs A may have been exhibiting disguised compliance. "*Mrs A's engagement with CSC is characterised by asking for help and seeming to engage with services; giving the impression that she is making use of advice, but not taking actions……. It is likely that Mrs A's behaviour was 'Disguised Compliance,'"* Children's Social Care IMR, (paragraphs 4.19.3 and 4.19.4).

4.89 The term 'disguised compliance' was first used by Reder, Duncan and Gray in their book *Beyond Blame (1993)*, a study of thirty five child death inquiries. The term described situations where parents appeared to agree to plans and to co-operate with professionals, but in reality their commitment was superficial and designed to placate, obscure and disguise their lack of compliance.

4.90 Brandon and colleagues further explored the concept of disguised or partial parental compliance in their overview reports of child death inquiries (2008, 2009) where they found it often prevented or delayed understanding of the severity of harm to the child, leading to situations where professionals would tolerate a longstanding lack of progress, all the while accepting excuses from parents and losing an objective view of what was happening.

4.91 In Brandon's second in depth study of serious case reviews (2009) three quarters of the 40 families did not co-operate with services. The patterns of hostility and lack of compliance included deliberate deception, disguised compliance and "telling workers what they want to hear", selective engagement, and sporadic, passive or half-hearted compliance.

[8] A reference to Children's Social Care

4.92 Professionals identified two problems in Mrs A's life that were impacting negatively upon David A: her relationship with Mr A and her drink problem. Mrs A addressed the first of these issues by being, by her and Mr A's account, the main instigator of their separation. She was less successful in addressing the second issue though she did attend counselling sessions at BADAS, (and later at New Highway and DHI).

4.93 Labelling her behaviour as "disguised compliance" misses the fact that the problem that Mrs A failed to address was her alcohol misuse; a hugely difficult problem to overcome and one that she had first mentioned to a professional, her health visitor, in 1998 when she said she *"fears that her only company is alcohol,"* joint chronology, February 1998.

4.94 The problem was not that Mrs A was disguising compliance but was probably struggling to overcome her drink problem. Professionals either failed to understand the impact that her drinking was having on David A, or they failed to take action to address it.

4.95 This should have been a fundamental part of the care plan developed after the child protection conferences with measurements set, not for Mrs A's reduction in drinking, but the impact that her drinking was having on David A's and Susan A's well-being.

Mr A

4.96 Mr A's interaction with professionals varied between positive and negative.

- School 2's staff formed a good relationship with Mr A; their IMR pointed out that he regularly attended parent evenings.
- Mr A praised Education Welfare Officer 1 and her manager, Education Welfare Manager 1, in his letter to the second review conference for helping him to sort out the new school for David A saying that this has been achieved through "*giving discipline and guidance a teenage boy needs without third party interference and 'pie in the sky' ideas",* (letter to review conference).
- Mr A's interaction with children's social care workers is described by the social care IMR author as "*often resorting to hostility*" children's social care IMR, (paragraph 4.19.2).
- There are times when Mr A loses his temper with professionals, an example being his telephone discussion with Social Work Manager 1 which finishes with him telling her that, "*if I can get any reprisal for this I will*" children's social care IMR, (paragraph 4.19.2).

4.97 There appears to be, as far as the social work records and reports are concerned, a lack of consideration about why Mr A may be behaving in this way. In particular there appears to be no acknowledgement that Mr A did not agree with the way in which social workers and CAMHS professionals were dealing with David A; he did not share their view of the problem.

4.98 Mr A's view, as described to the panel chair and the author of this report, was that there was nothing wrong with David A mentally and that "*pie in the sky*" ideas weren't the answer; instead David A needed discipline and to be made to go to school. He told us that he couldn't understand why, for example, when David A was refusing to go to school, he was rewarded by social workers with trips to the cinema.

4.99 In conversation with the chair of the panel and the overview author of this report Mr A said that meetings were often held in office hours. Given that he was a self-employed worker on building sites this would mean that he would have to lose a day's pay to attend. He mentioned this in his letter to the core group meeting of 24th January 2010.

4.100 The Oxford Health NHS Foundation Trust IMR author stated that "*CAMHS staff tried hard to meet both parents and appointments were arranged at times to suit Mr A*" Oxford Health NHS Foundation Trust (paragraph 4.19), though when asked for evidence admitted that *"I know that one evening appointment was attended, but am unable to say how many were offered"* e-mail to author 10/05/13.

4.101 A letter from CAMHS to Mr A on 13th March 2008 which includes: *"Please can you tell us when you would be able to take a day off to come here to a daytime appointment, and we will see if we can manage that,"* Joint chronology (13/03/08) appears to neither support the IMR author's view nor be very welcoming.
4.102 The health overview report author shares this view stating that she "*would question how accessible the service* (CAMHS) *was/is for working parents*," SCR health overview report, (page 30).

4.103 This report appears to be criticising CAMHS only for not offering services out of office hours but this is likely to be true for most service provision. It appears to be the case that all child protection, strategy and core group meetings took place in office hours; all likely to hinder the involvement of school age children and working parents. On the other hand CAMHS workers and social workers told the author of this report that they often visited the family after office hours.

4.104 In conversation with the chair of the panel and the author of this report Mr A expressed the view that the social work intervention was predicated upon getting him to leave the family and him being the problem. He wrote to a core group meeting *"any report puts me as the root of the problem. Now that I have been pushed out of the family I regret to inform you that nothing has changed for the better".*

4.105 This is not to say that his view was necessarily right but that professionals needed to consider whether Mr A's lack of engagement and aggressive behaviour might have come not from a psychological failing but have been a manifestation of his frustration about the services that were being provided to him and his family.

4.106 The children's social care IMR author questioned the rationale behind some of the social work decision making following the referral from advocacy service in November 2010. "*The question arises, whether there was an element of stereotyping that influenced social workers in their course of action. Would CSC have left David A with his father (Mr A) if he was exhibiting his mother's behaviours…? I would suggest the answer would be that CSC would not have left David A"* children's social care IMR, (paragraph 4.7).

4.107 In an analysis of serious case reviews Brandon et al. (2009) found a tendency for professionals to adopt rigid or fixed thinking about men. Fathers were labelled as either all good or all bad, reliable and trustworthy or the opposite, with the consequence that workers did not take the views of 'bad fathers' seriously.

4.108 Fathers were often labelled as dangerous, sometimes without the professional having had any direct contact with them. Whilst this label was not attached to Mr A it is interesting that the narrative of this review contains many references to Mr A not being seen and his views not being included in the assessments.

4.109 Child welfare workers tend to focus on mothers, who are seen as the primary caretakers, and exclude or at least make little effort to include fathers.

WORKING WITH DAVID A

4.110 It is clear from the events in the narrative that David A was a complex young man:

- He came to the attention of CAMHS at the age of 11;
- The chronology has 30 recorded examples of David A talking to his family or to professionals about killing himself or self-harming;
- He self-harmed by cutting his legs;
- He occasionally made apparent but not serious attempts to kill himself; (it is difficult to assess exactly how serious or otherwise these attempts were as he was never seen by a professional and treated medically following one of these apparent attempts);
- He was arrested by the police for having chemicals which could make an explosion;
- He was described by professionals as school phobic; having a social phobia; and having cognitive rigidity.

4.111 In contrast the deputy head teacher from School 2, in conversation with panel members, described David A as being polite, shy, enjoying school and being like many other boys of his age.

4.112 School 2 were excellent in their handling of David A; taking a child who had refused to go to a previous school for a number of months and helping him to achieve nearly 100% attendance and 9 GCSEs (in under two years) was a remarkable achievement. This appears to have been achieved by finding out what he wanted and respecting that. In particular they

- respected David A's wish to attend the school, and allowed him to have the appropriate support with as little fuss as possible
- considered which "House" he should be in
- allocated him a male tutor
- moved him up a set in English when he asked for this
- supplied funding for him to attend the battlefields tour
- allowed him to rejoin their 6th form shortly after his request to return to them from college.

4.113 Underpinning the school's approach was a careful listening to and respect for the views of David A and his father.

4.114 Although the children's social care IMR described David A as being "*a difficult young person to engage with*" children's social care IMR, (paragraph 4.20.4), this appeared to be the case only with social care workers and CAMHS; and after a prolonged period when he had regularly seen social workers and CAMHS staff. It is clear from the relationship that he formed with staff from School 2 that he was easy to engage providing that:

- his views were respected,
- he could see some value in the work that he was engaging in,
- he wasn't being made to look "special" (hence counselling after school).

4.115 The reason for the lack of engagement with social workers appeared to be David A's belief that "*nothing would change*" children's social care IMR, (paragraph 4.2).

4.116 As far as the child protection process was concerned David A's wishes and feelings were discovered and included in the reports. Furthermore he and Susan A were facilitated by an advocacy service to put their points across to the child protection conferences. There appeared to be less evidence, in the child protection process, that those wishes and feelings were being taken account of when decisions were being made about the provision of services.

4.117 Before the first child protection conference in 2009, David A talked to social worker 5 about not wanting to live. This was included in her report to conference but wasn't included in the child protection plan that followed. There was thus a difference between the risks that David A was concerned about and the emphasis from professionals whose focus, during the conference and subsequent plan was on the difficulty in the parental relationship. This type of disparity has been noted in research by the office of the children's commissioner, (2011)[9].

4.118 In some respects it did appear that David A was being listened to by social workers; he said he did not want a social worker so the case was closed. The social workers should though have taken more notice of the fact that the reason that David A no longer wanted to see them appeared to be because he didn't believe that their intervention was helpful. There appeared to be no professional reflection about why he didn't want to see social workers when he was engaging positively with many other professionals.

4.119 In interview with the children's social care IMR author, social worker 7 said that she took a person centred approach with David A, *"looking at where she might meet David A on his own terms, letting David A lead the conversation and using 'problem-free talk,'"* children's social care IMR, (paragraph 4.1.3).

4.120 McLeod (2000) in her study of looked after children and their social workers found that professionals and children have very different understandings of what is involved in listening. The young people in her research had an active view of listening involving action, practical support and self-determination. The social workers by contrast generally saw listening as a more receptive and passive activity involving having a respectful attitude, offering emotional support and encouraging self-expression. Her research revealed a situation where social workers felt that they were listening to young people while those same young people said they wanted to be heard but the social workers were not listening. This may well have been the case with David A and some of the professionals with whom he was communicating.

4.121 Mrs A and Susan A wanted there to be more help forthcoming from their GPs. The B&NES General Practice IMR author noted that "*There is no overall strategy from the GP team to manage engagement with David A. On numerous occasions he attended the surgery, with physical or psychological problems, but no plans are described for follow up, apart from referral or contact with other agencies*", B&NES General Practice IMR, (paragraph 4.20).

4.122 The calls from Mrs A and Susan A in July 2011 were requesting a home visit by the GPs. This was refused because, *"General Practitioner 2 felt that as knives had been mentioned, this would not be safe and the police should be called if necessary"* B&NES General Practice IMR (paragraph 4.20).

4.123 There is little information available about this incident but it is a poor risk assessment both in terms of the doctors and the patient. If there was serious discussion about knives, either as a threat to professionals or to David A, Susan A or Mrs A, then the GP should have been more pro-active in supporting the family or protecting other professionals. It is possible that the "mention of knives" was little more than that (a mention) and was used as an excuse to not visit.

[9] *'Don't make assumptions': Children's and young people's views of the child protection system and messages for change'*

5. CONCLUSION

5.1 David A killed himself in October 2012 and this appears to be the first serious attempt to take his own life. There are certainly no records of him harming himself so seriously previously that he required urgent medical attention. Had David A made a serious suicide attempt earlier, but survived, it is likely that his threats would have been taken more seriously.

5.2 Given the fact that David A had, on a number of occasions, said that he would kill himself but had apparently made no serious attempt to do so would suggest that his death could not be predicted simply on the basis that he made (a further) threat to kill himself. These threats, taken along with his emotional state and his feelings that "nothing had changed" (and perhaps more importantly never would change) for him should have indicated that self-harm and possibly suicide was likely. However his death came at a time when it appeared that he was more settled and his life was improving; so it is understandable that family members and professionals were not more vigilant to the danger at that time.

5.3 This review has identified a range of good practice from organisations and individuals. Whilst this conclusion will focus upon areas for improvement the review has identified that no one individual person, act or omission is responsible for the overall failure to keep David A safe.

5.4 The review has also identified that, in the later stages of his life, David A wasn't easy for social workers and CAMHS staff to work with, because he didn't want to see them and he was old enough and competent to make that decision. His lack of engagement with these agencies should have heightened professional realisation of risk. His father Mr A also did not want social workers and counsellors involved in his son's life and, even when there was a serious concern expressed about David A's safety in April 2012, - once the crisis had passed - his mother, Mrs A, and Mr A, told professionals that he was not about to kill himself.

5.5 This analysis is based upon the belief that all that could have been done to keep David A safe should have been. It has not identified any especially poor practice but it has identified a number of areas where practice could have been improved. These are:

- Listening to children and young people
- Focusing on the suicide risk that David A presented
- Working with fathers
- Analysis
- Setting of objectives and measurements
- Professionals preferring to refer rather than collaborate
- Rigour in assessment, planning and review.

5.6 These issues will be considered separately but, combined, they point to a failing in care planning; in particular throughout the child protection process, children's social care, CAMHS and the GP practice.

Listening to children and young people

5.7 David A was listened to, and his views acted upon, by social workers and CAMHS staff when he said he no longer wanted to be involved with them. His concerns about his mother's drinking however may not have been listened to in a way in which the young people interviewed by McLeod in 2000 wanted – not with sympathetic glances and expressions of support, but actual action.

5.8 It wasn't that he lacked faith in professionals; in the early days he was regularly seeing social workers, social work assistant 1 and CAMHS staff. He became disillusioned by their failure to achieve the change that he wanted.

Focusing on the suicide risk that David A presented

5.9 When reading case records, reports and referrals it could almost be that the word suicide had been proscribed. The professionals at the introductory meeting for David A at School 2 recorded his *"poor attendance at… School, his low self- esteem and emotional ill-health……the fractious nature of relationships at home and the impact they were having on David A"* School 2 IMR (Year 9 section) but nothing about suicide.

5.10 This report and the children's social care IMR has already covered the fact that the risks and objectives listed in the child protection plans, child in need plans and minutes of conferences failed to mention suicide.

5.11 Consequently the professional's gaze was refocused; primarily onto the parents' relationship difficulties.

Working with fathers

5.12 Mr A was viewed as being difficult and hostile without any thought about why he may be acting in that way. Parents feel a sense of powerless in situations where professionals are involving themselves in their lives; Mr A more so than Mrs A because,

- traditionally fathers engage less with caring and health agencies,
- he didn't want this involvement, and
- he didn't agree with the action that was being taken.

5.13 Meetings were mostly held in office hours, further inhibiting his ability to participate and possibly leaving him with a feeling that his contribution to the family (the breadwinner) wasn't held in high regard by the largely female workforce that he encountered.

Analysis

5.14 Analysis was often limited to a single cause view: for example David A's problems are caused by the parent's relationship; when they separate – problem solved. Another example is CAMHS insistence that David A should not be seen alone as this would give him the message that he is the problem.

5.15 Child care work is full of complexity and is multi-causal; not just that but the inter-play between the causes needs consideration as well; for example the role that alcohol played in the parental relationship.

Setting of objectives and measurements

5.16 Allied to single cause mentality was the failure to set child and outcome focused objectives and measurements. Aside from the measurements of David A's school attendance there is little that is measured.

5.17 This report takes a step further. The objectives, and therefore measurements for success, should have been focused upon David A's well-being.

Professionals preferring to refer rather than collaborate

5.18 Many referrals are made to other agencies by professionals, in particular;

- GPs to CAMHS
- GPs to children's social care
- Children's social care to CAMHS
- CAMHS to children's social care
- Children's social care to various providers of counselling and support for parents and children
- Children's social care to the Police

5.19 The long list of organisations offering support to Mrs A and David A may well have been helping them but there was no co-ordination of these services or measurement of their impact on David A's well-being.

5.20 This is not to say that it was inappropriate for professionals from different agencies to discuss but the narrative suggests that professionals were just passing the problem onto another agency for them to deal with rather than considering what they could do together. Two examples:

- CAMHS reference to their child protection referral to Children's Social Care: *"Concern that if we continue to see parents this will be seen as a solution and could prevent appropriate protective action being taken by SSD"*
- Children's Social Care referring to the 2nd strategy meeting: *"We're not going to get involved"*

Rigour in assessment, planning and review

5.21 All of the above issues could be jointly included under this sub-heading. To properly protect children and young people from self-harm and suicide, health and social care professionals must ensure that they are rigorous in:

- involving the children and young people, their parents and schools in assessments
- understanding that family problems are multi, not single causal
- setting child and needs led objectives and measurements
- organising services so that they complement one another
- involving themselves in a multi-agency responsibility for the child's welfare
- monitoring progress whether or not there is direct involvement with the family

and ultimately ensuring that the word suicide is used openly and is part of the plan.

5.22 Serious case reviews often consider whether the incident that led to the review could have been predicted and prevented. There are 30 references in the chronology to recordings made about David A making references to suicide and self-harm and he often said that things weren't any better. On the other hand, at the time of his death, his life appeared to be going well, he had enjoyed being the best man at his father's wedding, his father and he were building an extension to the house so that he could move in with him and he had achieved good grades at GCSE.

6. LESSONS LEARNED

6.1 There was good practice demonstrated by a number of individual professionals. These included:

- the social work assistant who kept contact with David A;
- The advocacy service at the initial child protection conference;
- the social work assessments produced by social worker 3 and social worker 5;
- School 2's ability to work with David A, Mr A and Mrs A;
    - their risk assessment and counselling sessions;
- CAMHS psychiatrist 2's continued involvement and attempts to support other staff members;
- the counsellors who did engage with David A;
- the assessments and actions carried out by the police.

6.2 School 2 described how they went about welcoming David A. *"Senior Staff 1 and… Senior Staff 3 looked to provide a structure where we knew the tutor would provide clear routines, high expectations and strong support in a caring and sensitive way as a male tutor(School Staff 1) As David A was living with mum we felt it would be beneficial to have a male tutor,*" email to overview author (01/05/13)

6.3 The practices that caused concern inevitably provide the many lessons contained in this serious case review; most have been identified before, poor assessment and care planning for example, and many agencies in Bath & North East Somerset have already learnt these lessons and implemented change.

6.4 CAMHS' referral criteria are more defined and, if David A were to be referred to them now, he would be offered services via their outreach service. They now routinely use the care planning approach, (CPA). Their IMR describes the difficulties that the lack of this approach had for David A, "*the lack of the CPA meant that care planning, regular review with other key professionals and having an identified care coordinator was absent…Consequently as the focus of the service quickly identified the primary need was to work to change the parental behaviours, there were no systematic arrangements for the assessment of David A's mental and physical health and social care needs and the degree of risk regarding self harm and vulnerability to exploitation or accidental harm,*" Oxford Health NHS Foundation Trust, (page 12).

6.5 Children's social care has developed a care pathway for young people who are vulnerable to suicide, included as appendix two to this report. This details the steps that should be taken by various professionals and sets targets for how quickly children and young people should be seen. It routinely includes the phrase "*Child's wishes and feelings to be sought and recorded*". Whilst this was done in David A's case the panel believe that more should have been done, such as really considering his views.

6.6 David A's wishes and feelings were sought and recorded at times during his engagement with services but not consistently so. There were critical times when the implications of his wishes and feelings were not properly considered e.g. the ending of the child protection plan when he was reported to be feeling no differently despite the changes at home. More should have been done to fully consider and seek to understand why he thought and felt the way he did. Professionals often seemed to rely on others' reports of David A's views rather than exploring with him how he saw his situation.

6.7 The child protection process may need changing if it is to remain the primary avenue for co-ordinating the care of young people who are threatening suicide and are considered to be at risk of significant harm. It will need to realise that as children get older, they become increasingly vulnerable to a broader range of risks, (Gorin and Jobe 2012) and chairs will need to develop skills in including and focusing upon the young person in a way which is different to the younger children who they are more routinely discussing. All child protection plans should include measurements that are focused upon outcome, not process as was the case with David A.

6.8 Services sometimes see fathers as 'all good' or 'all bad' and do not always give due consideration to why fathers may appear to be hostile or disengaged, when they have a crucial role in their children's lives.

7 RECOMMENDATIONS

7.1 The IMRs produced for this review have identified a number of single agency improvements that can be made, many of which have been implemented already.

7.2 This report has the task of identifying recommendations that may have been missed by single agencies and recommendations that relate to multi-agency working.

7.3 The overview author believes that a small number of recommendations aimed at a high level achieve more change than a large number of detailed recommendations. This report therefore makes just six.

7.4 The care pathway designed for use with young people who are talking of suicide contains four references to the following action: "Childs wishes and feelings to be sought and recorded". David A's wishes and feelings were sought and recorded: however the plans that were identified did not effectively address his concerns. Therefore

Recommendation One (a): Further words be added to the four references to child's wishes and feelings in Bath and North East Somerset's care pathway for identifying children and young people vulnerable to suicide. This will therefore read:

> "Child's wishes and feelings to be sought, understood, genuinely considered, recorded and, as appropriate, acted upon".

7.5 The Care Pathway may not emphasise the risk that young people face. Therefore

Recommendation One (b): That the following be added to the right of the Pathway:

> "At any stage refer to children's social care if child at risk of significant harm through their own behaviour or if no parental engagement/agreement re treatment plan."

7.6 This review has identified further guidance for working with young people who are threatening suicide and this is included as appendix three.

Recommendation One (c): That the LSCB Review and strengthen the care pathway for children and young people vulnerable to suicide using the specialist advice (appendix three) that has informed this review.

7.7 Social workers at the feedback meeting with the author of this report and the chair of the review reported that neither they, nor their manager were aware of the care pathway.

Recommendation One (d): That the LSCB ensure that the reworded care pathway be made available to all staff throughout LSCB agencies and that a review be carried out, three months later, to monitor the awareness of the Pathway and its usage.

7.8 This report recognises that it is less common for young people to be protected via the child protection process and accepts that chairs of conferences may lack skills in this area.

Recommendation One (e): All child protection chairs should be supported to develop their knowledge of risks and needs of young people talking about suicide and how to appropriately address these in the child protection process.

7.9 This review has recognised that talking with a young person expressing suicidal thoughts requires particular skills.

> **Recommendation One (f)**: That the LSCB develop an on-going, child-focussed, core training program to equip professionals to respond appropriately to young people who are talking about suicide and that this should be targeted at particular front-line groups (e.g. health visitors, social workers, chairs of conferences) and that this training be based around the updated care pathway for identifying children and young people vulnerable to suicide.

7.10 This review has identified that the action plan set during the child protection process did not address David A's suicidal threats or his emotional well-being and that an emphasis was placed upon the parents' separating. This report has identified that the objectives, and therefore the measurements set at the review, were not child focused and needs led. The LSCB sign off meeting in July 2013 confirmed that this issue has already been recognised and is not exclusive to this case

> **Recommendation Two**: The LSCB to commission work to ensure that staff are trained in outcome led thinking and child protection and child in need plans are written with needs led outcomes and measurements.

7.11 This report has identified that staff appeared rarely to speak directly with David A about his threats of suicide. The author of this report recognises that this is not easy and understands that professionals may need support in this matter. A series of training courses for key members of the LSCB agencies may therefore help to address this providing that the participants become ambassadors for supporting staff in working with young people who are threatening suicide.

> **Recommendation Three**: That the LSCB targets training for senior or experienced members of staff chosen to represent a cross section of workplaces and agencies and supports those members of staff in being a resource or in becoming leading practitioners in their agencies to assist other staff in working with young people who are talking about suicide.

7.12 This review has identified that child protection meetings, review meetings and core groups took place during school and work hours thereby reducing the opportunity for David A and his father to attend. It also identified that GPs were never present and that this was because of the fact that the meetings are held at such a time that a whole clinic would have to be cancelled for a GP to attend.

> **Recommendation Four:** That child protection conferences, reviews and core group meetings take place:
>
> a) out of school hours if it would be useful for children and young people to be present,
> b) flexibly and therefore not rigidly between the hours of 9am – 5pm if working parents are involved in the family
> c) at times and places that maximise the potential for GPs to be present in cases where they are key members.

7.13 This review has identified that Mr A felt disassociated from the social work, CAMHS and child protection processes.

> **Recommendation Five:** Social care and health staff need to develop skills in working with fathers, finding approaches which accommodate the different ways in which men respond to problems compared to women. These should include times of formal meetings in which working parents are seen, assessments not being signed off as completed by managers until fathers have been seen and their views considered and included and the positive impact that fathers have on their children's lives being added to a review.

7.14 Mrs A and Susan A identified their GPs as being key professionals, but the GPs were not particularly involved in the child protection process.

> **Recommendation Six:** That the LSCB commission or complete internally a review identifying the extent to which GPs attend child protection conferences, and if appropriate, the reason why the attendance is low with a view to identifying a plan to improve the representation of GPs at conferences. In particular the review should compare GP attendance at child protection and vulnerable adult conferences.

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APPENDIX ONE

Bath and North East Somerset

Local Safeguarding Children Board

Serious Case Review November 2012

TERMS OF REFERENCE

The core purpose of the Serious Case Review is for agencies and individuals to learn lessons to improve the way they work both individually and collectively to safeguard and promote the welfare of children. In this serious case review the following questions will be particularly explored to assist in this learning. (This will not limit the exploration of further relevant questions that arise as a result of review activities.)

The Serious Case Review was initiated as a result of David A's death in October 2012 and needs to consider the circumstances leading up to his death and how agencies worked together but also needs to consider an earlier period when agencies were actively involved with David A and his family, including when he was subject of a child protection plan.

The panel have determined that agencies should in their IMR's cover the period from January 2007 until October 2012. **However agencies should look also at events/involvement prior to 2007 and include these in their chronologies. Where relevant they should reflect on these in their narrative and final reports.**

For some agencies there has been significant involvement (or little but nonetheless of significance) with this child/family prior to 2007 and it is important that these are included and inform the IMR.

1. Were David A and his family offered appropriate services to help meet their needs throughout the time period?
2. Was information clearly and appropriately shared between organisations?
3. Was there appropriate shared assessment of the level of risk between relevant agencies throughout the time period?
4. Were actions taken by individual agencies appropriate to address the assessed risks?
5. Was there a well-informed, robust multi-agency assessment of the risks of significant harm that informed the decision to end the child protection plan in March 2010?
6. Was the decision to end the child protection plan consistent with the assessment of risk?
7. Was appropriate support offered to David A as a child in need following the end of the child protection plan?

8. Did the strategy discussion in February 2012 take appropriate account of David A's history?
9. Following the strategy discussion in February 2012 was there appropriate information sharing between agencies?
10. In particular was there a shared assessment of the level of risk of suicide in April 2012?
11. Were there effective strategies to manage differing levels of parental engagement with services?
12. Were there effective strategies to manage differing levels of engagement from David A?
13. Did agencies work effectively across the boundaries of Bath & North East Somerset and Wiltshire?

APPENDIX TWO

Bath & North East Somerset Council

NHS Bath and North East Somerset

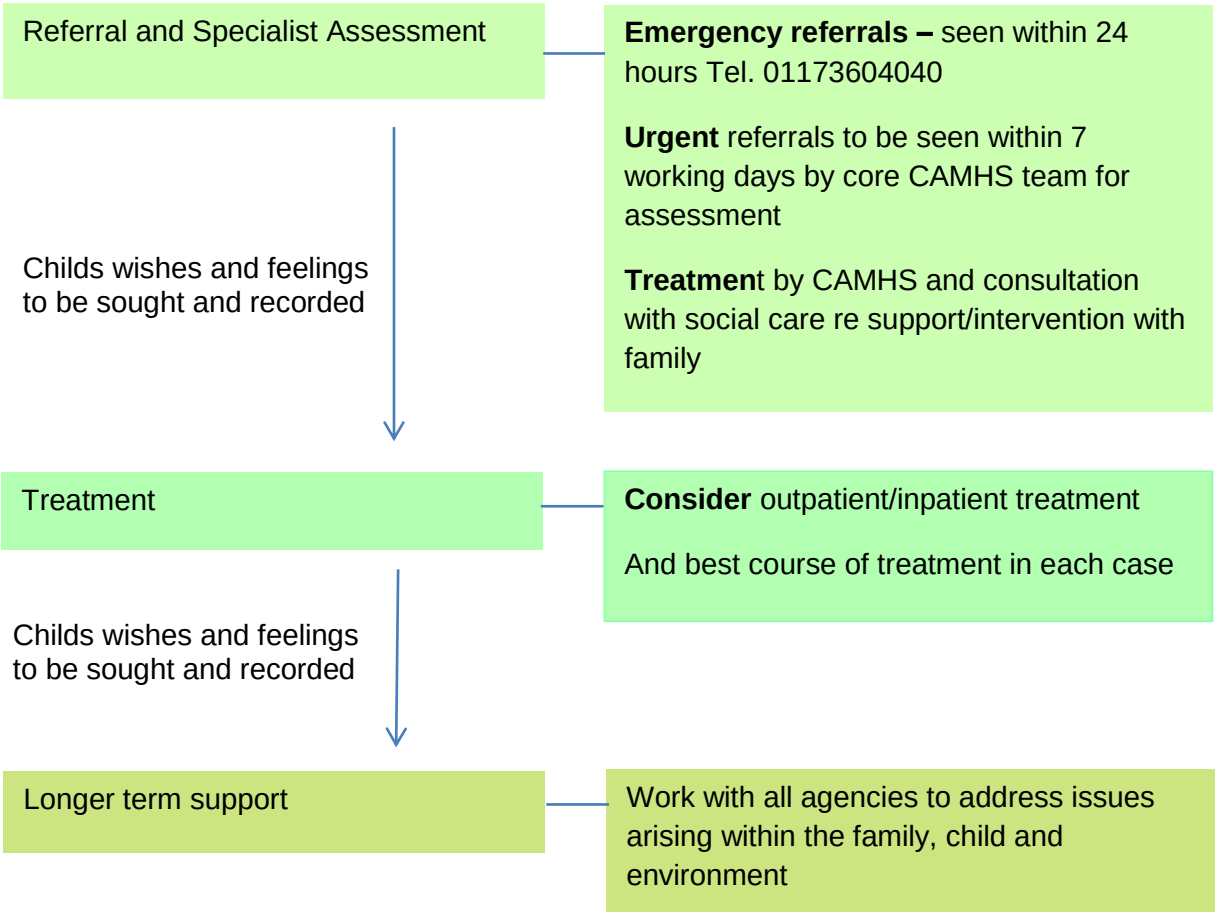
working together for health & well-being

Care Pathway for identifying children and young people vulnerable to suicide

Stage of pathway

Prevention/Health Promotion	Preventative programmes i.e. Seal programme, FRIENDS, school nursing, PSHE, early years
Early Identification	School staff; school nurse; Connexion Advisors; CAMHS; YP services; adult services; substance misuse services; DV services; A&E; Foster Carers, Social Workers, parents, GP, Health Visitor, LAC nurse, early years
Early Support/ Identification and Assessment	**Schools**- discuss with Designated Teacher and school nurse and agree next steps **School nurse** to monitor and may liaise with or refer to GP/CAMHS **School Nurse** to check child receiving appropriate support **Agencies –** consult/refer to school nurse/GP/CAMHS
Childs wishes and feelings to be sought and recorded	
Identification and specialist consultation	Consult CAMHS or GP. If; **Low Concerns** – agency to refer back to school nurse or GP continue monitoring at practice **High Concerns** – GP/CAMHS undertake immediate assessment
Childs wishes and feelings to be sought and recorded	

At any stage refer to Social Care as child at risk or significant harm if no parental engagement or agreement re treatment plan.


Referral and Specialist Assessment
Emergency referrals – seen within 24 hours Tel. 01173604040
Urgent referrals to be seen within 7 working days by core CAMHS team for assessment
Treatment by CAMHS and consultation with social care re support/intervention with family
Childs wishes and feelings to be sought and recorded
Treatment
Consider outpatient/inpatient treatment
And best course of treatment in each case
Childs wishes and feelings to be sought and recorded
Longer term support
Work with all agencies to address issues arising within the family, child and environment

APPENDIX THREE

Risk Assessment

The initial encounter with a young person who is expressing suicidal thought is critical, and the formation of a therapeutic relationship requires that it be conducted in a calm, confident, empathetic, and patient manner. A thorough history must include psychiatric history, previous suicide attempts, and history of familial suicide; this paper contains a series of questions that will assist. Discussing suicidal ideation and plans, including actual plans, access to the means and lethality of the plan is imperative.

It is recognised that someone who has self-harmed is at greater risk of suicide than the general population. However, this does not mean that everybody that has self-harmed is an immediate suicide risk.

One of the factors that should influence any risk assessment is whether the young person, and where relevant their parents/carers, is willing to engage with support services. *If not this will potentially increase the level of risk*. Where a family is referred for support by another agency but refuse to engage that agency should be contacting social care to discuss how best to respond to this. Agencies will need to consider all available options to manage such circumstances.

Suicidal intent has been found to be a good predictor of subsequent attempts. A 15-year prospective study of 80 formerly psychiatrically hospitalised adolescents who had had several suicide attempts showed that highest intent and lethality (i.e. potential to cause death) were better predictors of future attempts than intent and lethality of the most recent attempt[10]**.** Put another way: the better means of prediction for suicide in the future is by looking at the most severe previous attempt in terms of possibility of death and seriousness of wish, as opposed to these factors in the most recent suicide attempt.

For example if someone had made a dozen attempts with minor overdoses and always sought help at A&E in the last year they could be considered not to be too risky, but if they had also 18 months ago tried to cut their throat and needed a transfusion as they lost so much blood, their risk would be seen to be considerably higher due to higher intent and lethality although historical.

Protective factors are as important as risk factors, such as family cohesion, religious beliefs, significant relationships, supportive environments and core values.

What to do if a young person expresses suicidal ideation

- Form a good relationship, be empathetic and reassure regarding confidentiality
- Assess current mental health - determine symptoms (including duration and mode of onset) and associated disturbances e.g. sleep, school performance and friendships, family structure, appearance, behaviour, speech, phobias, obsessions, mental state examination, emotional symptoms, somatic symptoms, disturbance in relationships, speech and language, thinking, motor, antisocial and defiant behaviour
- Determine any support networks available to the young person
- Determine risk of further harm or suicide, using the questions below.

[10] Sapyta J, Goldston DB, Erkanli A, et al; *Evaluating the predictive validity of suicidal intent and medical lethality in youth.* J Consult Clin Psychol. 2012 Apr;80(2):222-31.

1.2 The following should be covered in a risk assessment

Violence and aggression
Has the young person a history of violence?
Does the young person misuse drugs/alcohol?
Is the young person experiencing delusions of persecution?
Has the young person made specific threats to harm others?
Has the young person expressed thoughts/fantasies of harm to others?
Does the young person have a history of antisocial behaviour?
Is the young person impulsive/displays emotional liability?
Does the young person have a history of rootlessness/social restlessness?
Does the young person have a history of problems maintaining stability in relationships?
Does the young person have a history of non-compliance/disengaging/DNA's with aftercare?
Has the young person recently been under significant stress?
Does the young person deny or minimise previous incidents of violence?
Is there any evidence of violence within the young person social network (family/peers)?
Have significant others expressed concern about the young person's risk(s)?

Suicide
Does the young person have a history of suicide attempts?
If so, did (s)he use a violent/perceived lethal method?
Has the young person made a plan to end their life?
Is the young person expressing suicidal ideation?
Is the young person expressing feelings of hopelessness?
Does the young person expressing high levels of subjective distress(from psychotic symptoms/situation)?
Does the young person express feelings of having no control over their life?
Does the young person misuse drugs/alcohol?
Does the young person display impulsively?
Does the young person live alone?
Does the young person have poor physical health?
Has the young person recently suffered significant loss/threat of loss?
Has the young person recently disengaged with care/stopped medication?
Has the young person recently been discharged from hospital?
Is there a family history of suicide/self harm? If Yes, please give details.

Self neglect
Does the young person have a history of previous self-neglect?
Is the young person failing to eat or drink properly?
Does the young person have difficulty managing their physical health?
Is the young person unable to look after his/her own hygiene?
Does the young person have difficulty communicating their needs?
Does the family have significant debt due to regular difficulties, managing their finances?
Is the family/individuals accommodation inadequate to meet their needs?
Is there a threat of eviction?
Does the young person deny problems perceived by others?

Other risks
Is there any evidence from the young person's history or current presentation of:
Risk of wandering? (give details)
Risk of sexual offences/inappropriate sexual behaviour?

Risk of deliberate fire setting?
Risk of deliberate self-harm? (e.g. cutting)
Risk of other self-harm? (e.g. eating disorders)
Risk of abuse or exploitation from others? (sexual/financial/physical/emotional)
Risk of cultural isolation?
Risk of accidental injury
Risk of absconding if an Inpatient?

Other:
Is the person a young carer?
What are the young person's support systems?
What protective factors does the young person have?

A number of screening tools are available and appropriate for use in the primary care setting, (see list at the end of this paper).

Principles in Working with Young People that Self-harm

The following core values are recommended by Truth Hurts: Report of the National Inquiry into Self-harm among Young People. MHF 2006

- Full involvement and consultation with young people to ensure that service delivery is well grounded in their view
- A clear underpinning approach or philosophy: that is, a working definition of what self-harm means and of the reasons why young people self-harm, and services based on this thinking
- Clear and consistent service provision goals/objectives – including short term plans and long term goals, and a clear knowledge of what the service can offer
- Comprehensive training for all members of staff specifically on self-harm, with appropriate debriefing/ supervision procedures built into day-to-day work and clinical supervision where appropriate
- Outputs and outcomes that are collected and monitored – in other words, an ethos of action research and self-reflection. These data makes it possible to see what works and why, and modify or enhance the service
- Integration with a very broad range of other services that are relevant to young people and families

Papyrus (Prevention of young suicide)

Recommend that young people who communicate thoughts of suicide, or who have attempted to harm themselves need to be

- seen quickly
- taken seriously
- treated with empathy, kindness and understanding

Followed by

- a full assessment by staff trained in suicide risk assessment and prevention methods
- fast track referral if deemed necessary
- frequent, regular contact with the same key worker or other mental health professional

- if required, easy access to appropriate inpatient care in accommodation suitable for their age group
- advice on what to do to manage their suicidality
- given information on how to access immediate help in a crisis, understand what has happened
- details of contacts and organisations that can give support, chat rooms, websites etc

What Young People Want

Frequent, regular contact with the same professional
Access to other options
Emotional support
Knowledge and information about depression and anxiety
Appropriate responses
Readily available support
People working together
Action to be taken based upon their views
Care plans

Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:

- prevent escalation of self-harm
- reduce harm arising from self-harm or reduce or stop self-harm
- reduce or stop other risk-related behaviour
- improve social or occupational functioning
- improve quality of life
- improve any associated mental health conditions.

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.

Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others.

Care plans should:

- identify realistic and optimistic long-term goals, including education, employment and occupation
- identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
- identify the roles and responsibilities of any team members and the person who self harms
- include a jointly prepared risk management plan
- be shared with the person's GP
- include a risk management plan and crisis plan

Useful assessment tools

NICE advise the following ~

“All healthcare professionals should routinely use, and record in the notes, appropriate outcome measures (such as those self-report measures used in screening for depression or generic outcome measures used by particular services, for example Health of the Nation Outcome Scale for Children and Adolescents [HoNOSCA] or Strengths and Difficulties Questionnaire [SDQ]), for the assessment and treatment of depression in children and young people”.

“Children and young people of 11 years or older referred to CAMHS without a diagnosis of depression should be routinely screened with a self-report questionnaire for depression (of which the Mood and Feelings Questionnaire [MFQ] is currently the best) as part of a general assessment procedure”

“Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer-based instruments (such as Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose but will require modification for regular use in busy routine CAMHS setting”

Others are: Columbia Suicide Screen, the Risk of Suicide Questionnaire, the Suicidal Ideation Questionnaire (SIQ), the Suicidal Ideation Questionnaire JR (SIQ-JR), Diagnostic Predictive Scales, the Suicide Risk Screen and the Suicide Probability Scale

Useful websites

Multicentre Study of Self-harm in England: Outcome of self-harm, including repetition and mortality
http://cebmh.warne.ox.ac.uk/csr/mcm/publications/outcomes.html

Multicentre Study of Self-harm in England: Epidemiology and trends in self-harm in the study centres
http://cebmh.warne.ox.ac.uk/csr/mcm/publications/outcomes.html

The Keith Hawton, Karen Rodham, Emma Evans, Rosamund Weatherall, paper
http://www.bmj.com/content/325/7374/1207

Paul Moran, Carolyn Coffey, Helena Romaniuk, Craig Olsson, Rohan Borschmann, John B Carlin, George C Patton
http://blogs.rch.org.au/cah/files/2011/11/The-natural-history-of-self-harm-from-adolescence-to-young.pdf

NICE C133 Self-harm
http://www.nice.org.uk/nicemedia/live/13619/57179/57179.pdf

NICE depression in children and young people CG28
http://www.nice.org.uk/guidance/CG28

Truth Hurts
http://www.mentalhealth.org.uk/publications/truth-hurts-report1/
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PAPYRUS
http://www.papyrus-uk.org/