Learning Review

Child B

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1 INTRODUCTION

1.1 This case review has been carried out because of the death of Child B at the age of 15 years and 10 months.

1.2 On 28th May, Child B's father went out to search for his son. Child B's father found him in woodland near their family home. Child B was found, unconscious, sitting in a hollow, with a washing line attached to a branch, around his neck. Child B died in a Paediatric Intensive Care Ward having suffered severe brain damage on 28th May 2017. He died soon after breathing apparatus was withdrawn on 5th June 2017.

1.3 The medical causes of death were hypoxic ischaemic encephalopathy and hanging. Following an inquest into Child B's death in February 2020 the Coroner recorded her conclusion as to his death "*(Child B) was a 15 year old boy with no history of mental illness until October 2016 when his family began to have concerns that he was isolating himself. In November 2016 he admitted to some self-harming behaviour and thereafter he was referred via his GP to the [Surrey Child and Adolescent Mental Health Service] and he remained under their care, and later under the care of the [specialist mental health service for young people with complex needs] until the time of his death. He did not have a formal mental health diagnosis at the time of his death although the clinical team worked with a case formulation that identified difficulties with emotional regulation, relationships, anxiety, and low mood. During the period from December 2016 to February 2017 he took four overdoses which resulted in hospitalisation. On 28th May 2017 he deliberately hanged himself from a tree, using a piece of rope as ligature. His intentions in doing so remain unknown. Thereafter he was taken to St. Georges Hospital where he was diagnosed with a brain injury, which resulted in his death at the hospital on 5th June 2017".*

1.4 The period for this review is September 2016 when he entered Year 11 of his school education, to 5th June 2017, the date of his death.

2 THE REVIEW PROCESS

2.1 Multiple agencies had been involved with Child B over the previous 8 months, and it was decided at a Post Child Death Review Meeting held on 18th July 2017 to refer the Case Review Panel. The Case Review Panel held on 19th September 2017 determined that a practice learning review should take place.

2.2 Following prolonged delay, the lead reviewer initially appointed withdrew from the process. Fiona Mainstone[1] subsequently replaced them in January 2019 and met with the Surrey Wide Associate Director of Safeguarding for initial briefing in March 2019.

[1] For details of the lead reviewer please see Appendix 1

2.3 The lead reviewer met with Child B's parents and younger brother at their home on 17th July 2019. During this meeting Child B's parents articulated numerous concerns about professional intervention in the months leading up to their son's death. The questions underlying their concerns were congruent with the terms of reference already determined by the Case Review Panel and related to:

- How risk assessments were conducted
- Whose voices were heard in those assessments
- How decisions about risk were made
- How the treatment plan and interventions to reduce risk were determined

2.4 The lead reviewer attended the first four days of the five-day Coroner's Inquest conducted in February 2020. This case review is therefore informed by oral evidence given to the Coroner together with three bundles of documented evidence.

2.5 An integrated chronology was completed on 24th February 2020. Thereafter a timetable for the review process was agreed, and a panel was appointed to oversee the review.

2.6 An initial panel meeting was held on Monday 30th March 2020. This meeting was conducted on-line using Microsoft Teams under special arrangements made because of the Covid-19 pandemic. The chair of the review panel is the Surrey wide CCG Designated Nurse for Looked After Children / Deputy Designated Nurse Safeguarding Children, NHS Guildford and Waverley Clinical Commissioning Group. The review panel consists of representatives from the Surrey and Borders Partnership NHS Trust; Surrey Police; the Named GP; Surrey County Council Children's Services and the Area Schools Officer.

2.7 The lead reviewer has accessed and reviewed the following documents:

- An integrated multi-agency chronology
- The three bundles of evidence compiled for the Coroner's Inquest
- The Safety Investigation Report (sic) prepared by the NHS Trust with responsibility for CAMHS services.
- The Case Record held by the above NHS Trust
- The specialist mental health service for young people with complex needs Operational Policy 2016 and 2019
- The Coroner's Inquest Conclusions
- Minutes of Post-Child Death Review Meetings held on 18th July and 19th September 2017

2.8 Under the direction of the panel and as part of the formal review process the lead reviewer conducted a series of interviews with relevant staff. Between 3rd April and 21st May 2020, the lead reviewer held meetings by phone or using Microsoft Teams with:

- The Student Support Officer / Deputy Designated Safeguarding Lead at Child B's School (no longer in post)
- The Designated Safeguarding Lead at Child B's School
- The Head Teacher at Child B's School
- The Consultant Child and Adolescent Psychiatrist, Child and Adolescent Mental Health Services (CAMHS)
- The Crisis Assessment Nurse, Child and Adolescent Mental Health Services (CAMHS)
- The Team Manager, School Nursing Service
- The Service Manager, specialist mental health service
- The Mental Health Nurse – specialist mental health service
- A group of three Service Managers from Surrey Children's Services.

2.9 This final report has been discussed at each stage with the panel and has been shared with Child B's parents. Child B's parents welcomed the report and formally requested that it should be published in full.

3 FAMILY BACKGROUND

3.1 The integrated chronology poignantly documents the commitment of both his parents to securing the best possible treatment for Child B and their persistence in trying to safeguard him from self-harm.

3.2 Child B presented a complex picture of troubled behaviour and unmet needs in the 8-month period leading up to his death. However, his family background is uncomplicated. His family household consisted of Child B's parents and his younger brother. The integrated chronology refers to his grandfather's death as a recent source of sadness, and the family had regular contact with his bereaved grandmother.

3.3 There was no professional involvement with Child B, or his family and no concerns are noted in relation to either his physical and mental health, or his educational progress until October 2016.

3.4 There is no known family history pre-dating the sudden emergence of Child B's distress in the autumn of 2016.

3.5 Child B's parents discussed his distress, troubled behaviour and disconcerting changes in his mood and thought processes with many professionals. They were open about their uncertainties about how to respond to his difficulties, and about their impact on life at home. The integrated chronology poignantly documents his parents' fears for Child B, their unquestioned commitment to him, their desire to protect him from harm, and their dedicated pursuit of help and guidance. They sought above all to understand, respond to, and meet his needs and to keep him safe from harm.

4 KEY EVENTS AND PRACTICE ISSUES ARISING FROM THE TERMS OF REFERENCE

4.1 This section of the report should be read in conjunction with the timeline set out in Appendix 3

How effectively did agencies work together to safeguard Child B in response to his increasing anxiety and deteriorating mental health?

4.2 By all accounts, until the autumn of 2016, Child B was physically active, intelligent and enjoyed good long-standing friendships. He was described by the Student Support Officer / Deputy Designated Safeguarding Lead at his school as "a radiant child with a great, cheery personality". It was anticipated that Child B would perform well in his GCSE's and no problems were reported in his family life. Difficulties associated with poor sleep and anxiety were not remarked upon in the family until October 2016. Child B first spoke with school staff about feeling anxious in early November. From that point on his moods changed at pace and were marked by extreme fluctuations in behaviour at home and at school. Child B's anxiety and deteriorating mental health manifested in several different ways and across the contexts of school, family, and friendships. The integrated chronology documents 21 separate entries describing destructive, erratic or uncontained emotions or behaviour within the first two months between mid- November 2016 and mid-January 2017 including two attempted overdoses. It is easy to trace both the frequency, and the escalation in intensity of "meltdowns" in the 5 months leading up to Child B's death. When talking to professionals, Child B explicitly and consistently described his mood as low. This self-assessment was echoed by those who knew him well (parents and school staff) as well as those who encountered him only briefly e.g. Police Officers called out to specific incidents. Child B appears to have experienced unremitting emotional pain, although his behaviour fluctuated between extremes and the manifestation of this distress was intermittent.

4.3 Working together was significantly compromised by fundamental disagreements. The difficulties affecting purposeful collaboration were perceived differently by contributors to the multi-disciplinary network, as well as by Child B's informal network. To a significant extent these different perceptions persist so that differences of opinion and perspective remain unresolved. Sadly both "sides" feel their view is vindicated by the specific circumstances of Child B's death. The fact that conflicted views persist despite opportunities for reflection and resolution in the intervening three years suggest persistent structural problems within some parts of the service and across the system interfered with professional capacity to achieve meaningful collaboration and work together to protect Child B from harm.

4.4 Staff at Child B's school were surprised when they became aware of his distress in early November 2016 because they knew him only as a lovely boy, who was always smiling, had lots of good friends, and was an able student who worked hard. Within days of Child B first speaking about his low mood and anxiety the Student Support Officer / Deputy Designated Safeguarding Lead encouraged his parents to ask the GP surgery to refer Child B to CAMHS for assessment. She also shared information about several potential sources of help such as Young Minds, Kooth, Headspace and Childline. As concern for Child B grew during December 2016, she undertook a risk assessment and kept in regular contact with Child B and his parents. From the perspective of school staff, the rapid deterioration in Child B's mental health in late December 2016 to mid-January 2017 was shocking. The behaviour they observed at school seemed to them to be out of his control. His extreme distress, anger and confusion bore no resemblance to their routine experience of pupils who are ill-disciplined or behave badly in school. They were in no doubt that he was unwell and in need of psychiatric treatment. Following his second overdose a comprehensive, timely and achievable support package was put in place to enable him to return to school safely on a reduced timetable. As the indicators of Child B's evident distress continued to escalate the Student Support Officer / Deputy Designated Safeguarding Lead sought guidance from the specialist mental health service about a risk management plan, and on 22nd March asked for him to be signed off from school and a referral made to Access to Education (A2E) on medical grounds.

4.5 When Child B first came to CAMHS' attention in mid-November 2016 with concerns about low mood, anxiety and sleep difficulties the children's health referral portal efficiently directed him towards a counselling service for individual counselling. Given that there was no prior history of mental health problems this was an appropriate and timely response to his apparent needs at that time. The school subsequently alerted the children's health referral portal to the escalation of Child B's self-harming behaviour on 22nd November and again the response was immediate and appropriate: he was provided with an emergency face to face appointment for assessment of his mental health needs. Thereafter until mid-January services were provided both from the counselling service's charity workers who had already engaged with Child B and by CAMHS Community Team practitioners.

4.6 On 10th/11th January Child B repeatedly reported an experience of being chased and assaulted by a group of unidentified assailants. His account at the time was considered completely implausible by both his parents and the police in attendance. When he talked subsequently about this incident in counselling with the counselling service's practitioner on 24th January, they too described him as agitated, distressed and experiencing paranoia. The Student Support Officer / Deputy Designated Safeguarding Lead was similarly impressed by the intensity of Child B's anxiety and concluded that Child B was describing an event that did not in

fact take place. His parents and professionals from these three different settings all formed the view that Child B himself fully believed that this chase and assault had happened and was genuinely upset and frightened. They have described his behaviour and physical presentation both immediately after returning home from "the chase" and in the days that followed as congruent with panic and terror. From their perspective, and from their lay understanding of psychiatric illness, they all worried that this event represented an episode of psychosis.

4.7 Child B was admitted to hospital for the second time on 17th January less than a week later. Child B was hospitalised and received 1:1 nursing care for three nights following an attempted overdose of approximately 35 paracetamols. Soon after taking the overdose Child B retreated into a locked toilet cubicle and it was with some difficulty and the help of Child B's father as well as Police Officers in attendance that he was taken to hospital. The Mental Health Nurse attached to the Community CAMHS team already working with Child B met with him while he was still receiving medical treatment (Parvolex), recommended psychiatric hospital admission for further assessment and was supported in this advice by the consultant on duty. Child B therefore remained on a paediatric ward for further assessment from a Psychiatrist and the specialist mental health service. This was in accordance with the pathway indicated where there is concern about risk and the need for psychiatric in-patient assessment or treatment.

4.8 Subsequent assessment by the Consultant Child and Adolescent Psychiatrist attached to the CAMHS Community Team and the specialist mental health service recommended discharge home. Child B was offered medication but declined this. The input from the counselling service continued until 24th March 2017. Responsibility within the CAMHS Community Team transferred to a Psychiatrist in training who met with Child B weekly from late January onward. The Consultant Child and Adolescent Psychiatrist attached to the CAMHS Community Team and the specialist mental health service retained medical responsibility and remained the Clinical Lead for Child B until his death.

4.9 Crucially involvement of the specialist mental health service marks the point at which Child B's mental health problems met the threshold for Tier 4 psychiatric services. The specialist mental health service's remit is to support cases of significant mental health difficulties with significant risk. The planned intervention consisted of several interwoven threads:

- A Mental Health Nurse, recently qualified and still within her preceptorship period from the specialist mental health service team, was assigned to conduct outreach work with Child B and his family in their home
- This outreach work was supported by the Extended specialist mental health Service that provides support outside of normal working hours until 11 pm.
- A trainee Psychiatrist then on placement in the CAMHS Community

Team began a programme of Cognitive Behavioural Therapy with Child B in accordance with Nice Guidelines for persons presenting with anxiety and depression.

- The counselling service agreed to continue their offer of counselling and family mediation

4.10 The Consultant Child and Adolescent Psychiatrist did not make a diagnosis of Child B's mental health status, preferring to use an ongoing process of case formulation to inform the treatment plan. During the final four months of Child B's life the risk he posed to himself was assessed as low. Child B repeatedly assured both the Consultant Child and Adolescent Psychiatrist and the trainee Psychiatrist that he was not intending to self-harm and that he had no suicidal intention. When he talked about suicidal ideation this was interpreted as unplanned and impulsive. It seems that the evaluation of risk rested on Child B's account of his thoughts, feelings and actions being taken at face value. The Mental Health Nurse providing the outreach service usually had weekly contact with Child B and his family at their home and her case notes provide a thorough narrative description of her conversations with them. Her case records describe many phone conversations and include details of email exchanges. These demonstrate frequent communication and evident goodwill flowing between the Mental Health Nurse, the Student Support Officer / Deputy Designated Safeguarding Lead in school, and Child B's parents.

4.11 Child B's voice is reported in this record alongside information provided regularly by Child B's parents and the school. Their information painted a picture of continued distress and repeated, often prolonged events of extreme crisis when Child B appeared to be in a profoundly altered state. In addition to Child B's initial superficial self-harm and subsequent overdoses there are repeated references throughout the Coroner's documentation to notes that Child B wrote and sent multiple texts to peers in which he spoke of plans to harm himself. There were also offensive posters decorating his room, sinister drawings, writing, symbols and slogans, aggressive and angry outbursts, and website searches relating to methods of suicide including hanging and overdose.

4.12 The integrated chronology indicates a dynamic between Child B's contact with mental health professionals and his episodes of self-destructive behaviour. This pattern was first seen on 29th November 2016 when Child B assured a CAMHS Mental Health Nurse that his mood was improved, and that he had no thoughts of self-harm, but took an overdose of paracetamol the following day and did not disclose this until another day later. Although it was recognised in this, as in many cases, that Child B's behaviour should be understood as communication, it seems that this pattern went unremarked even as Child B's mental health continued to deteriorate during the late winter and spring of 2017.

4.13 The Police were called out by Child B's parents on ten occasions between 19th December and 28th May 2017. At each of these attendances the police officers involved took every immediate step to safeguard Child B from harm. The integrated chronology demonstrates that his safety and protection were at the forefront of decisions made and action taken. Several police reports highlight how baffled they were by Child B's erratic and sometimes aggressive behaviour. Police officers deemed it necessary to use physical restraint on three separate occasions. The referrals they made to Surrey Children's Services demonstrate that police officers saw serious grounds for intervention to secure Child B's safety, were very concerned for the well-being of his parents, and noted the impact of Child B's distress on his younger brother.

4.14 Child B's parents have articulated the challenges they faced, and have continued to encounter since his death, because of the apparent discrepancies between agencies. They feel that whereas some professionals clearly understood the significance of the breakdown of his mental health, the intensity of his distress, and the challenges they faced in trying to fulfil their parental responsibility to keep him safe from harm, others did not.

4.15 As well as feeling baffled by the apparently inconsistent approaches to Child B's needs and vulnerability by practitioners from different professional disciplines, his parents found it especially hard to make sense of how different parts of the safeguarding system conceptualised risk. Police officers, Child and Adolescent Mental Health Service and Children's Services all use different vocabulary and measures to describe risk. The meaning of risk scores and the rationale behind them are not readily understood by anyone who does not work within those specific contexts.

4.16 Both the school and Child B's parents asked members of the specialist mental health service team for a risk management plan, and guidance about how to respond in moments of crisis. The Consultant Psychiatrist has said both at the time and more recently that no risk management plan or guidance offered could anticipate every possible contingency and that those involved would need at times to make their own judgements based on common sense. This, of course, is true. However, in the absence of a shared inter-professional understanding of Child B's needs, and of any agreed multiagency risk minimisation plan and management strategy his vulnerability increased and the capacity of his parents and of professional practitioners to keep him safe was compromised.

Was information sharing between agencies sufficient and timely in light of escalating concerns to understand Child B's support needs?

4.17 The integrated chronology indicates that information was shared appropriately between professionals during the period between November 2016 when Child B's support needs became apparent and his death in May 2017. A few lapses in

information sharing were of minor significance but did not interfere with agencies' understanding of Child B's support needs.

4.18 Crucially, however, although information was generally passed between the professionals involved and was recorded appropriately, there is little evidence of transparent debate about differing professional perspectives and the challenges of supporting Child B. A shared understanding of his needs and of the presenting risks was not achieved. Although there were phone conversations and some inter-agency meetings, nowhere in the record is there evidence of the whole professional network coming together to formulate a shared holistic understanding of Child B's complex needs. The fluctuations, inconsistencies and ambiguities in Child B's communication, behaviour and demands were not explored fully. Without full exploration of the various and conflicted views no consensus could be reached. An agreed and shared understanding of Child B's difficulties and needs was never achieved. This compromised the treatment plan and meant that no effective plan was in place to protect him from the risk that Child B would either come to harm unintentionally or enact his declared intention to kill himself. One meeting that came close to achieving this was on 27th April 2017 and attended by Child B, both parents, the trainee Psychiatrist, the Mental Health Nurse assigned to the case, the youth support worker, and the Student Support Officer / Deputy Designated Safeguarding Lead. Its focus was on crisis management within the home. It confirmed the intervention plan already in place, but it did not generate a purposeful risk management strategy or risk minimisation plan. When the youth support worker, trainee Psychiatrist, Mental Health Nurse and Student Support Officer / Deputy Designated Safeguarding Lead met again on 25th May 2017 a general sense of optimism was shared. The diagnosis / case formulation was discussed but no exploration of the ambiguities and differences of perspective was recorded.

The specialist mental health service intervention plan relied on case formulations and judgements about the level of risk based on the observations and judgement of the whole specialist mental health service team but ultimately determined by the lead clinician. The integrated chronology indicates that the Consultant Child and Adolescent Psychiatrist attached to the specialist mental health service met with Child B in hospital on 20th January 2017 and spoke on the phone with his father. The case record provided by the Consultant Psychiatrist to the Coroner verifies that from this time onward he held medical responsibility and was the Clinical Lead by virtue of his dual roles in the CAMHS Community Team and the specialist mental health service and through supervision of the trainee Psychiatrist. There is a record of a review conducted on 12th February, but it is not clear what form that took. The Consultant Child and Adolescent Psychiatrist led a "network meeting" on 28th February.

Was the school response to Child B's emerging and escalating needs in November 2016 sufficient?

4.19 Child B first asked to speak with the Student Support Officer / Deputy Designated Safeguarding Lead on 3rd November 2016. Until that point there had been no indicators of any concern for or about him. The integrated chronology demonstrates that the school took appropriate and timely steps in response to the evidence of Child B's escalating distress in school and to the concerns expressed by his parents.

4.20 A parents evening on 8th November provided an opportunity for Child B and his father to talk about their worries. The Head of year 11 followed this up with a request that the Student Support Officer / Deputy Designated Safeguarding Lead speak with him and circulated an email alerting all staff to the difficulties that had been shared.

4.21 The Student Support Officer / Deputy Designated Safeguarding Lead was available to and frequently saw Child B throughout November 2016. The integrated chronology records specific meetings with Child B on 9th, 22nd and 23rd November. She provided him with information about a range of relevant on-line resources that he could access for further help.

4.22 The Student Support Officer / Deputy Designated Safeguarding Lead liaised with Child B's father on 9th, 15th, 22nd and 23rd November. She actively encouraged and supported Child B and his father to secure a referral to and help from CAMHS and undertook to make additional contact herself if needed.

4.23 The Student Support Officer / Deputy Designated Safeguarding Lead liaised with CAMHS on 21st and 23rd November, shared relevant information and contributed to the intervention plan. Throughout the remaining months of Child B's life, he made frequent use of opportunities to share his worries with the Student Support Officer / Deputy Designated Safeguarding Lead and she gave him practical help and support. The Head Teacher and Head of Year supported her to create a risk management plan to ensure Child B's safety and the safety of others within school. They also worked creatively to support Child B completing his GCSE studies.

4.24 Other services could have been enlisted by the school when the first signs of Child B's difficulties emerged. The Early Intervention Team could have engaged with the whole family at home at this early stage but might still have been superseded by the involvement of the counselling service and CAMHS as the extent of Child B's mental health difficulties became apparent. Similarly, the School Nursing Service could have complemented the help given by the Student Support Officer / Deputy Designated Safeguarding Lead by bringing relevant expertise to understanding and managing Child B's established sleep problem, low mood, and his growing anxiety.

Could more have been done to support Child B?

4.25 Child B's school were consistently helpful to him and everything possible was done to ensure that he could attend school despite his escalating difficulties. His

temporary exclusion in late January was immediately followed by a meeting that put a plan in place to help him manage his anxiety in school with a view to resuming his studies. When it became clear in March that Child B simply could not manage the pressures of school life it was agreed with his parents that he need no longer attend. The school believed that this step could and should be supported on medical grounds. He was enabled to sit GCSE exams in the week before his death. Consideration was given to deferring GCSE exams to 2018 but Child B was keen to progress to sixth form. He was still enrolled at the school when he died.

4.26 The initial CAMHS referral to a counselling service in mid-November 2016 was appropriate to the difficulties known about at that time. When, within days, it became clear that he needed further assessment, CAMHS put appointments in place and began a parallel process of direct work alongside the contact already established by the counselling service. This level of service was similarly appropriate to the difficulties known about at that time.

4.27 Child B was admitted to hospital following his three attempted overdoses during the winter of 2016 / 2017 in accordance with the appropriate guidance (NICE, 2013). He received full nursing care and the correct safeguarding procedures were followed. On each occasion he was assessed within the hospital by an experienced Mental Health Nurse from the CAMHS crisis team. It seems that Child B found this process supportive since he subsequently asked to meet with him again. Thereafter, the focus of crisis intervention by the specialist mental health service practitioners was to calm and “manage” the situation. Although therapeutic sessions with the trainee Psychiatrist addressed some of Child B’s unhelpful thought patterns, the records do not indicate that Child B’s stated intention to harm himself or end his life were addressed.

4.28 Child B often disparaged the support he received. He is recorded as saying “nothing is helping, and nothing is changing”. He disliked having to repeat his story to different professionals. Child B often voiced his criticism of his parents, school, therapist, and support workers to other parts of the system but not directly to the person concerned. For example, he complained to his therapist about his father being critical, demanding and heavy handed, to specialist mental health service workers about being rejected by his school, and to his parents about the CAMHS therapist being unhelpful. These unfavourable comments were not examined as an expression of his bleak state of mind and catastrophic thinking processes. In the absence of constructive collaborative relationships between professionals this process seems to have gone un-noticed. When taken at face value, his complaints were open to misinterpretation, reinforced differences of opinion held between organisations, and fuelled a culture of blame and criticism.

4.29 Surrey Children’s Services offered to assign an Early Help practitioner in February 2017. The integrated chronology indicates that CAMHS Community Team, the

specialist mental health service and Child B's parents reached an agreement that this was unnecessary and could create "overload" while specialist mental health service workers were still involved. The specialist mental health service team includes Social Workers, but they were not involved with Child B or his family. This may have led to an erroneous assumption that the multi-disciplinary specialist mental health service Team was engaged in meeting all the needs of the whole family. The case was closed and an early opportunity for collaboration between Surrey Children's Services and the mental health professionals, working together to design and provide a holistic family intervention was lost.

4.30 As described elsewhere, the specialist mental health service undertook an assessment from late January 2017 and subsequently provided a comprehensive package of intervention for Child B. The service offered by CAMHS and the specialist mental health service has been examined by The Surrey and Borders Partnership NHS Trust and explored in evidence to the Coroner. The specialist mental health service Manager believes that the intervention fully met Child B's presenting needs.

4.31 There are several support and treatment strategies that were or may or may not have been considered but were never provided:

- School nursing service involvement at initial indicators of concern
- Help at the initial stages from Surrey Children's Services Early Intervention Team
- A child protection conference, plan, and intervention as the outcome of the Section 47 Enquiry undertaken by Surrey Children's Services
- Opportunities to revisit and reconsider recommending and prescribing appropriate medication
- Active encouragement to explore the benefit of prescribed medication targeted at helping to reduce his anxiety, raise his low mood, improve his sleep, potentiate psycho-therapeutic interventions. The specialist mental health service Mental Health Nurse recognises with hindsight that she could have provided more information to encourage Child B to reconsider his decision
- A period of respite from family life whether by calling on family and friends, using a foster placement or overnight stays in the specialist mental health service House
- Voluntary admission to psychiatric hospital for assessment
- Voluntary admission to psychiatric hospital to provide emotional containment
- Alternative psycho-therapeutic intervention when Child B proved unable to engage fully with the Cognitive Behavioural Therapy approach
- A working diagnosis, so that Child B could be helped to understand his disturbed thoughts/feelings/behaviour as mental illness, and

differentiate these from his core identity/sense of self
- Active support to restrict his engagement with social media and manage on-line communication with peers
- A risk minimisation or child protection plan that was agreed, "owned", and acted upon by all the key adults who supported him across different contexts
- A risk minimisation or child protection plan that provided a consistent workable strategy to promote Child B's well-being during periods of calm, and contain his anxiety during episodes of acute distress
- Certificated exemption from education on medical grounds, explicit encouragement to focus on recovery, and support to consider postponing his GCSEs.

Were police referrals into the MASH appropriately responded to against a background of an increasing frequency of missing episodes, concerns about possible psychosis and the impact social media could be having, as a factor affecting Child B's mental well-being?

4.32 When the police first referred Child B to the Multi-agency Safeguarding Hub on 20th December 2016, it had recently processed two earlier referrals from the Hospital on 2nd December 2016 arising out of Child B's first overdose of paracetamol, and from the Emergency Duty Team on 15th December 2016 because his father reported him missing.

4.33 The police referred Child B to the Multi-agency Safeguarding Hub on ten separate occasions:

- 20th December 2016
- 11th January 2017
- 17th January 2017
- 5th February 2017
- 10th February 2017
- 17th February 2017
- 24th February 2017
- 23rd March 2017
- 9th May 2017
- 27th May 2017

4.34 Crucially, none of these police contacts were perceived as child protection referrals and so none led to strategy discussions or to Section 47 Enquiries. The integrated chronology indicates that decisions to take no further action were generally based on the assumption that the existing involvement of the Community Child and Adolescent Mental Health Team, specialist mental health service and / or the Early Intervention Team already met all Child B's needs. It names 68 different staff within Surrey Children's Services who became involved in this case between December 2016 and May 2017 and suggests that 14 different managers took

responsibility for oversight of decisions made in Surrey Children's Services during this period. It is highly probable that discontinuity contributed to the service not recognising the complex interplay of factors affecting Child B's well-being as well as disregarding the escalating intensity and frequency of episodes reported by the police.

4.35 When the police referral was received on 9th May it represented the 3rd report of Child B as a missing person within a 90-day period. This triggered a protocol requiring a strategy discussion and the case was assigned to the Area Assessment Team. The Multi-agency Safeguarding Hub had, at that point, recently processed a referral from the Child and Adolescent Mental Health Team reporting an incident where Child B's father was believed to have used physical force to restrain him resulting in a fight between father and son. A timely assessment was completed but again concluded that there was no need for additional intervention and there was no further outcome from that referral. Should agencies have explored further the nature of the use of physical restraint and force, both in terms of the possibility of physical abuse and Child B's state of mind and the impact of this incident on his mental health and well-being?

4.36 The integrated chronology highlights how, when these multiple police referrals were received, social workers and the team managers with oversight of practice not only assumed that the mental health provision precluded the need for safeguarding intervention but also determined that Child Protection protocols need not be used because the parents were not a source of risk and were committed to protecting Child B.

4.37 This interpretation of the Multi-agency Safeguarding Hub's responsibility to take the lead role in assessing and managing risk meant that repeated opportunities were missed. As a result, the many complex and enduring factors affecting Child B were never fully understood as a source of harm or danger to him and to his family. The Youth Support Worker and Social Worker continued with a remit to support Child B within a preventative framework long after the Initial Child Protection Conference (ICPC) Threshold 4 had been reached and a Child Protection Plan could have been in place. (The Surrey Safeguarding Children Board operational guidance in place in 2016 – 2017 defined Level 4 as *"Children and families requiring specialist support in order to meet their needs, led by Children's Services, risk of significant harm. Children who require intensive help and support from a limited range of specialist services led by Children's Services. Agencies provide specialist services that are underpinned by wrap-around support services to help children 'step down'*)

How did agencies respond to "Child B's voice" and anxieties about delays in support, and his family's concerns?

4.38 Agencies witnessed and recorded Child B speaking in two distinct voices.

- Before the autumn of 2016 Child B was intelligent, articulate, increasingly mature and self-aware. In 2017 he was still, at times "his old self", and was able to present as competent to make his own decisions and choices when not in states of acute anxiety and distress.
- Child B persistently articulated low mood; catastrophic thinking; Intention to harm himself; morbid pre-occupations; plans to end his life; distrust of and growing anger towards family, friends, and all the professionals engaged with him; despair that "nothing is helping, nothing is changing".

4.39 The mental health professionals delivering his treatment prioritised the "competent" first voice. The case formulation promoted by the Consultant Psychiatrist and adopted by the specialist mental health service and the trainee Psychiatrist understood Child B's difficulties as emotional dysregulation especially in respect of relationship difficulties. His self-destructive and hostile behaviour was interpreted as a mechanism he learned to use to attract care and support in situations where he felt distress and lacked the capacity to self-soothe. This meant that his dips into extremely low mood, growing anger, and continuing suicidal intention were taken seriously as dysfunctional learned behaviour but were discounted as evidence of mental illness. The impact of this case formulation meant that mental health professionals prioritised the "competent" first voice and Child B's right to self-determination was privileged over his need for protection.

4.40 Child B's parents voiced their fears for his mental health and for his safety from November onwards to every agency with whom they had contact. Working together, they took action to safeguard Child B by instructing local pharmacists not to supply him with over-the-counter medication; locked knives and sharps away; confiscated ropes; tried to restrict his use of social media; monitored his internet searches; changed their working arrangements to be a continuous presence at home; searched for him whenever he went missing; and at times physically restrained him to prevent self-harm, destroying objects at home, or aggression towards family members. Some agencies encouraged and endorsed these steps, but they remained uncertain that their interventions would be supported. The absence of an agreed Child Protection Plan or risk management strategy left them with sole responsibility for determining how to behave, what to say, and how to seek the help of professional agencies during Child B's recurrent episodes of acute distress. At least 187 different personnel are named in the integrated chronology. Child B's parents explained their situation and concerns repeatedly to Police Officers, Social Workers, support workers, and mental health professionals in various roles. His father resorted to preparing their own document that summarised all agencies' involvement and key contacts. When he gave this to the police officer in attendance on 27th May it was described as "easy to read". Notwithstanding the services provided and the agencies involved it is understandable that his parents spoke of themselves as "as a family in crisis, crying

out for the help that never came".

How effective was family mediation and support for the family in coping with child B's increasingly violent behaviour and missing episodes?

4.41 In the early stages of Child B's difficulties, the counselling service offered him individual counselling and a series of family mediation meetings. These initial meetings were not difficult but nor, it seems were they especially helpful.

4.42 Child B's parents voiced the extent to which they felt out of their depth and overwhelmed many times. Several opportunities to consider the parents' need for support as carers of a child with mental health problems were missed by the Community CAMHS team, by the specialist mental health service and by Surrey Children's Services.

4.43 The Student Support Officer / Deputy Designated Safeguarding Lead at Child B's school listened, heard, gave due weight to their concerns, and worked closely with his parents. She shared the parents' sense that the sudden onset and rapid escalation of Child B's increasingly violent behaviour and missing episodes, as well as his apparent suicidal intention were driven by serious mental health problems. This affirmation of their worries by someone they trusted and who knew their son well was helpful, but it was no substitute for the effective support they needed.

4.44 Similarly, the Mental Health Nurse assigned by the specialist mental health service made regular home visits during which she listened to the parents' worries and fears. However, her apparent empathy for their struggles did not translate into treatment interventions that made a difference or effected sustained improvement in Child B's mood, thinking and ideation. She or her colleagues responded when the parents called for their help during emergencies, but ultimately their roles and responsibilities did not encompass the help the parents felt they needed from the psychiatric profession.

4.45 On 11th April 2017 Child B spoke with the trainee Psychiatrist about an incident two weeks earlier where his father had physically restrained him. This was not a one-off occurrence: his father had already been open with several professionals about other occasions when he had taken similar action to contain aggressive behaviour or prevent Child B from leaving the home. Indeed, the police had also made the judgement to use physical restraint several times and recorded their rationale for this course of action. In consultation with the Clinical Lead it was correctly agreed that this incident fitted the protocol for referral to the Multi-agency Safeguarding Hub as a child protection matter. But protocols, guidance and indeed the law prescribe what professionals can or sometimes must do, they do not determine how they should do it. In this case, the referral focused on the relationship between Child B and his father, and the father's use of force as a source of risk to Child B. Enquiries by the Social Worker within the Multi-agency Safeguarding Hub did not

lead to a strategy meeting and concluded that neither safeguarding intervention nor further additional services was required. However, the parents were left with the impression that physical restraint was prohibited. From then onwards they felt profoundly uncertain about how to manage those moments when Child B seemed likely to harm himself or go missing. The process deprived them of confidence in their own judgement and in their capacity to protect to Child B without being blamed or criticised.

4.46 Child B's parents repeatedly articulated their need for specific guidance about how to contain Child B's crises. There was a "Safety Plan" in place that was agreed, regularly reviewed, and updated. However, it was intended as a plan for Child B to follow when in distress. It was designed by him and did not serve as guidance for the parents who still held day-to-day responsibility for their son's well-being and safety. Child B's parents had the contact details of extended specialist mental health service and were provided with a list of potential sources of help out-of-hours. The overarching advice they were given by the lead clinician was that each emergency should be judged as it arose, and ordinary common sense should determine the correct course of action in each instance. This advice is not in itself wrong or misleading. However, as their anxiety for Child B deepened, their trust in professional judgement was compromised, and their confidence in themselves was undermined.

4.47 Although a Youth Support Worker and Social Worker were assigned to work preventatively with Child B and his family, the Integrated Chronology suggests that they played only peripheral roles in the case. The Youth Support Worker was rightly concerned that Child B's parents needed help to construct an agreed plan focusing on how they should support Child B through crises and keep him safe. This had not been achieved by the time he died. There is no evidence that their contributions had any positive impact on Child B's well-being or on his family's capacity to cope with his distress.

In January 2017 at the time of Child B's second paracetamol overdose in a six-week period, was there sufficient assessment of Child B's increasing risk of suicide?

4.48 The correct protocol for treatment and assessment was followed at the time of Child B's second paracetamol overdose in accordance with appropriate guidance (NICE, 2013).

4.49 The integrated chronology and documents prepared for the Coroner convey a strong sense of Child B's intense emotional distress on the day of his second paracetamol overdose. The events leading up to his hospital admission on 17th were highly charged: Child B's friends, his father, school staff, and police officers all tried without success to calm him, contain the situation, and prevent him from

harming himself. Those involved at the time believed that this incident represented a serious intention to kill himself.

4.50 Child B received medical treatment and 1:1 nursing care following admission to hospital. He remained on the ward for three nights.

4.51 Child B was assessed by a CAMHS crisis nurse who already knew him. This assessment was robust, systematic, and comprehensively recorded. It concluded with a recommendation for hospital admission.

4.52 Child B was subsequently assessed by the Child and Adolescent Consultant Psychiatrist attached to both CAMHS and the specialist mental health service. This assessment concluded with the recommendation to discharge him home and engage the specialist mental health service in community-based support. Neither the integrated chronology, the oral and written evidence given to the coroner, nor the lead reviewer's discussion with the Consultant Child and Adolescent Psychiatrist offer a detailed account of the risk assessment process and defensible decision making. It seems that the decision rested on Child B's vivacious presentation suggesting that he was "not particularly depressed", and on the score from his own response to the Child Depression Scale. The Consultant Child and Adolescent Psychiatrist has acknowledged that "it was all a bit unclear". In his clinical judgement Child B's presentation precluded a diagnosis of major depressive disorder, the likelihood of successful suicide was low. He concluded that hospital admission was contra-indicated. The record of the Child Death Review Meeting held on 19th September shows the Consultant Child and Adolescent Psychiatrist stating that "Child B did not meet the criteria for admission to a psychiatric hospital and there was clear professional consensus around this". He later asserted in evidence to the Coroner that "hospital was never a serious consideration because we had a comprehensive range of services in the community".

Was the response to Child B's deteriorating mental health appropriate and timely?

4.53 Child B's school responded effectively to his initial request for help and engaged in respectful communication with his parents so that they were able, to reach the conclusion together, and with Child B's agreement that he needed CAMHS support.

4.54 The CAMHS Community Team contribution to assessment when Child B's mental health problems first came to their attention was both appropriate and timely. The children's health referral portal triage intervention, and referral for individual counselling to a counselling service took place the same day that the GP's letter arrived. This immediate response was congruent with the very recent concerns about anxiety and poor sleep presented at that time.

4.55 Within the week following the referral to a counselling service information shared with the children's health referral portal, both by Child B's parents and the school,

led to a swift reappraisal of need. Following triage by a Mental Health Nurse from the Community CAMHS team on Friday 25th November she offered him an emergency appointment on Tuesday 29th November. Child B took an overdose of paracetamol the next day and was assessed in hospital by a Mental Health Nurse who was a colleague from the same team. The Community CAMHS team put in place a revised treatment plan involving ongoing appointments with the CAMHS Mental Health Nurse alongside the counselling appointments already agreed with the counselling service.

4.56 When Child B took a second overdose on 17th January 2017, he remained on the hospital ward for three nights. Once medical treatment was completed, the crisis assessment worker, a Mental Health Nurse attached to the Community CAMHS team already working with Child B, went out of his way to meet with him outside of his on-duty period rather than have him seen by his colleague who had no prior knowledge of Child B or of the treatment already under way. This was the same nurse that had met with Child B following the 1st overdose in December. Child B had, in fact asked to work with this same nurse rather than the practitioners assigned to his case. The written report resulting from this assessment indicates that it was approached in a thorough, systematic way. The report demonstrates that the practitioner has reflected on the whole story and brought robust analytical skills to bear on the complexity of Child B's troubled presentation. It reached the conclusion that Child B's mental health difficulties needed further investigation. Given the continued escalation of these difficulties throughout a period of planned community-based assessment and intervention, it recommended further assessment should at this stage take place in the context of a psychiatric in-patient ward.

4.57 It was therefore appropriate that the Consultant Child and Adolescent Psychiatrist for CAMHS Community Team and the specialist mental health service should conduct the next stage of assessment. The specialist mental health service is intended for young people experiencing complex mental health, emotional, social, and behavioural needs that could require a Tier 4 hospital admission. Its goal is to prevent or shorten hospital admission by meeting those complex needs while supporting the young person in their own home.

4.58 The Consultant Child and Adolescent Psychiatrist recommended that Child B's assessment and treatment be transferred to the specialist mental health service. This decision represents a crucial watershed moment in the decision-making process. As discussed in paragraph 4.73-74 this was a judgement made by the Clinical Lead with medical responsibility. Its rationale is not entirely transparent.

4.59 There followed a period of assessment by the specialist mental health service but there is no formal record of its conclusion other than a letter confirming that the specialist mental health service would continue to work with Child B and his family.

4.60 Oral evidence to the Coroner and interviews conducted in the preparation of this report indicate that subsequent intervention by the specialist mental health service and CAMHS practitioners rested on a case formulation that Child B did not suffer from mental illness and that his presentation arose out of maladaptive behaviour intended to attract care and support. It was anticipated that this maladaptive behaviour would take time to "unlearn". Nowhere in the record is this case formulation set out, nor is there any evidence to suggest that its implications were explained to other professionals or to Child B's parents. Indeed confusion arose out of letter from the trainee Psychiatrist to Child B's GP on 20th February 2017 that led those outside of the mental health professional network to believe that a formal diagnosis of 'Mixed Anxiety and Depression' had been made.

4.61 The specialist mental health service provided an intense intervention package from 24th January 2017 until Child B's death consisting of several threads:

- A recently qualified Mental Health Nurse was assigned to provide intensive community outreach with Child B and his family. She generally made planned visits to the family home at least once a week, liaised with his school, and responded to any specific requests for support in moments of crisis.
- Child B was offered cognitive behaviour therapy with a trainee Psychiatrist on placement within the CAMHS service.
- Child B's parents accessed the extended specialist mental health service if they needed help or advice during the evening or weekend daytimes.
- Once withdrawn from school in late March Child B was able to access the specialist mental health service Day Programme. Although there is reference to a timetable of 2 days each week, the calendar provided by his parents and the specialist mental health service case records both indicate that he attended on eight days during March and May.
- It is evident that the specialist mental health service provided a range of services to Child B intended to meet his needs from several angles. It is less evident that this strategy met his needs and addressed the continued deterioration of his mental health. The CAMHS Community Team and specialist mental health service practitioners asserted both in evidence to the Coroner and at interview that Child B's mental health improved as their intervention progressed. However, recurrent episodes of acute distress, repeated references to killing himself by various means, and growing anger were documented and shared both by his parents and school records throughout March, April, and May 2017 with only a brief period of relative calm reported in mid – late April.

4.62 The fact that Child B met the criteria for specialist mental health services means that his treatment needs outstripped what could be offered within the CAMHS community services at Tier 3. It implies that his needs could best be met, and risk safely managed within the community, whilst recognising that he reached the

threshold criteria for Tier 4 services i.e. assessment or treatment in a hospital setting. Within this context at the "edge" of Tier 4, the specialist mental health service differentiates between Low, Medium, and High risk. It also uses the colour coding "traffic light" metaphor to articulate risk.

4.63 Risk assessment is always a dynamic process. Inevitably it is also highly subjective. In the context of children's safeguarding the multi-agency network usually manages this in three distinct but interwoven ways:

- the use of explicit measures to describe risk
- multi-disciplinary discussions where different understandings of risk can be shared, compared and consensus agreed
- evidence-based and transparent threshold criteria to determine the fit between individual need and professional intervention

4.64 The integrated chronology indicates that these processes were not implemented effectively during the final 4 months of Child B's life. Despite the accumulation and escalation of indicators from February onwards that Child B's mental health continued to deteriorate, the specialist mental health service persevered with the original treatment plan. During their involvement with Child B he was mostly categorised as Low Risk. Although the service responded to crises as and when they arose, because escalations in risk were seen as sporadic, sudden and relatively short-lived his escalating needs were not re-evaluated. In the context of their work with children with significant mental health difficulties, and their extensive experience of working with self-harm, specialist mental health service practitioners need to guard against becoming desensitised to self-destructive behaviour in the same way that practitioners in Surrey Children's Services need to avoid internalising high thresholds for intervention.

4.65 Having declined medication in January 2017, Child B was not offered this option again. The question of whether Child B's symptoms met the criteria for a diagnosis of major depressive illness and whether medication should therefore have been recommended was rehearsed at length before the Coroner. Those who knew Child B well (his parents and teachers) and spent time with him every day believe that he did manifest the requisite symptoms of Major Depressive Disorder. We will never now know whether his difficulties would have responded to the evidence-based pharmaceutical interventions indicated for the persistent anxiety, low mood, sleep problems, and anger he experienced.

4.66 From February 2017 Child B attended a series of meetings with a trainee Psychiatrist under the supervision of the Consultant Child and Adolescent Psychiatrist. The minutes of the second Child Death Review Meeting together with the trainee Psychiatrist's evidence to the Coroner indicate that Child B was unable to benefit from the Cognitive Behavioural Therapy approach followed in these sessions. Crucially, he did not complete the tasks assigned to him between sessions that serve as the lynchpin of this form of therapy. It seems that as these

sessions progressed Child B continued to report low mood, couched his thinking in "black and white", catastrophic terms, and articulated angry feelings about both his school and his family.

4.67 The structure of the specialist mental health service is designed around the principle of multi-disciplinary collaboration. There are frequent and regular opportunities for case discussion within the team, and for different perspectives to be heard. The Mental Health Nurse's case notes record that Child B was discussed within the specialist mental health service team on 29th March 2017. Although the notes name various issues the process of this discussion is not on record.

4.68 In the case of Child B, effective multi-disciplinary collaboration did not extend beyond the specialist mental health service team. Each agencies' records report information-sharing by phone, via email and in some face to face meetings. However, these records convey little sense of purposeful collaboration. Referrals were made to Children's Services but there is no evidence that the Consultant Child and Adolescent Psychiatrist in his role as Clinical Lead sought to integrate the social work assessment and subsequent intervention with the mental health service plan. The school's prior knowledge of Child B, engagement with his parents, insights into his relationships with peers, and direct experience of his acute distress were not harnessed to inform the assessment. Education professionals who had worked with Child B for five years felt that their information and perspective were not heard, acted upon or respected by the mental health professionals. Their view of the dynamic between the school and the psychiatric services has been borne out in the process of this review.

4.69 The view of the Clinical Lead was, and is still, that the treatment plan for Child B was the optimal approach to meet his needs, and that his mental health improved accordingly during the spring of 2017. His thinking during that time shifted towards the view that the source of Child B's distress lay within the family dynamic.

4.70 An incident where Child B's father physically restrained him prompted referral to Surrey Children's Services as a child protection matter and resulted in a Section 47 Enquiry. An internal referral was made for family therapy within CAMHS and this was due to start in late May 2017. These are telling examples of Child B's account of family life being taken at face value without due reference to context.

4.71 Review of the integrated chronology offers another interpretation of this period. There were indeed fewer episodes of acute distress during April. This period partly coincided with the school holidays. Child B stopped attending school in late March 2017, when the Safeguarding Leads and parents together took the view that being in school put unmanageable pressure on Child B. They were united in their concern that performance anxiety, a sense of failure and troubled dynamics within his peer group at school were important components of Child B's distress. They

hoped that being out of school would remove the pressures that previously served as triggers for Child B's "meltdowns". He was not excluded from school or removed from the school register.

4.72 Child B's parents were still extremely worried throughout the spring. They continued to express urgent concern about his low mood, possible substance misuse, his trips to the woods with ropes, the impact of contact with friends via social media, and his research on suicide websites. These were shared with the mental health professionals as well as voiced to social workers conducting the Section 47 Enquiry. His parents acknowledge the relative calm of this period when there were fewer dramatic episodes and "meltdowns" but did not feel that Child B's difficulties were resolved or even diminishing.

Despite there being significant multi-agency support for Child B, was there an agreed co-ordinated care plan in place?

4.73 There was no agreed multi-agency co-ordinated care plan. No child protection plan was put in place to guide the multi-agency network's input to keeping Child B safe.

4.74 The integrated chronology highlights several missed opportunities for Surrey Children's Services to step into a lead role to drive a co-ordinated plan that could promote a constructive treatment plan, address the parent's need for ongoing support with the challenges of safeguarding Child B, and oversee a jointly agreed inter-agency strategy for minimising risk and managing crises.

Was a lead professional identified?

4.75 The case notes of the Consultant Child and Adolescent Psychiatrist within CAMHS Community Team and also attached to the specialist mental health service clarify that he held medical responsibility and was the Clinical Lead for Child B.

4.76 From late March 2017, a worker from the Youth Support Service had some involvement with Child B and his family. In April 2017, a brief assessment resulting in no further action was carried out within the Multi-agency Safeguarding Hub in response to the only safeguarding referral made by CAMHS. On 10th May 2017, the case was allocated to a newly qualified Social Worker in the Assessment Team. Since she was unable to begin this work it was re-assigned to a Senior Family Support Worker on 24th May. There is no record within the Integrated Chronology of any Strategy Meeting, Child Protection Conference, or Child in Need in meeting. It is not clear therefore what formal mandate underpinned the work of Surrey Children's Services during this period.

4.77 Child B's parents have stated that they did not know who to go to as the key professional with oversight of his care.

4.78 Neither the Consultant Child and Adolescent Psychiatrist nor any personnel within Surrey Children's Services enacted the role of lead professional. The integrated chronology gives no indication of a lead professional being identified.

Was there appropriate clinical supervision?

4.79 Clinical supervision is only applicable to health professionals, nursing and medical staff. There is insufficient detail within the Child and Adolescent Mental Health Service and specialist mental health service contributions to the Integrated Chronology to afford insight into the quality of clinical supervision in this case or analyse how clinical supervision influenced practice and decision-making.

4.80 The Terms of Reference and scope of the Safety Investigation Report prepared in September 2017 by Surrey and Borders NHS Trust made no mention of clinical supervision. The Safety Investigation Report makes neither comment nor recommendations in respect of clinical supervision.

4.81 It has not been possible to examine records of the supervision process in this case nor review the quality of supervision received by CAMHS and specialist mental health service practitioners.

4.82 Interviews with the Service Manager and the Mental Health Nurse within the specialist mental health service assigned to Child B and his have clarified the supervisory arrangements within the specialist mental health service as follows:

- The Mental Health Nurse received both line management and clinical supervision from the Lead Nurse on a one-to-one basis
- Cases could be raised for discussion at weekly local team meetings led by the team manager
- Each of the professional disciplines met for monthly group discussion led by one of the therapists
- Each team met for monthly group discussion led by an independent therapist
- The Team managers met for monthly group discussion led by an independent therapist

4.83 Witness evidence given to the Coroner by the Consultant Child and Adolescent Psychiatrist and the trainee Psychiatrist indicated that they met weekly for supervision but did not always discuss Child B. The trainee Psychiatrist could also discuss Child B informally with colleagues in the hub area.

5 FINDINGS

5.1 Child B's experience highlights how the multi-agency network's responsibility to safeguard children in mid-adolescence is affected by ambiguity and subjectivity. It is inevitable that each individual practitioner's approach to these ambiguities is

influenced by their core beliefs; professional values; personal and professional experience; training background; practice context; team culture; organisational practice and policy; and supervision. Each of these factors varies from individual to individual both within each profession and across the different professional disciplines.

5.2 Decision-making and practice were affected by unresolved differences of opinion between professionals within the multi-agency safeguarding network. The experience of Child B and his family was determined by differing perspectives in relation to the following themes that commonly arise in similar situations:

5.3 **Competence:** UK statute is profoundly confusing regarding children's rights and responsibilities. The age at which children become responsible for their own decisions varies in relation to criminal responsibility; consent to sexual activity; marriage; health choices; leaving home; the right to vote. The Mental Capacity Act, 2005 provides frameworks to empower and protect adults who may not have capacity to make certain decisions for themselves, but it does not apply to children under 16.

5.4 **Self-determination and personal growth:** Practitioners across the multi-agency network face challenges when charged with responsibility for safeguarding children in mid-adolescence. Achieving the right "fit" on the continuum between taking necessary steps to protect a vulnerable child placing themselves in danger and affording them opportunities to understand and manage risk for themselves is the central challenge of safeguarding practice throughout the secondary school years.

5.5 **Safeguarding Responsibility:** The Children Act, 1989 determines that parents retain parental responsibility to the age of 18: read alongside the statutory guidance contained in Working Together to Safeguard Children the powers and duties of the multi-agency network include safeguarding children to the age of 18. All parents and professional practitioners recognise that these responsibilities must be enacted differently as children grow and develop. However, the detail of when and how children should be afforded opportunities to exercise freedom and learn to look after themselves varies from child to child, parent to parent, family to family, across cultures. Inevitably, in adolescence all children assert their need to choose their own friends and ways of spending time and every parent must decide how to manage this while still making sure that their child is safe. These dilemmas are compounded by ambiguity about the relationship between the individual, family and state that lies at the heart of safeguarding practice.

5.6 **Hospital Admission and Treatment**: Most people make a rational choice to avoid being admitted to hospital until or unless necessary. Nursing practice and treatment processes in hospitals can leave people feeling disempowered (Department of Health, 2001). For many patients there is a risk that they will become "institutionalised" and soon feel unduly dependent on medical care. These

risks apply regardless of whether patients are admitted to hospital for physical or mental health problems. Nevertheless, most people take rational decisions and follow medical advice to go into hospital when they need to. In the UK our mental health legislation emphasises professional responsibility to ensure that, regardless of age, treatment for mental health problems is provided using the "least restrictive alternative" and sets out safeguards to ensure that psychiatric patients are only assessed or treated compulsorily in hospital according to strictly prescribed criteria. Hospital care for children with mental health problems carries known risks, should never be recommended lightly, but is sometimes necessary for their safety, and can serve as the threshold for recovery in the same way for children as for adults.

5.7 **Risk assessment.** Theories of risk are complex and hotly contested (Power, 2004; Webb, 2006). Within the field of safeguarding children, it is widely acknowledged that actuarial risk assessment methods and clinical judgement are both useful, but both are also flawed. Reaching a consensus about risk is difficult because risk analysis is highly subjective. Risk assessment is a dynamic process that considers fluctuations across time and different contexts. Sometimes assessments fail to discuss families' needs because safeguarding procedures align with scarce resources to drive practice into responding primarily to specific incidents where harm was perpetrated by person(s) who abused the child. Professional practitioners with responsibility for assessing and analysing risk assessment need to bring skill, knowledge and experience, and an open mind. Risk analysis should address all foreseeable sources of potential harm. No professional practitioner can be expected to predict and prevent every possible danger to a child but must be able to demonstrate defensible practice. Practitioners across different services may take quite different approaches to risk assessment. Talking about risk, how risk is perceived and respective approaches to risk assessment is therefore fundamental to effective collaboration. There is always ambiguity but all professional practitioners can be expected to articulate how they have gathered and examined information, explored, and weighted different opinions, drawn on the professional evidence base and guidance, formed their judgement and reached their conclusions.

5.8 **Risk Management:** Effective plans for risk-taking, tolerating uncertainty, risk-minimisation and promoting safety rely on robust risk analysis. Outcomes are easier to predict when risk is low than in high-risk situations (Hayes and Spratt, 2009; 2012). Risk management like risk assessment is an inexact science, never fail proof and therefore must be completely transparent in process and content. It is appropriate that practitioners working to minimise risk of harm to a child should feel anxiety since complexity and uncertainty are inevitable, but their burden can be shared across the multi-agency safeguarding network: 'a trouble shared is a trouble halved'.

5.9 **Understanding and communicating with children:** The principle of understanding behaviour as communication is as relevant for children in mid-

adolescence as for younger children. As with adults, what they say cannot be taken at face value but must be weighed against what they do. Difficult behaviour in mid-adolescence is often best understood as an indicator of distress, just as it is in earlier childhood. When children place themselves in the way of danger, whether intentionally or unintentionally, their behaviour is always a safeguarding concern.

5.10 **Social media and on-line communication:** Adolescence is a period of fundamental and sometimes rapid physical, neurological, psychological, and intellectual change in preparation for adulthood. It is also therefore a period of potential susceptibility (Stein, Ward and Courtney, 2011 cited by Brown and Ward, 2012). The fact that young teenagers are second only to babies in suffering untoward death is testament to their vulnerability (Brandon, Bailey and Belderson, 2010). There is little discussion or consensus about the kind of care adolescents need within families and from the state. The increased incidence of self-harm and child sexual exploitation have exposed the detrimental impact that technological advances have had on some young people. The significance of social media for young people's physical and mental health in the short and longer term is not yet fully understood. The evidence for both positive and negative impact is sketchy and further research is needed. Anecdotally, some parents are thought to be learning from difficult experience with their own teenagers that they need to restrict the access they afford younger children to computers, tablets, and phones. Bullying, body-shaming, rumourmongering, manipulating, shifting loyalties, questioning gender identity and sexual experimentation are all familiar aspects of early teenage life but are now conducted on-line within the family home and in classrooms as well as in the playground and streets. The pressure of continuous contact with peers via messaging is increasingly recognised as a potential source of anxiety and distress for some children, especially when they stay on-line at night and sleep patterns are interrupted.

5.11 **The rule of optimism:** The work of professional practitioners in the multi-agency network is primarily directed at creating change and enabling development. The contemporary emphasis on strengths based / recovery models across many fields of practice mirrors this expectation. However, in the safeguarding arena it is necessary to guard against naivety. In the context of danger, the presence of strengths does not necessarily represent safety.

5.12 **Skill, knowledge, and experience:** Public, voluntary, and not-for-profit organisations working with children and families find it increasingly difficult to recruit and retain experienced and professionally qualified staff. The multi-agency network has become reliant upon employing inexperienced unqualified staff and newly qualified practitioners to fill vacant posts and sustain the establishment needed. To engage purposefully with complex cases practitioners in all the different roles across the safeguarding network need depth of knowledge, breadth of experience, refined emotional literacy, and flexible interpersonal skills. They must be able to

access knowledge that is often highly specialised and understand the significance of evidence from research. They must be able to do this while simultaneously holding in mind the unique experience of each child and their family. Only a few new recruits bring this capacity with them when they start out. It also takes time to integrate the personal, professional and role authority that underpin professional practice. Practitioners cannot exercise authoritative practice with children and families until these have been assimilated. The ability to debate, challenge, understand, negotiate, and resolve differences of opinion across the multi-agency network relies on practitioners having overcome all these developmental challenges. They must find a way to internalise their early practice experience to form a personal / professional identity that will sustain them through their working lives as instruments of change and positive role models. Professional education, in-house training programmes, and individual commitment to independent learning are not enough to enable practitioners to achieve these transitions. Workplace learning is and always has been the cornerstone for professional development that equips practitioners with the diverse range of skills demanded in work with children and families where needs are complex and risks uncertain. The role of experienced work colleagues and practice leaders in creating purposeful teams cannot be underestimated. At best, where work-based learning is neglected the development of good practice is likely to be compromised and at worst, opportunities are created for poor practice to take root.

5.13 The multi-agency network shared information about Child B and his difficulties well-enough. The difficulty lay in making sense of that information. Differences of opinion arose between professionals as to the meaning of his distress and behaviour. These differences were mirrored within the informal network that Child B turned to for help. All the issues outlined in paragraph 5.2 (above) played a part. Essentially a split developed whereby the same information was interpreted differently. The school and Child B's parents believed that he suffered rapid onset of mental illness that should be diagnosed and treated. Their awareness of his morbid preoccupations and repeated insistence that he would die soon led them to believe that he planned and intended to take his own life. The mental health professionals formed the opinion that Child B was unable to regulate his emotions and lacked the ability to self-soothe when he experienced stress. Relationships between practitioners were friendly and constructive. This meant that the extent to which they disagreed was not understood, issues were not challenged, and differences of opinion went unresolved.

5.14 Because the differing perspectives of the various agencies involved with Child B were not exposed they never informed an agreed and integrated assessment of risk. Opportunities were missed to convene Strategy Meetings and a Child Protection Case Conference, either of which could have afforded a forum to explore and get to grips with the safeguarding issues in this case. This in turn affected the planning process. The "safety plan" spelt out Child B's chosen strategies for

managing his emotions, and the “care plan” described interventions to be made by the mental health services. Neither was intended to help the parents or school perform their responsibilities. There was no multi-agency risk-minimisation plan, risk management strategy, or child protection plan put in place to enable the safeguarding network to help his parents protect Child B from placing himself at risk of harm. These missed opportunities indicate a whole-system problem.

5.15 The climate of the multi-agency network caring for Child B seems not to have afforded opportunities for constructive challenge. Disagreements became embedded as conflicts and gave rise to distrust between agencies. Far from achieving a sense of working together to meet the needs of Child B, the School Safeguarding Leads, the professionals who had the most long-term understanding of Child B and who knew his personality and behaviour well came to feel unheard and misunderstood by decision-makers in the mental health services.

5.16 The fact that differences of opinion were not explored suggests that a lack of professional curiosity served as a counterpoint to and reinforcement of the systemic difficulties around constructive challenge. Every time different perspectives were voiced between members of the team around Child B there were missed opportunities to examine meaning. For example, with the benefit of hindsight it is clear that numerous questions were not asked such as:

- Did the agencies involved with Child B hold different information about him?
- Did the agencies hold the same information but understand or interpret it differently?
- Did some professionals hold specialist expertise that could be shared with a view to enhancing the interventions of others?
- Did any general organisational objectives interfere with meeting the individual needs of Child B?

5.17 Had these and other questions been explored, new insights could have informed the plan to address and manage Child B’s deteriorating mental health in the months leading up to his death.

5.18 Several entries into the integrated chronology indicate that the practice of the many police officers that became involved with Child B and his family was clearly described and explained. The account provided of the work undertaken by the Student Support Officer / Deputy Designated Safeguarding Lead is detailed and explicit. The crisis assessments undertaken immediately after Child B’s first two hospital admissions for overdose were exemplary. The specialist mental health service’s Nurse’s case notes provide a full descriptive narrative of her contact with Child B, his parents, and other agencies. The trainee Psychiatrists records and letters to Child B’s General Practitioner outline the content and process of his therapeutic sessions with Child B.

5.19 The key practitioners interviewed for this case review have been able to articulate how and where they reflected on what they observed and heard. However, their reflective and analytical process is not contained in the record, nor is it evident in the documents that were shared across the network. Whereas professionals and parents may have thought they were all working together and "on the same page" Child B's death has exposed how little they had developed a shared understanding of his distress. Profoundly different perspectives on the meaning of his distress inevitably led to different ideas about the best way to intervene, treat and manage Child B.

5.20 The Surrey and Border Partnership Trust's case record does not clarify how the Consultant Child and Adolescent Psychiatrist formed his opinion of Child B's mental health status and planned his treatment. The Child and Adolescent Consultant Psychiatrist's records of his direct contact with Child B are very brief: they describe Child B's presentation and summarise his clinical judgements in note form.

5.21 The Child and Adolescent Psychiatrist's view that Child B did not suffer from a diagnosable mental illness and was at low risk of actual self-harm or suicide informed the mental health service intervention plan even though it was repeatedly contradicted by parents and school staff who perceived Child B as seriously ill and a real source of danger to himself.

5.22 Several clinical decisions were queried within the Safety Investigation Report prepared by the Surrey and Borders Partnership in the early autumn of 2017 and in their medical review of the serious incident, dated 30th October 2017. In particular this report highlights that on 2nd December 2016 and 12th May 2017 it would have been more appropriate to rate Child B's risk as High / Red or at least Medium / Amber (behaviours have escalated) rather than Low / Green (engaging with services, attending school, placement intact).The reasoning behind these decisions has not subsequently been made transparent in the evidence provided to the Coroner or in the interviews conducted for the purpose of preparing this report.

5.23 Child B's story exemplifies how essential it is that all practitioners across the whole safeguarding network articulate how and why they reach the judgements on which subsequent actions rest. Every intervention should be evidence-informed, and every decision should be defensible. Responsibility for transparency and accountability is a matter of professional ethics. It requires more than simple compliance with guidance and procedures. Whether in case notes, within minutes of meetings or within supervision records whenever practitioners do not commit critical reflection to the written word opportunities for explicit examination of meaning and shared understanding are lost.

5.24 Child B and his family struggled to live with his sleep difficulties; low mood; anxiety; his self-harm and risk-taking behaviour; morbid interests; and episodes of bizarre or aggressive behaviour. Initially his parents offered unconditional love and support

matched with clear boundaries and expectations. As his distress escalated and his behaviour became more shocking and difficult to contain, they openly shared their sense that something was seriously wrong with Child B. They repeatedly asked for advice and most importantly explained that they no longer knew how to keep him safe from harm. They locked away all sharps and household medication, attempted to minimise the impact of social media and on-line communication, asked local pharmacies not to supply over-the-counter medication to Child B, confiscated knives and ropes, and on occasion physically restrained him to prevent him from causing material damage, injury to himself or others and from leaving the home in an agitated state. They were candid about the stresses this placed on them, their concerns for their younger son living alongside Child B, the disruption to everyday family life, and changes in their employment that they felt compelled to make in order to be continuously available. As his distress deepened their love and support met with his anger and sometimes open hostility. Once Child B was demonstrably in serious emotional and psychological distress, suffering sleep problems, continuous low mood, and frequent episodes of acute anxiety they could and should have been regarded as his carers. The involvement of the specialist mental health service marks a recognition that Child B's second overdose brought him to the threshold of admission to hospital. When it rapidly became clear that the parent's responsibilities towards Child B exceeded those of a healthy 15 – 16-year-old their needs as carers should have been assessed under the provisions of the relevant legislation. Had the parents' requests for support been understood as the consequence of their role as carers their need for advice, guidance, and services (including respite care) could have been framed very differently. The Child in Need plan for Child B missed the mark because its frame of reference was mis-directed. The Child and Adolescent Mental Health Service should have been there to meet Child B's need for effective treatment. The proper role of Surrey Children's Services was to identify a package of care to meet his parents' need for guidance, practical help, and emotional support and to co-ordinate a multi-agency plan.

5.25 Since Child B's difficulties escalated sharply in November / December 2016 to meet the threshold for CAMHS Tier 3 services and continued to escalate towards the threshold for Tier 4 (hospital admission), reasonable adjustments to meet his educational needs should have been managed on medical advice. In late January, after his second overdose and the traumatic context in which it arose, the Designated Deputy Safeguarding Lead put in place a risk management plan to be used when Child B returned to school. In the weeks that followed it became clear that Child B's anxiety and distress could not be contained safely within school. Consequently, Child B's parents and school staff improvised a plan to relieve him from the pressures of school, he stopped attending altogether, individual tutorial home visits were arranged, and the specialist mental health service day programme stepped in with part-time provision. Sadly, Child B persistently misconstrued this arrangement as a rejection and directed much anger towards the school staff. These arrangements could and should have been supported with

exemption from education on medical grounds and referral to Access to Education (A2E). Having been out of school through March, April and early May he went back into school to sit GCSEs only in the week immediately before he hanged himself.

5.26 Child B's parents and the professionals who knew him well shared concerns about his use of social media, and the negative impact of communicating with his friends and peer group by text. The Student Support Officer / Deputy Designated Safeguarding Lead were shown texts by his friends that described his despair, thoughts of self-harm and plans to end his life. Child B's parents worried that they witnessed his mood plummet or anger rise in response to text messages that upset him. His parents often had to rely on his friends to alert them when Child B put himself in danger. When his parents attempted to monitor Child B's on-line activity, they discovered visits to websites about suicide and specifically death by hanging. It is difficult to know, even with hindsight, how Child B's on-line activity affected his sleep and mood. Its contribution to his mental illness, fluctuating presentation and rapid deterioration will never be fully understood.

5.27 It was difficult for Child B's parents and school staff to make sense of his rapidly escalating anxiety and episodes of intense emotional distress. As discussed above, opinions differed across the network as to the severity of his problems and risk of suicide but there was broad agreement that the causes of his distress were uncertain, and his needs were complex. With an evolving set of interlocking issues and constraints and no definitive solution, Child B and his family needed the multi-agency system to adopt a collaborative and inclusive approach if they were to find a purposeful way forward (Grint, 2005). Although it has become commonplace for case reviews to identify the challenges of working together as a root cause of child deaths the issue is not trite and still needs to be addressed. Detailed examination of Child B's experiences and the fact that he took his own life (whether intentional or not) suggests the need for a transformational approach to collaborative practice in similar cases. Current research across diverse academic subjects indicates that interdependence is a powerful asset when allied with social intelligence. The various practices and disciplines across the multi-agency network draw on similar concepts, ideas, and words. Understanding how these migrate and move from one to the other is vital to how professional groups communicate knowledge to one another. It is now widely recognised across all fields of endeavour that creativity flourishes most readily between existing disciplines, calling for an openness of mind that is best fostered by sharing a common goal with people of contrasting approaches. Child B's death highlights the significance of contextual safeguarding where the primary source of danger is the child himself. Practice innovation is needed to ensure that the multi-agency network come together to plan holistic constructive intervention and treatment as soon as such safeguarding concerns are raised in any part of the system.

5.28 Over time Child B was at risk of harm in several different contexts and in several different ways. The many ways in which Child B placed himself intentionally and unintentionally in danger were not construed as safeguarding concerns. This suggests a difficulty across the whole system in recognising the need for a risk assessment and child protection plan in Child B's case. When the Multi-agency Safeguarding Hub conducted a Section 47 enquiry it was unclear whether the focus should be the general context of risk or the specific concern that Child B's father was known to use physical restraint. The fact that Child B's parents were committed to keeping him safe was understood as a strength, but the extreme difficulties they faced that ultimately prevented them from achieving this goal were not recognised as a risk factor. The Signs of Safety model had been adopted across the multi-agency network at that time. This model enabled these strengths and risk factors to be named, but the fundamental principle that "safety is strengths demonstrated as protection over time" was overlooked (Turnell and Edwards, 1999).

5.29 That Child B's behaviour placed him at risk of harm but was not recognised as a safeguarding issue is particularly significant for the roles and responsibilities of Surrey Children's Services. Since the Section 47 enquiry concluded there were no concerns about risk to Child B from within the family, no further Child Protection processes were undertaken. The danger Child B posed to himself and clear statements from the parents that they no longer felt confident to protect him were not considered to meet the threshold for continuing child protection intervention. Subsequent input by the (local) Assessment Team did not include a risk minimisation plan that enabled a helpful distribution of roles so that CAMHS and the specialist mental health service could focus on treating Child B's mental illness, while Children's Services helped his family to keep him safe. This raises fundamental questions about the role of Surrey Children's Services in cases where other children are in a similar position i.e. receiving treatment from The Child and Adolescent Mental Health Service, at risk of making decisions / taking actions that place them at risk; not at risk of harm within the family, and the family commit to day-to-day responsibility but are unable to ensure safety. Structures and practice within Surrey Children's Services have changed in the intervening three years. The Adolescent Safeguarding Teams include CAMHS practitioners and now routinely assess and continue working with similar cases. In principle this enables co-working arrangements whereby the Child and Adolescent Mental Health Service focuses on the child's mental health needs, while the Adolescent Safeguarding Team support the family in the challenges of keeping the child safe.

5.30 The use of a range of different risk assessment protocols was profoundly confusing for Child B and his parents. It also gave rise to misunderstandings across the multi-agency network. For example:

- The various agencies across the network used different frameworks for assessing risk at different points in time and in different contexts.

- Organisations working at low thresholds for concern might deem a particular risk to be high while the same behaviour could score as low in a system that routinely works with a higher threshold
- Different assessment frameworks used various terms and metaphors to describe levels of risk e.g. low / medium / high; scales of 1 – 10; red / amber / green so that it was not always possible to discern whether assessments had yielded discrepant accounts
- It was sometimes unclear which risk factor was under assessment e.g. child to parent violence, physical abuse, domestic abuse, self-harm, harm to others, suicide
- The purpose of the child safety plan, the care plan and the child in need plan were unclear

5.31 The impact of these confusions on Child B and his family highlights the importance of systems that ensure risk assessment documents integrate all the information available to the child, the family and the whole multi-agency system so that they can inform an effective risk-minimisation plan. The various plans in place in this case did not address all the contexts in which Child B was likely to experience harm and did not make sense to the child, the family, and all the professionals involved.

5.32 Each organisation generated and worked to various kinds of safety plans, risk management plans and plans to meet Child B's needs. This was confusing and unhelpful. Child B's death highlights the need to build on recent service improvements achieved by the Adolescent Safeguarding Team's current approach to similar situations. Safety planning and risk management approaches will be further improved by adopting a collaborative multi-agency approach to the preparation of comprehensive risk-minimisation plans. A collaborative risk-minimisation plan should:

- be worked towards at first point of referral and generated as soon as possible e.g. as an outcome of strategy discussions
- complement and include the "Safety Plan" written and owned exclusively by the child,
- be prepared in close consultation with the child's parents, and informal network of carers, extended family, or friends as appropriate
- be drawn up by the whole network of relevant organisations involved with the child
- make sense as a holistic strategy so that each organisation's interventions are congruent with the plan and support its overall goals
- consider all the different contexts in which the need for it are likely to arise
- be explicit about the different kinds of danger, risk or harm that is anticipated
- name and outline the purpose of the different risk assessments that have been completed

- if actuarial risk assessment procedures have been used, explain the meaning of scores, how they have been interpreted, and spell out their implications
- be pragmatic and anticipate the challenges that those with responsibility to enact the risk minimisation plan are likely to face in practice
- co-exist with, complement, and carry the same weight as any Child Protection Plan in place
- carry the same weight as a Child Protection Plan where none is needed
- incorporate contingency planning to anticipate foreseeable problems
- be distributed to all relevant organisations involved with the child
- be provided in hard copy to the child, parents and any other people in the informal network that have accepted a role within it
- be made available (as appropriate regarding confidentiality) to other organisations that might become involved e.g. the Ambulance Service, Surrey Children's Service Emergency Duty Team
- be subject to regular multi-agency review meetings in close consultation with the child, parents, and the informal network for updating, amendment or revision.

5.33 Child B's presentation was indeed complex and fluctuated between extremes of apparent distress and calm. It was sometimes hard to understand. Various meanings were attributed to his behaviour by different parts of the multi-agency safeguarding network. The most telling feature of professional practice and decision-making in this instance is that treatment and intervention plans rested on an evaluation of Child B's difficulties and needs that did not change. A fixed view was sustained within the lead agency. Even though risk assessment, the safety plan and the care plan were reviewed, the support and treatment programme initially offered in late January was still in place in late May. This plan included appropriately intense service provision by mental health professionals but did not demonstrably improve Child B's mental health and safeguard him from intentional or unintentional harm. This was especially detrimental because the fact that Child B was offered this highly specialist and intensely resourced service perhaps led other professionals to step back. It is not clear from the documentation available why or how a fixed view came to affect the work with Child B. The perpetuation of a fixed view sometimes arises out of systemic difficulties that can affect the work of any team e.g. "groupthink", bullying or coercion, closed working alliances, poor boundaries, rigid hierarchies, rivalries, inappropriately low or high confidence, misplaced loyalties.

5.34 Child B's experience of the specialist mental health service's input underlines the need for continuous meaningful collaborative working even where highly specialist and well-resourced services take the clinical lead. It is important that the specialist

mental health service inter-disciplinary team should work holistically alongside services with long-term knowledge and understanding of the child and family. The work undertaken by the specialist mental health service should from the outset anticipate how other services will pick up the thread once their intensive input achieves change and their treatment outcomes have been met. For example, Child B ardently hoped to re-join his peers in the school's sixth form in September 2017. However, with his school attendance interrupted, uncertainty hanging over his GCSE outcomes and concern that he might not be well enough to progress to A-level studies in the autumn, Child B's plans for the future were in jeopardy. At this important watershed in his school career there was a particular need for the specialist mental health service to support him in working constructively towards his plans.

5.35 The interdisciplinary team working with Child B and his family from late January to May 2017 was mostly made up of relatively inexperienced staff. The record shows that individuals meeting regularly with Child B and his family made well-intentioned and conscientious contributions to the overall care plan. Child B's presentation of distress was difficult to understand, his needs were complex, and his parents found it overwhelmingly difficult to keep him safe. It is not clear whether the practitioners charged with responsibility for direct work in this case were able to process the ambiguous information they held, negotiate the contradictions, and make sense of uncertainty to provide the support and guidance Child B and his family needed. This team may not have had the knowledge and experience needed to be sufficiently open-minded, authoritative, skilful, flexible, and containing.

5.36 Several lapses of procedure and technical errors should be noted although they may not have contributed directly to Child B's death:

- The concurrent input of a counselling service (from 23rd December 2016 to 24th March 2017) initially with the CAMHS Community Teams and latterly alongside the specialist mental health service was well-intentioned but incongruent with the threshold criteria for these services. It was already evident by 2nd December that the risk was too high for the counselling service and psychological therapy should have remained with the CAMHS Community Team
- There was no formal re-evaluation of risk recorded by CAMHS in spring and early summer of 2017 when concerns about Child B's self-harm and attempts to take his own life escalated.
- Surrey Children's Services did not provide feedback from the Section 47 Enquiry in late March 2017 to reassure the parents that no further action would be taken
- The Integrated Chronology suggests that Surrey Children's Services did not clarify the outcome of referrals made by the police about call outs
- The rationale for involving the Youth Support Worker was unclear

6 RECOMMENDATIONS

Recommendation One

Surrey and Borders Partnership should ensure that the specialist mental health services engage in effective collaboration and meaningful co-working with the team around the child, the child's parents, and the child's informal network of care throughout their involvement with children. This will require not only exchange of information but also full and frank exploration of the meaning attributed to information so that collaboration and co-working rest on shared understanding and agreement about each child's needs, risk of harm, intervention strategies, and intended treatment outcomes. Agreements and plans should be shared not only with the formal team around the child, the child's informal network but also with organisations likely to become involved at points of crisis e.g. police, ambulance and acute hospital services. The Safeguarding Lead for Surrey and Borders Partnership should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Two

Surrey and Borders Partnership should ensure that specialist mental health service engages with the team around the child, the child's parents and the child's informal network of care to pro-actively plan for the end of their involvement and transition back into engaging with the CAMHS Community Team and all other relevant services. The Safeguarding Lead for Surrey and Borders Partnership should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Three

Each partnership organisation should review risk assessment procedures and reports to ensure that they are transparent, that risk is articulated clearly in a way that can be understood by practitioners in other settings and explained by practitioners to the child, parents and informal network supporting the child. This recommendation should be considered in conjunction with the review and the Suicide Prevention Toolbox that has recently been completed within Surrey Safeguarding Children Partnership: "Thematic Review: Deaths of children and young people through probable suicide 2014 - 2020". The Safeguarding Lead for each partnership organisation should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Four

Each partnership organisation should ensure that staff throughout the service are aware of and consider a range of potential sources of early help for children and families while waiting for specialist assessment or input. This recommendation should be considered in conjunction with the review and Suicide Prevention Toolbox that has recently been published by Surrey Safeguarding Children Partnership: "Thematic Review: Deaths of children and young people through probable suicide 2014 - 2020". Safeguarding Leads of each partner organisation should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Five

Each partnership organisation should review and rationalise plans that are drawn up on behalf of children with a view to ensuring that planning contributes to integrated, coherent and consistent holistic multi-agency working to manage both need and risk. This recommendation should be considered in conjunction with the review and Suicide Prevention Toolbox that has recently been published by Surrey Safeguarding Children Partnership: "Thematic Review: Deaths of children and young people through probable suicide 2014 - 2020". Safeguarding Leads of each partner organisation should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Six

Surrey Safeguarding Children Partnership should consider the use of risk-minimisation plans as outlined in paragraph 5.32 (above).

Recommendation Seven

The Safeguarding Children Partnership should seek assurance that difficulties which arise frequently do not continue to compromise working together:

- CAMHS practitioners engaged in work with a child do not always contribute to or attend meetings called by other agencies
- Expectations about confidentiality and data protection between partnership agencies are unclear. Each partner should re-issue guidelines or consider further training on confidentiality and data protection so that partners have confidence to share information where appropriate and necessary in accordance with the guidance in Working Together, 2018.
- Communication between agencies when children have been treated and are discharged from hospital sometimes fails
- Child in Need meetings and plans do not routinely involve General Practitioners and outcomes are not shared with them
- CAMHS routinely notify General Practitioners about mental health interventions with children and young people. These are not currently copied to Surrey Children's Services.

Recommendation Eight
Each partnership agency should ensure that practitioners across the multi-agency network know, understand and are confident to use the agreed processes set out in the "Professional Disagreement Escalation Policy" approved by the Surrey Safeguarding Children Partnership in April 2020 in situations where there are intractable differences of opinion as well as where there is a need to escalate safeguarding concerns.

Recommendation Nine
Surrey Children's Services should ensure that the Initial Child Protection Conference (ICPC) threshold relating to children who have attempted serious self-harm or suicide is implemented consistently so that they are always managed with a team around the child, regardless of whether they are subject to a Child in Need or a Child Protection Plan. This recommendation should be considered in conjunction with the review and Suicide Prevention Toolbox recently published by Surrey Safeguarding Children Partnership: "Thematic Review: Deaths of children and young people through probable suicide 2014 - 2020". Surrey Children's Services Safeguarding Lead should overview progress and provide evidence to assure the Surrey Safeguarding Children Partnership that this recommendation has been fulfilled.

Recommendation Ten
Surrey Children Safeguarding Partnership should consider implementing a robust process for audit and quality assurance. This process should support and promote consistently transparent, fully accountable, and defensible practice and decision-making across the whole multi-agency network so that the rationale for decisions made and action taken is clear in all written communication i.e. e-mails, letters, case notes, plans, agreements, supervision records, and reports.
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Recommendation Eleven
Surrey and Borders Partnership should ensure that the specialist mental health service engages with the team around the child, to include school and / or college representatives, the child's parents and the children's informal network of care to actively plan for reintegration into education (wherever that might be).

Recommendation Twelve
The Surrey Safeguarding Children Partnership should explore how to support and promote work-based learning and evidence-informed practice especially in relation to creating a culture of authoritative challenge, effective collaboration, and creative discourse both within and between the partnership organisations.

For example:

- Experienced practitioners and practice leaders should be supported to contribute to staff development and the promotion of best practice across the multi-agency network, so that they can help colleagues learn to be assertive, advocate for the child and family, elicit other's expertise, be authoritative, challenge others, hear and accept challenge, listen for all relevant voices, exercise empathy, work collaboratively, engage in critical reflection with others.
- Opportunities should be created for skills development / workplace learning between the partner agencies such as direct observation, co-working with colleagues, action learning sets, structured approaches to reflective group supervision, special interest groups, reading groups.

7 APPENDIX 1 - THE LEAD REVIEWER

7.1 Fiona Mainstone worked in local government social work settings from 1977 until 2003. She completed her post-graduate qualification as a Social Worker in 1983 and subsequently achieved the Advanced Award in Social Work in 2007. Between 1978 and 1997 she provided community social work services to children at risk of harm, children in care, adults with mental health problems, disabled adults, adults with sensory and intellectual impairments, and with older people. In 1985 she qualified to perform the duties of an Approved Social worker under the Mental Health Act 1983, retaining these functions until 1997. From 1997 to 2003 Fiona Mainstone occupied a senior consultancy role within a child protection team working with families where there was severe and complex risk of harm. From 2003 to 2010 she was employed as a Senior Lecturer within the Faculty of Health, Brighton University, contributing to both undergraduate and masters-level teaching across the Faculty. She secured post-graduate qualifications in Child and Marital Therapy in 1991, Child Protection in 1993, Solutions Focused Psychotherapy in 2002, and an MSc in Child Forensic Studies in 2009. She has worked as an Independent Social Worker, and as an Associate of In-Trac since 2005.

8 APPENDIX 2 – TERMS OF REFERENCE

The following terms of reference were initially set out in 2017 and subsequently confirmed by the Case Review Group in February 2020

1. How effectively did agencies work together to safeguard Child B in response to his increasing anxiety and deteriorating mental health?

2. Was information sharing between agencies sufficient and timely in light of escalating concerns to understand Child B's support needs?

3. Was the school response to Child B's emerging and escalating needs in November 2016 sufficient?

4. Could more have been done to support Child B?

5. Were police referrals into the MASH appropriately responded to against a background of an increasing frequency of missing episodes, concerns about possible psychosis and the impact social media could be having, as a factor affecting Child B's mental well-being?

6. How did agencies respond to "Child B's voice" and anxieties about delays in support, and his family's concerns?

7. How effective was family mediation and support for the family in coping with child B's increasingly violent behaviour and missing episodes?

8. In January 2017 at the time of Child B's second paracetamol overdose in a six-week period was there sufficient assessment of Child B's increasing risk of suicide?

9. Was the response to Child B's deteriorating mental health appropriate and timely?

10. Despite there being significant multi-agency support for Child B, was there an agreed co-ordinated care plan in place?

11. Was a lead professional identified?

12. Was there appropriate clinical supervision?

9 APPENDIX 3 - TIMELINE

November 2016	**Child B talks with Student Support Officer / Deputy Designated Safeguarding Lead about anxiety for the first time**
	Father shares concerns with school and GP
	School advises father to see GP with a view to referring to CAMHS
	GP refers to CAMHS
	The children's health referral portal conduct triage and refer to a counselling service
	Concerns escalate within a week of referral
	CAMHS complete crisis assessment and plan for continued intervention by mental health nurse
	1st paracetamol overdose
	CAMHS crisis assessment in hospital plans for continued intervention by mental health nurse
December 2016	**Continued distress and agitation at home reported on six separate nights mid-month**
	Parents lock away medicines and knives
	Close friend shares multiple text messages about self-harm etc. with Deputy Safeguarding Lead
	Community CAMHS continue to assess and offer support
	Deputy Safeguarding Lead actively supports child and parents
	The counselling service input begins
	Police attend 1st call out to home and notify MASH
January 2017	**Child B reports inexplicable / implausible incident of chase and assault**
	Police attend 2nd call out to home and notify MASH
	Community CAMHS and the counselling service both continue to assess and offer support
	The counselling service report concerns about chase incident and possible psychotic presentation to CAMHS
	Child B takes 2nd overdose.

	Police attend 3rd call out, intervene at school with physical restraint, transport to A & E, and notify MASH
	Crisis assessment in hospital recommends Tier 4 assessment and intervention in hospital setting
	CAMHS / specialist mental health service Psychiatrist assesses in hospital. Case closed to Community CAMHS and transferred to specialist mental health service
	The counselling service continue to offer support
	Child B returns to school with support plan
February	**Continued distress at home**
2017	**Parents find suicide note**
	Child B goes missing from home and school
	Intervention team offers support but withdraws because of specialist mental health service involvement
	Police attend 4th call out to home and notify Mash
	Family mediation meeting called by CAMHS
	Child B goes missing and takes 3rd overdose
	Police attend 5th call out to home, locate Child B transport to hospital and notify MASH
	CAMHS / specialist mental health service psychiatrist carries out follow up review
	Child B goes missing? 4th overdose
	Police attend 6th call out, transport to hospital, and notify MASH
	Deputy Safeguarding lead conducts risk assessment and creates school's management plan
	Child B talks about plans for suicide
	Child B goes missing
	Police attend 7th call out, liaise with CAMHS / specialist mental health service Psychiatrist, and notify MASH
	Child B creates suicide DVD
	Specialist mental health service continues to support with weekly appointments

	CBT sessions begin
March	The counselling service withdraw
2017	**Child B returns to school but has extreme difficulties with peers within first two days**
	Parents decide, with school's agreement that Child B should not attend school
	School asks for medical sign off so that Child B can be referred to A2E
	Child B goes missing
	Police attend 8th call out notified to MASH
	CAMHS internal referral for family therapy
	Early Intervention worker operates watching brief
	Specialist mental health service continues to support with weekly appointments
April 2017	**Child B discusses earlier incidents at home where father physically restrained him**
	CAMHS make safeguarding referral to MASH
	S47 Enquiry quickly resolved with no further action
	Early Intervention worker operates watching brief,
	Early Intervention worker offers Child B 1:1 meetings **and** advice to family ref de-escalation to avert physical restraint
	Specialist mental health service Day Programme arranges timetable of twice weekly attendance
	Specialist mental health service continues to support with weekly appointments
	CBT sessions continue
May	Surrey Children's Services allocate case to local Assessment Team
2017	**Child B goes missing, and carries/ drinks / intends to drink bleach**
	Police attend 9th call out, report as RED and notify MASH
	Missing episode triggers Child and Family Assessment by local Assessment Team
	Child B refuses return home interview with Social Worker

	Family Support Worker allocated
	Specialist mental health service Day Programme timetable continues
	specialist mental health service continues to support with weekly appointments
	CBT sessions continue
	Social worker begins process of Child and Family Assessment
	CAMHS Family Therapy appointment offered
	Child B expresses worries about feeling manic to Deputy Safeguarding Lead
	Prolonged crisis over 3-day bank holiday weekend culminates in Child B found unconscious in woods
	Police attend multiple call outs during 3-day period
	Specialist mental health service nurse visits home and meets with Child B as well as parents
	Extended specialist mental health service nurse visits home and meets with Child B as well as parents
June 2017	Child B on life support in intensive care
	Child B dies without regaining consciousness

10 APPENDIX 4 – REFERENCES

Brandon, M., Bailey, S., and Belderson, P. (2010) Building *on The Learning from Serious Case Reviews: A Two-Year Analysis of Child Protection Database Notifications 2007 – 2009.* London: Department for Education.

Brown, R., and Ward, H. (2012). *Decision-Making Within a Child's Timeframe: An Overview of Current Research Evidence for Family Justice Professionals Concerning Child Development and The Impact of Maltreatment. Working Paper 16.* London: Childhood Wellbeing Research Centre.

Carers (Recognition and Services) Act 1995.

Carers and Disabled Children Act, 2000.

Carers (Equal Opportunities) Act 2004.

Department of Health (2001) *Your Guide to the NHS*

Grint, K. (2008) Wicked Problems and Clumsy Solutions: The Role of Leadership. *Clinical Leader, 1, 2,* 11 – 15.

National Institute for Health and Care Excellence (2013) Self-*Harm Quality Standard QS34*

Stein, M., Ward, H., and Courtney, M. (eds.) (2011) Special Issue on 'Young People's Transitions from Care to Adulthood' Children *and Youth Services Review, 33, 12,* 2409 – 2540.

Surrey Safeguarding Children Board (2019) Effective Family Resilience Surrey. Every Child in Surrey Matters.

Surrey Safeguarding Children Partnership (2020) *"Professional Disagreement Escalation Policy"*

Turnell, A., and Edwards, S. (1999) *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection.* New York: Norton.