Essex

Safeguarding Children Board

Serious Case Review

Child T

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1. INTRODUCTION AND REVIEW PROCESS

1.1 This serious case review was commissioned following the death of Child T, who was seventeen years old and a patient in a Child and Adolescent Mental Health Unit. Child T had taken her own life through hanging in February 2018.

1.2 Essex Safeguarding Children Board were aware that Child T had a significant number of vulnerabilities including a severe eating disorder and had been in receipt of community mental health services prior to her admission to the in-patient unit.

1.3 On 10th May 2018, the decision was taken to carry out a serious case review under the national guidance in place at that time[1] and an independent lead reviewer was commissioned to carry out the review. The exact scope and terms of reference for the review were agreed in August 2018 taking account of information from the serious incident report prepared by the local mental health trust.

1.4 Also in August 2018, the inquest into Child T's death concluded that Child T had killed herself by hanging. The Coroner added a narrative conclusion which noted two concerns about Child T's care in hospital. These concerns[2] were conveyed by the Coroner to the mental health trust via a Coroner Regulation 28 report[3].

1.5 The independent lead reviewer worked with a review team comprising senior managers from local agencies. The team comprised:

- Area Manager: Eating Disorder Service: North East London NHS Foundation Trust- Emotional Wellbeing & Mental Health Service.
- Consultant Psychiatrist: Essex Partnership University NHS Foundation Trust.
- Designated Safeguarding Children Nurse - Local Clinical Commissioning Group (CCG)
- Detective Inspector: Essex Police.
- Safeguarding Manager for Schools and Early Years, Specialist Education Services, Essex County Council.
- Service Manager, Assessment & Intervention & Children with Disabilities, Essex County Council.

1.6 The agreed terms of reference are attached at Appendix One of this report. The timeframe for the detailed chronology and focus of the review was agreed as from October 2015 when Child T was aged 15, last saw her GP and was referred to mental health services through to her death in February 2018.

1.7 Chronologies of involvement were requested from the following agencies

- Anglian Community Enterprise – GP involvement
- East of England Ambulance Service
- Local Borough Council
- Local Clinical Commissioning Group – GP Involvement
- Essex County Council – Education Services

[1] This guidance was *Working Together to Safeguard Children 2015.*
[2] The two concerns were that Child T's shoelaces had been returned to her and that the physical environment in the rooms at the hospital was dreary.
[3] This is a report under Coroner's Regulation 28 to prevent future deaths.

- Essex Partnership University NHS Foundation Trust
- Essex Police
- Integrated care 111 service
- Hospital 1
- Hospital 2
- North East London NHS Foundation Trust
- School Nursing Service.

1.8 The lead reviewer also received the following written reports:
- results of the post-mortem
- the Coroner's Regulation 28 report
- EPUT (Essex Partnership University NHS Trust) serious incident report

1.9 The independent lead reviewer convened a practitioner's event in March 2019 and also contacted Child T's mother to ask whether she would wish to contribute her views to the review through meeting in person of via a written contribution. An e-mail was received from Child T's mother in April 2019 setting out a number of issues and concerns. These were used to inform the final findings of this report.

1.10 After completing three draft reports the independent lead reviewer was not able to complete the review and the current lead reviewer[4] was appointed in May 2020 with a remit to review work that had been undertaken so far and complete the report.

1.11 The report was agreed by the Executive of the Essex Safeguarding Children's Board in October 2020.

1.12 A telephone discussion with Child T's mother prior to publication checked the accuracy of this report and agreed the level of family detail that it would be appropriate to include in the final version.

2. FAMILY BACKGROUND

2.1 Child T was the youngest of three siblings. Their parents separated before Child T's fourth birthday and she lived with her mother from this point onwards. She had no regular face to face contact with her father or his new family.

2.2 Throughout Child T's primary school years, the family lived in Essex. After eighteen months of secondary education she moved school because she was at risk of exclusion due to poor behaviour and non-attendance. Her mother had told this review that she feels that more effort could have been made to understand why she was not participating in education rather than taking her out of class.

2.3 Child T settled well at her new school and was described as popular and friends with a group of confident outgoing girls. Attendance remained poor at 80%.

2.4 Just prior to Child T's 14th birthday the family moved within Essex, hoping that this would be a fresh start for Child T. This move involved changing GP practice and

[4] For a short biography please see Appendix Two

school. Child T struggled to settle in her new school and her Mother describes her experiencing “horrible stuff” in her time there. Records suggest this related to a problematic relationship with another pupil and she was seen twice by the GP with a history of vomiting in the mornings. She also attended accident and emergency and was also seen by nurse practitioner at the GP surgery with ongoing abdominal pain and vomiting and nausea. These were thought at that time to have a medical cause.

2.5 The problems at school prompted the family to move to stay with a friend in another area of Essex whilst arranging the sale of their house. Child T started at a third secondary school and was on the school roll there in October 2015 at the start of this review period.

2.6 Mother, Child T and an older Sibling eventually settled in their own property a few miles away in December 2016. Child T’s other older sibling lived locally with her partner and children.

3. CASE SUMMARY AND EVALUATION OF PRACTICE

3.1 In October 2015, Child T was seen by her GP (practice 1) with a one-year history of self-harm, depression and anxiety and was referred to the local children’s Emotional Wellbeing and Mental Health Service (EWMHS). In line with local protocols the referral was “triaged”. This is a review of the written referral to decide as to whether an assessment is needed. The decision was that Child T should be assessed by the service and she was seen less than a month later.

3.2 Both Child T and Mother were seen individually by EWMHS and gave differing accounts of the problems and issues. Various stressors within family relationships were discussed and the assessment concluded that the problems experienced by Child T were relationship based and Mother was offered a place on the next Families Learning about Self-Harm (FLASH) course. EWMHS agreed to liaise with Child T’s school to ensure that she was accessing support.

3.3 This was a reasonable conclusion and plan but before the plan could be implemented, Mother decided to withdraw Child T from school because of concerns about the negative impact of a relationship with another pupil and the family moved out of the area. The GP did not receive a letter from EWMHS and was unaware of the outcome of the EWMHS assessment. The potential implications of the family not accessing any of the suggested support was therefore not followed up.

3.4 Child T started at a new school in Year 10 in January 2016 and in February registered with a new GP practice. There is no indication from the GP new patient screening that they were aware of the previous referral to child mental health services.

3.5 Child T’s school attendance was disrupted by time off sick, mainly with reports of stomach pains. She had been seen twice by the GP surgery and an appointment was

arranged for a consultation with the appropriate specialist consultant for her medical condition.

3.6 School described her as having a small friendship group and as quite 'closed' and private and difficult to read. She had no specific learning needs and was very keen and enthusiastic to work in childcare. By June 2016, her attendance was 80%.

3.7 In early February 2017 Mother told the school that she had noticed evidence that Child T had self-harmed and she would be taking her to the GP. Child T told the GP that she had been self-harming for some years and did not want any help. There is no evidence that the GP probed further regarding any suicidal thoughts and although they did leave an open door for Child T to return to the GP at any time, there was no proactive encouragement to use support services available.

3.8 One week after the GP consultation Child T was seen in the local accident and emergency department following an overdose. She was admitted overnight, received appropriate medical care and was assessed as fit for discharge after being seen by the EWMHS crisis team in the hospital. The EWMHS assessment identified her as high risk due to suicidal ideation, a four-year history of self-harm and constant low mood. A risk plan was agreed with Child T and her mother and she was referred to the EWMHS community crisis team. At this point the assumption was that risks could be managed adequately by Mother. There is no evidence within the chronology that any immediate alert was sent to the GP or permission was sought to discuss the risks with Child T's school.

3.9 The EWMHS community crisis team followed up by telephone after seven days and made sure that Child T was aware of the relevant EWMHS contact numbers. She was then discharged from the crisis service. The next day Mother informed the school to tell them about the overdose and that EWMHS were involved. The school immediately contacted EWMHS and were informed that Child T would be discussed at a meeting the next day. At the meeting it was agreed that an urgent initial assessment would take place within ten days.

3.10 Before the assessment Mother had further contact with the school which raised their concerns as to whether they were able to keep Child T safe. They again contacted EWMHS, asking for a discussion after the assessment had taken place as they had "safeguarding concerns". There was a follow up call from the school to EWMHS asking for information to inform a risk assessment but no evidence that this discussion took place. From this point the school sent work home and Child T did not return to school.

3.11 During this period there was an opportunity for a more joined up approach to understanding the influences on Child T's behaviour and planned collaboration and across agencies, most notably between mental health, school and the GP.

3.12 During the EWMHS assessment, Child T disclosed that since the age of eight she had been obsessed with her diet and had subsequently developed eating disorder symptoms. This resulted in a referral to the eating disorder service. There were four

more appointments with the community EWMHS team during which time they became more concerned about her symptoms and expedited an urgent appointment with the eating disorder service.

3.13 The assessment by the eating disorder team in early April 2017 was that Child T was high risk. A letter was sent to the school and GP to inform them that she had been seen by the service. The GP was also informed by the local accident and emergency that Child T had been seen with chest pains possibly the result of not eating.

3.14 Following Child T's assessment by the eating disorder service the practitioner queried whether the community team should also be involved to manage the more generic mental health issues. This was discussed by the multi-disciplinary team who concluded that her issues related to an eating disorder and therefore the case should be managed by the eating disorder service.

3.15 During the summer of 2017 there is evidence that the school tried to support Child T by sending work home and liaising with EWMHS to obtain support for exams to be invigilated at home. Mother has told the review that the family did not experience this as supportive, rather feeling overwhelmed and inundated with work.

3.16 From April to December 2017 Child T was seen at least weekly by the eating disorder service. She was seen regularly by the same psychologist with a careful handover during holiday periods to a colleague. The pattern throughout this period was of Child T reporting binging and purging and concerns about the impact of this on her physical health. These concerns led to liaison with the GP and regular blood tests.

3.17 Although the GP was appropriately involved in monitoring her physical health needs there is less evidence of GP consultations fully considering her emotional health. For example, when Child T consulted the GP about a facial skin condition there was no exploration by the GP as to a possible link with her eating disorder, self-harm behaviour and worries about her appearance. A month later she was seen with her mother due to a drop in blood pressure and although the GP noticed signs of self-harm, she was not seen alone to explore this further.

3.18 The reports of the sessions with the psychologist document persistent problems relating to family relationships and dynamics but, although the eating disorder service use a family intervention model, and the psychologist was very experienced in this model of work, it is not clear from the records seen for this review, to what extent treatment focused on this aspect of Child T's life. From the perspective of Child T's mother, the focus was on the eating disorder rather than looking more broadly at why this was occurring and helping the family to cope.

3.19 Child T's progress was regularly reviewed by the multi-disciplinary team and deemed to be high risk. This risk was managed by the eating disorder service. For example, when in August 2017 the psychologist noted that she had self-harmed to stop vomiting, the possibility of an in-patient referral was explored with Child T and her mother. A risk assessment was carried out and Child T's Mother was given advice to

remove all tablets from the home due to her daughters' suicidal thoughts. Soon after that episode there was another crisis where Child T threatened suicide which led to a consultation with the team's psychiatrist and a recommendation that she commence anti-depressant medication. During this crisis for the first time Child T disclosed that she was using her eating disorder to "kill herself slowly".

3.20 There were further discussions with Child T regarding in-patient treatment as her condition began to deteriorate during the autumn of 2017. During this period, she refused to take the anti-depressant medication as it stemmed the urge to purge, and tensions continued between Child T and her mother about managing this behaviour.

3.21 In early autumn Child T spoke to the psychologist about a memory that "something had happened" with a male adult when she was a child. Following a family holiday a few weeks later, Mother told the psychologist that Child T insinuated that she may have experienced sexual abuse in her past but did not want to talk about it. Child T also self-harmed on the holiday. There was insufficient information to warrant a formal child protection response at that point, but this was an opportunity for mental health practitioners to be curious about Child T's comments and ask questions aimed at exploring this further. There is no evidence that this happened and there is nothing in the therapists clinical or safeguarding supervision records to show that any concerns about Child T were discussed in supervision. Supervision is discussed further in Finding Three.

3.22 At the end of November, the psychologist told Child T that she was leaving the service in January 2018. It was anticipated that this would be hard for Child T due to the positive trusting relationship that had developed. Two days later Child T presented in accident and emergency with suicidal thoughts and having self-harmed by cutting herself with a razor blade. She explained that she was upset because her therapist was leaving. She was referred to the paediatric mental health liaison team and was then discharged and advised to follow up with her GP. Support was then offered over the weekend by the mental health crisis team and via a telephone call from her psychologist. A bed was found in the local psychiatric adolescent unit and Child T was admitted voluntarily at the start of the following week.

The period before Child T was admitted to hospital is characterised by a timely response by the mental health service followed by sustained input from the eating disorder service via a consistent relationship with the same psychologist. There was also good communication with the GP regarding physical aspects of her care. The issue of whether her care should have sat solely within one team within mental health services is discussed further in Finding Two of this report.

There is less evidence of a joined-up approach across professional boundaries when considering Child T's relationships and the factors impacting on her emotional wellbeing and mental health. Issues that have emerged from the information submitted to this review are:

1. *The need for greater liaison and communication between the child mental health service, Child T's school and the GP to enable a more holistic approach to understanding and meeting her needs in all settings.*

2. *The need for a better understanding of family history, stresses across the whole family system, the interaction between them and how these impacted on Child T's mental health.*

3. *The possibility of a coordinated early help response which actively supported Child T's mother in her caregiving role.*

4. *Effective supervision which promoted professional curiosity and ensured that there was sufficient exploration of any emerging safeguarding concerns relating to possible past abuse.*

Child T's treatment and care in hospital

3.23 Child T was admitted to a psychiatric adolescent unit and in view of her continued weight loss, eating disorder and suicidal thoughts, a risk assessment and body mapping was completed on admission.

3.24 Child T was enrolled in the on-site school. She interacted well with other young people and presented as a caring, empathetic person, particularly with others more vulnerable than herself. Child T engaged with a range of therapies and care plans were developed in seven different areas:

- admission
- physical health
- leave
- smoking
- Mental Health Act
- Self-Harm
- medication.

3.25 Notably there was no care plan specifically focused on her suicidal ideation although suicide risk was noted as being present throughout her time on the unit.

3.26 Her care and treatment included the development of a meal plan and hourly checks increased to 1:1 nursing observation for one hour after meals. Sleeping difficulties were noted as well as compensatory behaviours of cleaning and tidying at unusual times (often at night).

3.27 Periods of leave were subsequently granted under the care of Child T's mother and these are described in the mental health records as challenging for her mother to contend with. There were issues with the maintenance of boundaries, sticking to meal plan, binging/purging and acquiring laxatives. A specific period of leave was granted over Christmas, but Child T returned to the ward early. Notes indicate that this was because of her mother's concerns about her binging and purging but her mother recalls that Child T asked to return. Throughout this time Child T was an informal (voluntary) patient in the unit.

3.28 When she returned, the weight loss that had been noted prior to Christmas was reviewed by the multidisciplinary team and the plan was to increase the intensity of her plan of care. Child T was not agreeable to this and the consultant psychiatrist

took the decision that Child T should be detained under the Mental Health Act 1983 initially under Section 5(2) and subsequently Section 3[5].

3.29 On 29th December 2017 when Child T's mother was visiting the ward, Child T attempted to ligature in front of Mother with a headphone cable. Mother alerted staff and the situation was deescalated. Following this, the serious incident report completed by the mental health trust notes that Child T's presentation was one of compliance punctuated by brief intense periods of challenge. Notably:

1. On 6th January kicking, punching, and banging her head on doors.
2. On 12th January 2018 on return from a period of leave from the ward with her mother Child T was searched and a small blade and 3 tablets (prescribed medication) were found concealed in a pack of pens.
3. On 20th January leave was suspended because Child T persuaded her Mother to leave her unaccompanied at the cinema with friends.

3.30 On 24th January, Child T was informed that the psychologist from the eating disorder service would be visiting to say goodbye the next day. That night she was up all-night cleaning her room including the air vents in the ceiling. With hindsight this may have been significant due to the circumstances of her death but would not have been regarded as particularly unusual behaviour at the time.

3.31 The visit from the eating disorder therapist to say goodbye was clearly difficult for Child T and Child T's mother told the review that she was devasted to have lost this trusting relationship. What is not clear, is how this event was understood and assessed in relation to any increased risk to Child T. There is no record of a plan to mitigate any increased risk within the Psychiatric adolescent unit notes.

3.32 There were opportunities to explore further Child T's suicidal thoughts but no record that this took place. For example, a few days after the goodbye meeting with the therapist a nursing report records that another patient was speaking to Child T how her brother took his own life. This would have been an opportunity to talk to both young people about the meaning of this conversation.

The most significant practice issue emerging from this period is the lack of specific focus on the risk associated with Child T's suicidal ideation. This should have been assessed separately from the risk of self-harm and her eating disorder and a risk management plan put in place at points of significant stress – including the departure of her therapist and tensions within the family.

Events leading up to the serious incident

3.33 On the 1st February 2018, following a family therapy session, Child T became highly distressed, throwing her plate of food on the floor and screaming. Staff intervention de-escalated the situation and she later settled. It was also disclosed she had used a pencil sharpener blade to self-harm, provided by a fellow patient.

[5] Section 5 (2) allows for a voluntary in patient to be detained in hospital for assessment for up to 72hrs. Section 5 (3) applies when there is a need for treatment and can apply for a maximum of 6 months.

3.34 On the 5th February 2018, Child T started banging her head against a mirror whilst looking at herself and describing sensations of feeling "*out of it*" and "*not feeling like herself*." When Child T returned from weekend leave two days later, she appeared hyperactive, her eyes were red, and she smelt of alcohol. She was breathalysed and drug tested, both tests were negative. Child T's mother telephoned the unit at 10pm to say the reason they returned late from leave was four 'Senna' laxatives were found on the car seat after arriving back at the hospital. Child T denied they were hers, but later admitted she stole them from a supermarket a week previously. She insisted she had not taken any, had put them in her pocket and had forgotten about them. This was discussed at a clinical review meeting with a decision to make no change to the management plan, but for the incidents to be further discussed with a family therapist and within the multi-disciplinary team meeting the following week. Child T was later found by staff in her bedroom, curled up crying and distressed because of family issues and her Mother not being available so she could not go on leave the next weekend.

3.35 Later that day Child T's mother visited her in the unit and recalls Child T being in a good mood and appeared very happy.

3.36 On Sunday 11th February 2018, Child T was upset after a telephone call as she had heard that a friend had taken an overdose but later that evening she was laughing and joking with the staff. She stayed on the ward longer than usual as there was a social event before going to her bedroom at 10.30pm.

3.37 The hospital log records that there were then checks on Child T in her bedroom at 11pm, 12am, and 1am. When she was checked at 2am, staff noted a 'lump' in the bed which seemed too large for her. On closer inspection, staff noticed she had put clothes in her bed to give the impression she was in the bed sleeping. Child T was then found with a ligature (black shoelaces taken from her trainers) around her neck, suspended from the light fitting in her bathroom. She had used the sanitary bin as a climbing tool. A message was written on the bathroom mirror by Child T.

3.38 Staff commenced CPR and called an ambulance which arrived soon afterwards and attempted the resuscitation of Child T without success and she was pronounced dead at the scene at 2.43am.

3.39 Investigations after the event revealed that the 12am check had been a conversation with Child T who was in the bathroom – she was not seen. The 1am check had not taken place.

During this period there were again issues identified in respect of the impact of family relationships and dynamics on Child T and there were challenges in understanding the complexity of her behaviour and developing an effective response. The Serious Incident Report noted a changeable presentation and fluctuating risk throughout her time on the unit

Although Child T was detained under Section 3, home leave was arranged. This should have been fully risk assessed, including Mother's capacity to keep her safe but there is no such assessment clearly set out within the records.

The lessons relating to the specific circumstances of Child T's death have been reviewed by the mental health trust and the coroner. Practice issues have been identified in respect of suicide prevention and immediate actions taken were:

- *Replacement of sanitary bins with cardboard ones which are less weight bearing and a lower height.*
- *Ceiling furniture and switches sealed with anti-pick mastic to reduce the risk of tampering.*
- *Improvement in the way the light fittings of the in the bathroom are secured*
- *Introduction of preventing suicide by ligature e-learning for all Trust staff.*
- *Review of any necessary HR responses in relation to the failure to complete the expected checks at 12am and 1am.*

4. FINDINGS AND RECOMMENDATIONS

4.1 Child T's records describe a young person with empathy, a dry sense of humour and ability to do well at school. Alongside this there are also reports of a troubled young person displaying signs of distress through an eating disorder and self-harm. Understanding the depth of her distress and the cluster of factors that made her vulnerable to suicide was a challenge for all those that knew her. Situations where family and professionals are working with the combination of eating disorders and mental health concerns are complicated. They are likely to result in conflictual complex relationships and all the findings in this report should be understood within that context. It is important to note that Child T's mother at times felt helpless and unsure where to turn to for help and support.

4.2 The overarching finding of this review is the need for a whole system approach where a young person is talking about taking their own life. This is in order to understand the balance between clusters of stressors, vulnerabilities and the capacity of the family and young person to develop the level of resilience required to thrive and survive. Throughout this case, across all settings, there was a tendency to expect Child T's mother to keep her safe without the full understanding of stresses within the family and assumptions were made about what help might be most useful. Mother's input to the review made it clear that she felt the help given to Child T fell short in many areas. Findings One and Two address working with level of complexity evident in this case.

4.3 Managing risk in such situations is emotionally demanding work for practitioners involved and there are examples of professionals really trying to help Child T. What is less clear is how far supervision was used to support practitioners to manage this emotional impact, reflect on their work and identify risks. This is addressed in Finding Three.

Finding One

This was a complex family situation which needed a multi-agency approach to understanding dynamics, risks and the support needed for adults in a parenting role.

4.4 Information suggests that Child T's mother would have been experiencing a number of challenges in meeting the needs of all her children. Details are limited in reports seen for this review, but there is little evidence that a whole family support service was available and offered to the family at the time when Child T first began to experience difficulties from around the age of 12 onwards.

4.5 At the time Child T came to the attention of the GP and EWMHS with mental health concerns there was an opportunity for a coordinated approach which addressed the specific individual needs of Child T alongside provision of support to the whole family. Child T's mother was offered help from a group for families learning about self-harm but when she did not take up this offer it would have been helpful to explore from her perspective what help and support might be most useful. This was important as before Child T was admitted to the in-patient unit practitioners were relying on her mother to manage risk and keep her safe.

4.6 There was an opportunity for a more joined up approach when Child T was struggling to remain in school although from the school's perspective they were receiving mixed messages as Child T was apparently still wanting to take some of her exams and the school was attempting to support with that. The school were worried about whether they could keep her safe and did try to engage with EWMHS in order to understand of how to best meet her needs. The school clearly tried to help by sending work home and arranging home invigilation for exams, but this was perceived by Mother as overwhelming and resulted in Child T withdrawing from education at this point.

4.7 In summary, there is no evidence that there was an assessment of Mother's support needs and her capacity to keep Child T safe. This was particularly relevant when Child T was visiting home from the inpatient unit. What is known is that from time to time Mother felt overwhelmed and found it particularly hard to maintain boundaries and expectations when Child T was on home leave from hospital and from time to time this led to giving a more positive account of home leave than had been the case.

4.8 The term "disguised compliance" can too readily be used to explain Child T and her mother's apparent failure to always be honest about Child T's behaviour whilst on home leave. This is an overused term which evolved from a complex idea related to a specific analysis of child deaths and unfortunately, it has become a label effectively blaming families for "pulling the wool" over the eyes of professionals. This has moved the spotlight away from the way in which behaviours of practitioners and services may support these behaviours. In this case, rather than simply applying a label, it is vital to reflect on what could have been done differently to enable a really effective working relationship with Child T's mother by all the practitioners in contact with her. This requires professionals to take a challenging and questioning approach, i.e.

professionally curious practice which will be supported by effective support and supervision. This is discussed further in Finding Three.

Recommendation One
Essex Safeguarding Children Board should work with partner agencies to make sure that there is wrap around support for families where a child has a complex mental health condition and this support is based upon a full multi-agency assessment of needs within the whole family.

Finding Two
There were challenges in responding to the complexity of mental health needs within one service and there was consequently a loss of focus on risk of suicide.

4.9 Throughout Child T's involvement with mental health services it was clear that her needs were complex and required a focus (separately and together) on eating disorder, self-harm and risk of suicide. All three required an understanding of the factors both in the past and present that were contributing to her condition.

4.10 This level of complexity is not uncommon in young people who take their own lives and can mask the degree to which risk of suicide has become high. This presents a challenge for all professionals as "*the life trajectories and histories of adolescents who commit suicide are likely to be similar to those of adolescents who express their unhappiness through other types of high-risk behaviou*r"[6].

4.11 What has been found[7] is that when a young person has taken their own life, factors that were present often included previous self-harm, loss and rejection in early life and that vulnerabilities were compounded by the cumulative effect of abuse and neglect and the challenges of adolescent development. Services need to understand the risks associated with these factors through a full understanding of early history and exploring the *causes* of behaviours through multi agency support.

4.12 As discussed in Finding One above, this multi-agency approach was not in place and after an initial assessment by the crisis team and community mental health team, work was led by the eating disorder service. The level of input and the strength of the relationship that was forged with her therapist was positive but there was some debate as to whether the community team should also have been involved in order to ensure sufficient response to the totality of her mental health needs. A broader approach could have had the benefit of assessing risk when it was known that her therapist was leaving and then working with the in-patient unit to develop a risk management plan.

4.13 Within the inpatient unit it is notable that the focus was on self-harm linked to the eating disorder and medical needs. The meaning of Child T's suicidal ideation and risk of suicide was not seen as a separate issue requiring ongoing assessment and

[6] Sidebotham et al (2016) *Pathways to harm, pathways to protection, a triennial analysis of serious case reviews.* London: Department for Education Page 100
[7] Op.Cit Page 118

planning. This is perhaps not unreasonable within the context of knowledge that many people who self-harm do not wish to end their lives[8]. In addition, a recent academic paper noted that although suicidal thoughts and non-suicidal self-harm are strong predictors of suicide attempts only a third of adolescents who have suicidal thoughts go on to make a suicidal attempt. Factors involved in suicidal thoughts are distinct from those involved in the transition from thoughts to attempts. [9] However, this study went on to report that adolescents are likely to be high risk of moving from thoughts to action where both suicidal thoughts *and* non-suicidal self-harm are present. Other important factors are drug use and sleep problems. This suggests that in the case of Child T, the range of risk factors, past and present should have led to a separate focus on the risk that she may take her own life.

4.14 Specifically, there should have been a more formal risk assessment in relation to home leave when Child T was under Section 3 and included within this assessment Mother's capacity to keep her safe.

Recommendation Two
Agencies across Essex should work together to clarify expected roles, responsibilities and practice when working with young people and their families where there are complex mental health needs in order to ensure that there is a full understanding of life history, risk factors and a coordinated response.

Recommendation Three
Where a young person has a combination of risk factors including loss and rejection, possible past abuse, self-harm and suicide ideation, care plans in both community and in-patient settings should include a specific focus on risk of suicide.

Finding Three
Supervision systems did not provide sufficient opportunity to reflect on practice and to ensure that safeguarding concerns were considered and acted upon

4.15 Along with disguised compliance, professional curiosity can be an overused term. Whilst all good safeguarding practitioners *should* be professionally curious this can be challenging in a fast-paced environment without space to stop and think. It also requires a degree of self-awareness and capacity or consider the assumptions and biases that might be driving professional behaviour. It is not enough to *tell* people to be professionally curious, they need the time, space, and support to be so.

4.16 There are a number of points in the records where a more curious approach was warranted yet there is no evidence that any practitioner was receiving supervision which gave them time to think, challenged their thinking, encouraged them to consider the assumptions that might have been influencing their responses and therefore supported then in asking professionally curious questions.

[8] https://www.nhs.uk/conditions/self-harm/
[9] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30030-6/fulltext

4.17 At an early stage, the GP made an appropriate referral to mental health services but from that point onwards the focus of GPs was on physical health. There seems to have been no opportunity stop and to consider the overall safety of Child T, and the potential link between physical symptoms and emotional wellbeing.

4.18 There is some suggestion within the records that Child T alluded to alleged sexual abuse by a family member when she was a child. This issue was not followed up in any depth by the mental health service and there is no evidence that the therapist discussed the possible implications within any supervision forum. This is significant for two reasons:

1. A fuller understanding of any abuse experienced by Child T could have led to a better understanding of the factors underlying her behaviour and therefore been used in planning therapeutic responses. There were challenges in achieving this as, although self-harm may be an indicator of sexual abuse it is also widely acknowledged that sexual abuse is rarely disclosed until it is safe to do so. Practitioners do however need to be alert to the possibility of sexual abuse and any indication that the child may be ready to talk about their experiences.
2. It is possible that the adult she spoke about could pose a current risk to children.

4.19 There are no easy ways to respond in these circumstances but there should at least have been full and thorough reflective discussion within supervision to explore alternatives and record the reasons why a certain course of action had been agreed. Supervision is well established within mental health services and all psychologists should receive clinical supervision. It is not clear whether this was received in this case and if so whether there was sufficient focus on child safeguarding practice.

4.20 Child T's mother has asked why more consideration wasn't given within schools as to why Child T was struggling. Supervision is less well established within schools although the important role it can play in keeping children safe is now better understood with guidance for inspectors stating there should be evidence that: *Staff and other adults receive regular supervision and support if they are working directly and regularly with children and learners whose safety and welfare are at risk.*[10] There is evidence that Child T's final school were worried as to whether they could keep her safe and took steps to liaise with the mental health service. When the school did not get a response to their queries this was not pursued or escalated – an opportunity for the Designated Safeguarding Lead to be supported in their role through supervision may have been helpful. This would have included considering how best to engage others in the professional network where there are safeguarding concerns

4.21 Within the hospital, there are several points where staff could have questioned the meaning of her behaviour, for example when she tied a ligature in front of her mother, when she was awake during the night after her goodbye session with her therapist and when she was discussing suicide methods with another patient. There

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/828763/Inspecting_safeguarding_in_early_years__education_and_skills.pdf

was no evidence within the reports seen by this review that staff received supervision which promoted a questioning and curious approach in these circumstances.

Recommendation Four
Essex Safeguarding Children Board should ask partner agencies to review the supervision provided for staff and make sure that they have appropriate arrangements in place to support staff in reflective, curious and authoritative safeguarding practice.

5. SUMMARY OF RECOMMENDATIONS

Recommendation One
Essex Safeguarding Children board should work with partner agencies to make sure that there is wrap around support for families where a child has a complex mental health condition and this support is based upon a full multi-agency assessment of needs within the whole family.

Recommendation Two
Agencies across Essex should work together to clarify expected roles, responsibilities and practice when working with young people and their families where there are complex mental health needs in order to ensure that there is a full understanding of life history, risk factors and a coordinated response.

Recommendation Three
Where a young person has a combination of risk factors including loss and rejection, possible past abuse, self-harm and suicide ideation, care plans in both community and in-patient settings should include a specific focus on risk of suicide.

Recommendation Four
Essex Safeguarding Children Board should ask partner agencies to review the supervision provided for staff and make sure that they have appropriate arrangements in place to support staff in reflective, curious and authoritative safeguarding practice.

6. APPENDIX 1: TERMS OF REFERENCE

Serious Case Review

Terms of Reference

1. Subject of Review

Subject: Child T

Family Members:
Mother
Sibling 1
Sibling 2
Father (estranged)

2. Reason for the Review

Child T was a 17-year-old who took her own life in February 2018 whilst resident at a Child and Adolescent In-patient unit.

Child T had a significant number of vulnerabilities including a severe eating disorder and suicidal ideation. Professionals from the Eating Disorder Team had been working with her in the community for seven months prior to her admission to the psychiatric adolescent unit in December 2017, which was initially on a voluntary basis. She was later sectioned under the Mental Health Act.

The inquest in to death of Child T was held in front of a jury and concluded with a verdict of suicide with a narrative that Child T killed herself but that failings from the state contributed to her death.

3. Relevant time period for the review

27th October 2015 (when Child T was last seen by a GP and was referred to CAMHS) to 12th February 2018.

4. Review Team Representatives

a) Essex Children Social Care
b) Essex Police
c) Essex Education
d) Designated Nurse
e) Mental Health Practitioner (EPUT)
f) Eating Disorders Team representative (NELFT)

5. Issues and Questions to be considered

This SCR was asked to focus on the following themes and questions

A. Consideration of what support was being offered to Child T in the community from the start of the review period until she was admitted to the Psychiatric Adolescent Unit, in particular from mental health services and the GP.
   - What was the impact of this support?
   - Was information shared effectively between agencies?
   - Were the actions taken by agencies following the overdose in February 2017 appropriate?

B. The care and support provided to Child T at the hospital including:
   - An understanding and analysis of Child T's history of self-harm and suicidal ideation
   - The risk assessment – was the level of risk during the in-patent admission appropriately and accurately assessed?
   - An understanding of the potential risks in respect of home leave
   - Following of policies and procedures including observations of at-risk patients
   - Staffing and training of staff around awareness of risk
   - Consideration of whether the risk guidance needs revising

C. Information concerning Child T and her family:

   - Did Child T's Mother receive appropriate advice about the dangers of leaving Child T unsupervised and in relation to her eating disorder when she was given home leave?
   - Were there any communication failures between professionals working with Child T and her Mother and if so why did these failures occur?

D. Consideration of the likely impact on Child T over the weekend before the incident in respect of her mother being away, a staff member with whom Child T had a good relationship leaving, and a friend having attempted suicide. Was this considered as an enhanced risk and what additional actions were or could have been taken to minimise the impact and risk for Child T?

E. Was the voice of Child T heard and acted upon?

7. APPENDIX 2: REPORT AUTHOR

Jane Wonnacott

Jane qualified as a social worker in 1979 and has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on child protection practice. She has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed in excess of 150 serious case reviews, many of national significance. She has a particular interest in safeguarding practice within organisations and was the lead reviewer for two reviews into abuse in nurseries and the serious case reviews into St Paul's School and Southbank International School London. She has contributed to the literature exploring effective safeguarding education settings. Jane is a member of the National Child Safeguarding Practice Review Panel pool of reviewers.

As Director of In-Trac Training and Consultancy, Jane has been instrumental in developing a wide range of safeguarding training and oversaw In-Trac's contribution to the development of the "Achieving Permanence" training materials for the Department of Education. She has a long-standing interest in supervision and developed a national supervision training programme for social workers with the late Tony Morrison. She has recently worked with colleagues to apply this model in school settings.