South Lanarkshire Child Protection Committee

SIGNIFICANT CASE REVIEW

SUMMARY LEARNING REPORT

CHILD N

Lead Reviewer: Wendy Harrington

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Brief summary & data protection

Child N was a 16 year old female secondary school pupil at the time of her death - caused by suicide. She lived at home with her parents, both in their 40's, and younger sibling. Child N

had a history of being bullied at school, which she and her family felt had not been dealt with effectively. Child N had stated her intention to end her life on several occasions and was receiving support from CAMHS, her GP and from school support groups at the time of her death.

This Learning Summary Report contains as much information from the full Significant Review Report as possible whilst respect for private and family life, in terms of Article 8 of the European Convention on Human Rights. Consideration has been given as to whether the information released is lawful, necessary and proportionate. Disclosure of sensitive personal data must comply with the Data Protection Act, 2018. Child N's parents have agreed to the release of this information to support learning and help other young people.

1. Introduction

1.1 The local approach to protection activities

1.1.2 South Lanarkshire is the 5th largest Council and Health and Social Care Partnership and the 11th largest geographical area in Scotland. It has a growing population of approximately 317,100 people. South Lanarkshire's public protection approach links all protection disciplines at strategic and policy level under the governance of their Public Protection Chief Officers Group. Whilst Social Work Resources are the lead statutory agency for Child Protection work, multi-agency co-operation is a central tenet of established best practice. South Lanarkshire's Strategic Significant Case Review Group, working with both the Adult and Child Protection Committees, provides scrutiny and strategic leadership and is responsible for developing and implementing child protection policy, protocols and strategy across the agencies, as described in the National Guidance for Child Protection in Scotland (2014). South Lanarkshire's vision is for -

' ..children, young people and their families to be safeguarded and supported to reach their full potential and thrive within their communities.."

South Lanarkshire Children's Services Plan (2017-2020)

1.2 Criteria for a Significant Case Review

1.2.1 It was determined that the national criteria for holding a Significant Case Review (SCR) had been met, i.e. - *"when a child dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and… the death is by suicide or accidental death…." (Scottish Government; 2015)*

1.3 Purpose of Significant Case Review

1.3.1 The purpose of the significant Case Review (SCR) is, through application of a multi-agency process, establish the facts of, and learning from, lessons from situations where children have been killed or seriously harmed and services were, or should have been, involved. SCRs should be viewed in the context of the need for continuous improvement through reflection on day-to-day practices and the systems within which those practices operate National Guidance for Child Protection Committees Conducting Significant Case Reviews (2015)

1.3.2 A SCR is not an enquiry into why a child or young person died. Families are not able to insist upon a SCR being held, unless the above criteria are met-although other alternatives exist to raise issues and questions, including through the criminal justice systems or through employer disciplinary procedures, where appropriate. The SSCR Group, after considering the Initial Case Review findings and being aware of the Scottish Government's commitment to reducing suicide (Scottish Government, 2018), decided that a Significant Case Review of the circumstances around Child N's death would produce useful learning.

1.4 Terms of reference

1.4.1 The period covered in the Review is from August 2014, when Child N started secondary school, to December 2018 when she died. This allows for a wider consideration of Child N's school experiences, along with agency actions and their impact on outcomes.

1.4.2 The SCR was directed by the Lead Reviewer, Wendy Harrington and supported by the Lead Officer, Child Protection, the Chair of South Lanarkshire's CPC, the SSCR Group and a local Review Team. The Lead Reviewer and Review Team extends thanks to the Support Officer Child Protection, for the invaluable administrative support during the Review.

2. Review Approach

2.1.1 Methodology

This review used a systems-based methodology developed by South Lanarkshire's Adult and Child Protection Committee, informed by the Scottish Government's '*National Guidance'* for conducting a Significant Case Review (2015), the Social Care Institute of Excellence's (SCIE) structured systems-based model, '*Learning Together'* and the Welsh '*Child Practice Model'*. The aim was to produce a locally relevant, evidence-based, proportionate review model.

2.1.2 The approach used aims to avoid hindsight bias in the review and understand what happened in the context of the professional skills, knowledge and supports that were in place at the time. Retrospective analysis of practice provides an understanding of how the wider organisational systems worked. Contextual information was also provided by a 'Review Team' made up of senior managers from each of the services involved. Practitioners who had been

directly involved– the ‘Case Group’ gave information on practice. Issues identified were articulated as ‘findings’. The Lead Reviewer did not have an opportunity to speak directly to Child N’s GP.

2.2 Questions for the Review

2.2.1 The focus of the Review was directed by questions which it was felt would produce the best learning for the partnership, namely-

1. How well do we recognise and respond to risk of significant harm with children and young people across South Lanarkshire?

2. What are the challenges for professionals in engaging with families where mental health crisis is a feature?

3. What helps or hinders multi-agency working in these situations?

2.3 Family involvement

2.3.1 This review concerns the death of a young person, referred to here as “Child N”. Child N was described by all those who contributed to the review as an empathetic, kind, warm, nurturing young woman. She was greatly loved by her family, respected by, and respectful of school staff and she had many friends. Child N was active in the community, supporting younger children and she had many talents. The Lead Reviewer and the Review Team would like to extend their deepest sympathies to Child N’s family and thank them sincerely for their contribution to this work. They wished to help prevent other families from experiencing such terrible loss. Their involvement gave clarity of purpose and momentum to the Review. Child N’s loss is deeply felt in the school and community, but mostly within her family.

3. Case details

3.1.1 Child N died at sixteen and a half years at the end of 2018. After what had seemed like a happy evening with her family at home, watching a video and preparing for a trip abroad, she cartwheeled across the floor, went to her room and hung herself. This did not seem like a cry for help. She chose a lethal method and used it when she was unlikely to be detected. Such was the confusion and despair in her parents over her death and the circumstances around it that they wondered, if they should have picked a different video that night.

3.1.2 Child N’s parents described good, close family relationships in their immediate and extended family. Child N was the “apple of her father’s eye”. Father, a big character, had a job which required him to work long, late hours although he and Child N’s mother made time for their children; the whole family shared community interests and hobbies. They enjoyed having fun and laughing together, being able to describe many such occasions. There was some family history of depression.

3.1.3 Child N generally had good health, being one of the smallest children for her year until she grew very tall when about thirteen years old. She was skilled at sports and had many interests. Child N had enjoyed Primary school and started secondary school in 2014, almost immediately experiencing physical and verbal bullying largely from the same male pupil. These behaviours started as "mean comments" and grew in seriousness. For example, in February and May 2015, she received threats that her Instagram account would be "hacked" to shame her. She was tripped in the corridor and, in December 2015, she was witnessed being threatened by the boy with a hammer in class with the words- "you will be next".

3.1.4 Pupil Support staff seemingly acted upon each referral and whilst they were clear that bullying would not be tolerated, as stated in the school policy, Child N reported to her parents that she felt she was not believed as she had been told, at one point, that "it was her word against the boys". It was acknowledged in pastoral notes in December 2015 that the approach being taken was not working, but there continued to be an over-optimistic view taken after each incident that the matter was resolved. A wider view would have quickly identified that bullying behaviours were continuing and, in fact, increasing in seriousness. Child N did not like to be seen as a nuisance and was very sensitive to how others viewed her. In this context, she tended to advise teaching staff that things were "fine".

3.1.5 The bullying ceased in year three, approximately two years before she ended her life. Child N's ongoing distress initially became obvious in the home environment and her anger and pain were, at times, directed towards her parents. She became upset by any conflict with peers, anxious and ruminating over possible consequences. Child N started to self-harm through cutting her skin in the summer of 2016, which she mostly kept secret from those around her and which she later said had brought her little relief. Child N later told her psychologist that she felt "worthless" as a result of being called "fat" and "ugly". She did not understand why she was targeted, and she felt "different" and isolated.

3.1.6 The chronic nature of Child N's ongoing anxiety became more apparent in the year before her death. Child N was also burdened by exam stress at this time and she became anxious about achieving the grades she required for her chosen career. In June 2017, a disappointing exam result indicated Child N may need to stay on at school an additional year to achieve the results she needed and a letter home from the school added to her anxiety.

3.1.7 Child N wrote of her hopelessness and suicidal ideations in a school essay in October 2017. Her parents again desperately sought help from the school, and she was placed on a waiting list for school counselling where she remained for three months, unseen. A referral to the specialist CAMHS service resulted in her being placed on an eighteen-week waiting list. The school's Pupil Support Teacher provided individual support as other demands allowed.

3.1.8 The Pupil Support Teacher had responsibility for over two hundred pupils and operated an 'open door' policy to enable pupils to seek help when they most needed it. The teacher was off work for several months unwell and during this time, Child N began experiencing panic attacks. She had called her mother from the school toilets in great distress, stating she did not know where to go for help.

3.1.9 Mother again sought help from the school and from community-based workers whom she knew. The workers liaised with the school although they had felt that Child N presented as "bubbly and upbeat". Child N's real feelings were not obvious to people outside of her family. Her tendency to "act in ", rather than "act out" concealed her distress.

3.1.10 There was intermittent consideration of Child N's situation at the school's multi-agency Joint Assessment Team and in March 2018, the team referred for CAMHS and social work intervention in view of the increasing concerns described by the Pupil Support service. A referral to Educational Psychology was ruled-out in view of the CAMHS referral.

3.1.11 In April, 2018, Child N contacted ChildLine at night and informed them that she had just attempted suicide by hanging and had made at least seven previous attempts. She stated her ongoing intention was to end her life. ChildLine immediately informed the police, who also responded promptly and called at the home to advise the parents. The parents described to police their struggle to help their daughter; they had not been aware of her previous attempts to end her life.

3.1.12 Other agencies were alerted of the risk and concern at that point, including the GP and Social Work. Mother and Child N attended school the next morning in crisis. Child N reiterated her intention to end her life by hanging. The school applied the national 'Lifeline' procedures - the Depute Head became involved and the Educational Psychologist was informed due to the possible link with exam stress. During this period, the parents attempted to change their daughter's school although this did not go ahead due to the unavailability of certain subjects.

3.1.13 CAMHS specialist mental health services responded immediately and a Specialist Counselling Psychologist saw Child N the same morning. Regular therapeutic sessions were then delivered- covering safety planning and suicide prevention advice, personal therapy, the role of family and practical techniques to support change. She also attended school-based support groups for exam stress, referred by the school's Joint Assessment Team. Child N's mood improved during the therapeutic session and a prompt follow-up appointment was arranged.

3.1.14 Child N later attended her GP with her mother who was concerned by her daughter's continuing low mood. The GP gave advice on avoiding social media. Child N later said she felt

that she had not been understood. The Pupil Support Teacher recognised a possible link with exam stress and 'special exam measures', including a separate room for Child N to sit in to take the exams if she so wished, was implemented with family agreement.

3.1.15 On the 26th April, Child N attended CAMHS again, with suicidal ideation and self-harming behaviours greatly reduced. However, her confidence remained low and she reported significant social anxiety. A programme of work was devised by the psychologist to focus on these issues, which was delivered in the sessions with home tasks to help improvements.

3.1.16 All agencies, and the parents, felt there had been an improvement and Child N's serious suicidal intentions seemed to disappear, although her low mood continued. Her 16th birthday was celebrated with a party. She generally presented as being happy and involved, although her lack of resilience was occasionally seen when she became extremely distressed over minor incidents.

3.1.17 In June, Child N sat her last exam of the period. CAMHS appointments continued and whilst she remained anxious and distressed, there was no suicidal ideation reported, although there were thoughts of self-harm. Child N was taught behaviour and thought management techniques to practice at home, but she was unconvinced this would be helpful and was reluctant to do the work. She did, however, report to feeling better from unburdening herself. However, she was vulnerable to the views of others and their perception of her, so her mood often dropped quickly and unpredictably during the day or evening.

3.1.18 Social Workers met the parents a week after the ChildLine call, aware of other agency involvement. They intended to allocate the case, but in view of the improvements reported by school, the case was closed months later without further direct contact with Child N.

3.1.19 Child N had taken a part- time job and was taking on leadership roles at school and seemed well. Eight out of twelve therapy sessions were attended, with others being cancelled due to Child N's work or due to family error.

3.1.20 Child N's paternal grandmother, whom she was close to, died in September 2018 and she was acutely aware of the significant distress this caused her father. Child N attended her first funeral and stated she felt she had "needed more time with her grandmother".

3.1.21 CAMHS was not aware of the bereavement until the next session. Child N seemed to be coping better by then and she asked for a break in therapy to focus on exams. The CAMHS service offered, as an alternative, emergency appointments and a phone support service, which was not taken up. A review of progress was held by CAMHS in October. Child N felt that "everything was falling to bits"; she felt isolated and was self-loathing. She later attended the GP

with her parents who were concerned by her mood and received anti-depressants. CAMHS, which had the lead professional role, only learned about the anti-depressant medication days after it had been prescribed-despite their potential risks, as well as benefit, for actively suicidal patients.

3.1.22 There seemed to be a lasting reduction in suicidal ideation and Child N also appeared to the school to be growing in confidence. She had attended seven or eight of the school's support groups and she was thought to be "thriving". The school stated, "She did not fit the pattern of someone with escalating mental health problems".

3.1.23 The evening before school started for the week, the family had watched a film, then Child N had gone to bed, seemingly relaxed and happy. There, she used her belt as a ligature and took her own life through hanging. Her parents had heard a thud but thought nothing of it. Her father, who found Child N after a short time, tried to resuscitate her, as did the ambulance service. However, Child N tragically died in hospital later the same day. A note was left which indicated that bullying was the reason for her action. The note was found within Child N's papers and it was not clear when it had been written. The police investigated but found no evidence of bullying in recent years.

3.1.25 The Education Department's 'Critical Incident Procedure' was implemented and Educational Psychologists provided support to very distressed pupils and staff. The Pupil Support Teacher worked tirelessly to assist affected pupils and his own health was impacted. CAMHS advised the school on coping strategies. Child N's chair sat empty in the classroom for the remainder of the year. There has been, since Child N's death, an increase in pupils reporting suicide ideation. Counselling services have been increased.

4. Analysis of practice

4.1.1 At the time of transition between Primary and Secondary school, children lose the support of familiar staff, whilst being expected to cope with a much larger school and a more complex environment. Child N transferred to a secondary school with a pupil roll of 1350. She had experienced bullying almost immediately. Pupils transferring with learning or physical disabilities benefited from a planned transition, including pre-transfer meetings and information being shared with class teachers to ensure a consistent approach. This process does not generally take place for children and young people who have emotional or mental health needs, unless these are presenting very acutely. The schools are often not equipped to identify and support children with these mental wellbeing issues**- see Finding 3**

4.1.2 The Care Inspectorate had described the school as 'nurturing' in a recent Inspection and the school's policies on bullying were pupil-centred, sensitive, informed and balanced. The Senior Managers and Pupil Support Teacher informed the Review that the school implements a strict and widely communicated policy of 'no tolerance' of bullying. They had worked hard to reduce the

stigma of reporting emotional problems and encouraged children to seek help. There was evidence throughout the review that this approach had been successful. Pupil Support Teachers had dual responsibility for teaching and supporting up to 200 pupils- although Child N's Support Teacher focused solely on 'pupil support', having responsibility for a larger group of pupils as a result.

4.1.3 The teaching staff were proud of their 'truly comprehensive' school, which catered for a wide range of learning abilities in one inclusive environment, but they also reflected on the additional demands, in terms of lesson preparation, that this diversity placed on them. There was evidence that education staff were under considerable pressure from high levels of pupil need relating to mental wellbeing/ health issues and struggled to balance their responsibilities. School senior staff estimated that at least another five Pupil Support Teachers were required at the school -**see Finding 3**

4.1.4 Within any secondary school population, there is a number of children who, statistically, are at risk of self-harm and suicide. It was the practice in Child N's school for all teachers to be trained in recognising these issues and in acting, using the national 'Lifeline' procedures. The Pupil Support Teacher at Child N's school had undergone basic training in mental health, including the Applied Suicide Intervention Skills Training (ASSIST) and had attended a two-day Mental Health course. This enabled teachers to better recognise issues and signpost children and young people who needed help. However, due to waiting lists for specialist support, teachers within minimal training were expected to intervene, over a considerable period, in complex mental health problems for which they were not trained, usually alongside teaching duties- **see Finding 3,4.**

4.1.5 Children who are vulnerable to poor mental health and who have internalised their anxiety, may present as being quiet and 'well behaved' and can be difficult to recognise. Factors such as personality, early childhood experiences and genetics can all play a part in predisposing children to develop later difficulties. It is important to reduce risk and increase resilience at universal level, in addition to targeting interventions at 'high risk' populations, as not all vulnerabilities are obvious and even resilient children cannot be protected from life's challenges. Evidence-based programmes which actively nurture emotional intelligence, empathy and resilience within all infants and toddlers- for example pedagogy techniques in nursery-will support the development of a healthier population and a stronger service continuum for mental health in partnerships. The aim should be to reduce both bullying behaviour and the resilience of children affected by such behaviour -**see Finding 3**

4.1.6 Child N's Pupil Support Teacher operated an 'open door policy' to encourage pupils to seek help for well-being issues and worked to reduce associated stigma. Child N spoke to the school about the bullying she was experiencing early on, and about her suicidal intentions. This indicates that a healthy culture had been created where children felt able to be open. At all points in the

review, education staff stated they were willing to learning about any changes which may improve practice. This openness is systemic, relating to organisational culture; this is good practice- **see Finding 4.**

4.1.7 Mother visited the school several times, expressing concern over the continuing and escalating nature of the bullying of her daughter and the distress this was causing her. The Pupil Support Teacher appeared to have responded to all episodes of bullying and escalated concerns to the Senior Manager in the school at certain points. The school's approach, however, was episodic and failed to understand or address the chronic nature of the problem and the underlying causes of the bullying. Whilst the challenge of recognising the level of Child N's distress is not underestimated (as she tended to conceal it until a real crisis arose), it is unclear why the school felt that stern words to the child who was bullying was a useful way forward, when this had not worked previously. In fact, matters were escalating. Threatening a pupil with a hammer is a very serious matter. The school had a responsibility to both children; it was recognised that the child who was bullying had his own personal challenges. However, Child N was left in this unacceptable situation for too long.

4.1.8 The impact of the intervention to stop the bullying was not followed up robustly enough in the school and not enough cognisance was taken of how difficult it is for bullied children to speak out repeatedly about their situation or how long term emotional consequences can result from past bullying. When the bullying behaviours temporarily stopped, it was optimistically presumed that the situation had been resolved. A wider, more informed overview was required. This may have led to a different approach **see Finding 2**

4.1.9 The school used the 'Treat Me Well' and local 'Anti-bullying Behaviour Guidance (2018)'. The Pupil Support Teacher followed established school practices, although the review has not seen operational guidance which details the thresholds for escalation of concerns by both the number of, and seriousness of, bullying incidents. It is expected, however, that multi- agency meetings, along with an integrated assessment and a Child's Plan are used for all situations of complex need and risk. Quality policies based on good principles were in place but best rhetoric was not usefully translated into clear advice for busy staff. Without a stepped pathway for action on bullying, informed by a chronology of incidents, an approach was taken which viewed periods of remission as 'success' **see Finding 2.**

4.1.10 School pastoral recordings in the SEEMiS electronic system were brief, with infrequent entries over large periods of time. Details which would have been helpful to the review, such as the date of Child N's essay in which she had detailed her suicidal ideations, could not be found. There was no consistent cross-referencing with Joint Assessment Team decisions, and without a single source of information, the significance of accumulated bullying incidents was less obvious to staff-**see Finding 2.**

4.1.11 Child N reported to feeling hopeless in therapy. Both ‘hopelessness’ and ‘self-harm’ are precursors of suicide. Child N was acutely sensitive to the views of others and whether her reports of being bullied had actually been believed. No one really understood the emotional world that this adolescent lived in- **see Finding 1**

4.1.12 There is a significant and growing national demand for specialist mental health services for young people which has been known, for many years, to outweigh resource availability. The Scottish Government has a priority policy on mental health, with a clear agenda for prevention and early intervention (2018). In 2017-18, NHS Boards spent £1billion on mental health services, with additional workers being provided in key settings, and £5m to support transformational change across Scotland. There is a stated commitment to ensuring, by the end of the academic year 2019/20, that every local authority will be offered training for teachers in mental health first aid, disseminating the learning through the school, linking the agenda with Adverse Childhood Experiences (ACES) and ‘nurture and trauma informed practice’. The Government funds a national anti-bullying programme, ‘Respectme’**.**

4.1.13 The Child and Adolescent Mental Health Service (CAMHS) involved with Child N covered a population of 300,152 children and young people. Referrals were accepted only from professionals on young people up to eighteen years of age (if they remained at Secondary School). Due to demand, the service had an eighteen -week waiting list, and expected evidence of ‘significant impairment in day to day functioning’ resulting from ‘moderate to severe emotional, behavioural or mental health difficulties’ before allocation. There was, however, no -one involved in Child N’s day-to-day life at school who was sufficiently expert to be able to identify the severity of her emotional difficulties, or the impact this had on her daily functioning**- see Finding 3.** The service also had extensive exclusion criteria in place, one being “exclusively school-based problems”. It is questionable whether schools would necessarily be informed of home-based difficulties without multi-agency information sharing.

4.1.14 The Partnership’s ‘Mental Health Support Pathway’ for children and young people emphasised the importance of a continuum of support -from short-term issues in response to one off events, to more complex, enduring mental health problems. Pressure on specialist CAMHS provision from more serious issues, and perhaps from insufficient early intervention services, had resulted in a concentration of expertise at the higher end of the continuum. This subsequently required the school’s Pupil Support Teachers to deal with complex matters without being adequately equipped to do so-**see Finding 3**

4.1.15 Teaching staff described the relentless demands for pastoral support. The impact of this situation on the teacher’s wellbeing was clear -**see Finding 4.** The lack of sufficient resources to deal with children’s mental health issue in school is found to be ongoing and systemic – **see Finding 3**

4.1.16 There was evidence that mental well-being services had developed somewhat organically in the school, with a considerable level of self-determination being allowed locally in how national resources could be used to purchase support. It was unclear what data on need had been applied in the decision to commission a particular service, how the services worked as part of a whole system approach and how outcomes were measured. There was a feeling amongst specialist mental health workers that more consideration needed to be given to these issues, and to the advantage of strengthening the internal Psychiatry/ Psychology service rather than increasing external counselling services- which may better address priority need. Strengthening existing mental health services, which operate under a common governance and standards framework, and which work as established organisational planning partners in a whole system way, may lead to a less fragmented system which currently is characterised by blockages in care support. Child N's mother stated "it was left too late to help her"- **Finding 3**

4.1.17 The deterioration in Child N's mental health became more apparent when she contacted ChildLine following an unsuccessful suicide attempt. She described several previous attempts and had a plan to end her life. These were very significant risk factors. ChildLine's action to inform the police, who also responded quickly to speak to the parents and alert Social Work, was all good practice.

4.1.18 The Pupil Support Teacher followed internal procedures and contacted Senior Management and also CAHMS, requesting an urgent consultation for Child N. CAMHS responded to "an immediate and significant risk of harm" according to their 'Deliberate Self Harm/ Admission Protocol' and saw Child N the same morning. This was all good practice- **see Finding 4.**

4.1.19 Throughout the review, the professionalism and skill of the Psychologist was mentioned repeatedly by services, particularly school staff, who had great confidence in the service. In some respects, other agencies were over-optimistic about the ability of the CAMHS service to address complex risk matters without other agency support. There appeared to be, from discussions with education staff and from the Joint Assessment Team (JAT) minutes, a collective 'sigh of relief' that Child N was now receiving the help she needed**- see Finding 1**

4.1.20 Whilst the CAMHS service has an internal tradition of mutual peer support and group case discussion, research also highlights the importance of wider service involvement -"no-one single source or authority, however, defines the standard of care in suicide risk assessment" (Simon, 2006). Connections with other agencies were, however, limited to occasional updates, rather than being in the form of joint planning. Throughout the period, there had been no multi-agency chronology, no obvious Lead Professional role undertaken and no joint assessment or Child's Plan- so decisions were made on a silo basis by agencies, based entirely on how Child N presented. Her presentation however changed rapidly.

4.1.21 Duty Social Work contacted the parents seven days after Child N's call to ChildLine and it was eleven days before the family was seen. Social Work was aware of other agency involvement

and did not see the situation as a priority for their service, but rather as a health matter. It was unreasonably presumed that the parents could, or should, manage the risk. It is unclear what Social Work perceive their role to be, more generally, with adolescents who are at risk of self-harm and suicide. Other agencies viewed Social Workers as only having capacity to work with traditional 'protection cases'- **see Finding 5,1**

4.1.22 Despite an intention to allocate Child N, Social Work closed the referral after learning that mental health services were involved. At the time, the Duty Social Work Service was overwhelmed with more than 200 referrals waiting for attention. The case was closed when Child N was actually 16 years old, without Social Work speaking directly to her to ask her view on this. This was not respectful and denied her the right to choose. The review found that Social Workers were unclear about their responsibility for, and role with, young people who were at significant risk but who had no 'carer safeguarding' issues. They were not supported by practitioner guidance relating to self-harm and suicide **see Finding 5, 1**

4.1.23 The stated aim of the Scottish Government is that "anyone contemplating suicide gets the help and support they need." It is not a simple task to determine what each individual "needs", and what is the best methods for delivering this. What is clear, however, is that mental health problems impact widely on individuals and therefore any effective plan of action must mirror this presentation-"mental health is not a discrete entity which can be meaningfully considered in isolation from the rest of life.." (NHS Scotland, 2003). Bullying, also, is a complex problem that requires a multi-faceted approach.

4.1.24 The tendency for mental health specialist social workers to be placed within Adult Social Work Services, and for CAMHS' multi-agency teams not to include a social worker (rather a generic clinical worker who is often a nurse), has resulted in an erosion of mental health expertise in children's social work and also reduced access to the Social Work perspective and skills at CAMHS level. 'Social Workers acknowledged the 'consulting' services provided by CAMHS for allocated cases but felt that it was usually not sufficient to allow them to effectively help very troubled young people - **see Finding 5, 3.**

4.1.25 The parents felt that the JAT became involved too late and reported that their involvement and view was not sought. The JAT seemed to function largely as a gateway to resources, relying mainly upon the view of teachers as to the level of mental health difficulty. Some staff contributing to the review were confused about the purpose and function of the JAT. There seemed to be no clear reason why Child N had not been discussed at each meeting and certainly this was not procedurally correct- **see Finding 2**

4.1.26 The JAT meeting was not, anyway, an acceptable substitute for a multi-agency 'Team Around the Child' meeting which, under the 'Getting it Right for Every Child' national policy, should have been considered. Despite significant risk, at no point was an integrated assessment, a chronology, or a Child's Plan sought by the JAT or key/ lead professional –which may have

evidenced Child N's vulnerability and shown that she met the criteria for an urgent CAMHS appointment much earlier. It was assumed that Child N's mental health issues would be receptive to a single agency intervention. The risk associated with Child N's mental health presentation was viewed differently to an equivalent risk associated with typical child protection matters, leaving her more vulnerable. Child N's father felt that services had not worked together to help his daughter as "they, as a family, did not tick enough boxes" - **see Finding 1, 5.**

4.1.27 There was insufficient communication and collaboration with the Pupil Support Teacher by the Psychologist, which resulted in the Teacher being reluctant to "say too much" to Child N and "upset the work of the Psychologist". Information sharing by CAMHS with other agencies is not collaboration and often not even communication. In addition, the GP did not discuss an intention to prescribe anti-depressants with the Psychologist, despite being aware of CAMHS involvement and regardless of the risks (as well as benefits) of anti-depressants for individuals who are actively suicidal. The Psychologist was informed by letter, days later. This should have happened sooner, regardless of the undoubted work pressures that GPs cope with. This is reported to be standard practice and is systemic.

4.1.28 The Psychologist did write to inform both the referring Pupil Support Teacher and the GP of progress, although well outside of the five-day timescale standard set in the CAMHS protocol. Despite the very high regard the school has for the CAMHS service and for the Psychologist involved in particular, they reported liaison was often limited and it is presented here as a systemic finding- **see Finding 3, 1.** There appears to be a compartmentalisation of systems and services in the field of mental wellbeing for young people, each operating with separate agendas, lacking connectivity and working independently **- see Finding 1, 3**

4.1.29 During this period, CAMHS continued to provide psychological therapy. From April 2018 until Child N's death, a total of twelve appointments were offered at regular intervals; eight were attended, two were cancelled due to Child N's part-timework and two were not attended due to family error. Over the exam period, Child N asked that no therapy appointments be arranged, and she was provided with the Psychologist's office number to use if a crisis arose. This consistency, quality and flexibility of therapy was good.

4.1.30 The therapeutic approach and techniques used has the most evidence for effectiveness in cases presenting with suicidal ideation and self-harm. In order to reduce risk, a Crisis Management and Safety Plan was developed, which included a plan to restrict Child N's access to the means of suicide, and this was reviewed each therapeutic session to take account of the fluctuating nature of suicidal feelings. It is widely acknowledged that removing all possible means of hanging is particularly difficult, even in hospital settings, due to the large number of possible sources. The formulation, assessment and therapeutic programme was clear, evidence-based, structured and well recorded-**see Finding 4**

4.1.31 During therapy, Child N reported that she was struggling with the death of her grandmother and she was aware of the impact this had had on her father, who was bereft. By this time, despite her upbeat presentation, Child N had numerous high- risk indicators and this was potentially a period of acute risk for Child N. Self -injurious and suicidal behaviours, along with suicidal intent, plus an adverse life event are known predictors for suicide (Hawton et al, 2012). Child N had already stated that she intended to choose hanging as a method of suicide, which has a higher risk of fatality- 70% from studies. The review considered whether the decision to treat Child N in the community, as opposed to arranging hospital admission, was the correct one, given the knowledge that was available to the mental health service at that time. The review sought the view of Senior CAMHS staff, considered the risk factors which were present and also researched 'predictability' findings.

4.1.32 The CAMH's 'Assessment and Admission Protocol for young people who present following an episode of deliberate self-harm or with a mental health emergency' (reviewed June 2019) details the governance and accountability for admission decisions. The CAMHS Consultant Psychologist advised that, on balance, the protective factors within Child N's life- the presence of supportive parents, positive engagement within the community, planning for the future, engagement in therapy and improved presentation- meant that the decision to treat Child N in the community was, without the benefit of hindsight, the correct one. Child N had, in fact, ended her life after she had described a lasting reduction in symptoms and suicidal intention with apparent progress across various domains of her life.

4.1.33 Research, anyway, indicates that the existence of high-risk factors cannot reliably predict suicide. In 2014, only 0.12% of all suicides were individuals who died in the period after contact with psychiatric out-patient services. In their nationwide psychological autopsy of suicide, Isometsa et al (1995) found that only a small minority of patients who completed suicide had spontaneously communicated their intent during their last healthcare appointment. De Leo et. al. (2013) reported similar fs. ScotSID has stated –"these data confirm the view that the prediction of even short term risk of suicide at the individual level is highly problematic".

4.1.34 Furthermore, Fox et. al., 2004 found that only a small proportion of adolescent suicides showed evidence of planning immediately before the death occurred, concluding- "even the most powerful risk factors for suicide have poor predictive ability". Child N died just before her preliminary examinations, which may have been a factor in her decision to end her life. Her mood was rapidly affected by external factors and it is not known what led to her decision, or whether her real intention was to end her life, given other, unsuccessful attempts. The Scottish Government is concerned over the increase in the suicide rate in the under 25 year's age group –currently at its' highest level since 2007 and is amongst the highest rate in Europe (Scottish Government; 2018). National policy has focused on prevention and early intervention, aware that predictability of completed suicide at an individual level is poor. The review concluded that there was no indication for professionals or the parents that Child N would end her life at that time.

4.1.35 Following Child N's death, children in the community groups were very upset; council services were not fully aware of the breadth and depth of the distress that Child N's passing, and the circumstances in which it took place, had caused.

Good Practice

The Review found the level of commitment and skill in engaging and helping young people at different parts of the mental wellbeing continuum- particularly with the CAMHS Psychologist and school Pupil Support Teacher- was very high, and that there has been a personal price to pay for the stressful work they undertake in difficult circumstances. Pupil Support Teachers and their senior management colleagues have worked hard to successfully develop a non-stigmatising, open culture within the school which supports young people to seek help. It was obvious that this service was well utilised by pupils. The Community Support Workers showed an impressive commitment to supporting the community, continuing group work in their own time when the service ceased. The support from the Educational Psychologists to the school staff and pupils, following Child N's death, was rated highly.

5. Findings & Contributory Factors

1. GIRFEC guidance is not being followed in universal services for young people presenting with complex mental health problems, resulting in the child/ young person's world not being fully understood.

Areas to consider -

- Development of local-multi agency practitioner guidance for working with self-harm and suicidal ideation in children/ young people; measure outcomes.
- Achieve parity for high risk mental health issues with child protection (intervention priority and professional skill development.)
- Clarity on the role and remit of the Joint Assessment Teams including the line of demarcation between JAT business and matters for an operationally- based multi-disciplinary forums

2. School procedures are not sufficiently robust in relation to escalating matters of persistent/ serious bullying, with the potential for a lasting, significant impact on children and young people with reduced resilience.

Areas to consider-

- Is the Education service confident that all establishments have developed local procedures for addressing bullying as required in the 'Treat Me Well' policy?
- Is the partnership confident that bullying procedures recognise the impact that sustained/ serious bullying can have on less resilient children and young people and include appropriate escalation measures?
- How can schools be supported to effectively and timeously address bullying whilst taking account of the needs of all parties involved?

3. Strategic planning of mental wellbeing and mental health services, informed by data on need and outcomes, should ensure that mental health expertise and resources are more evenly spread across the support continuum.

Areas to consider-

- Greater involvement of local mental health experts, working in operational services and schools, in planning and strategy. Shared design of mental health services across primary and secondary health, social care and schools aiming to strengthen the whole continuum of services from prevention through to targeted expert help.
- Robust quality assurance measures in relation to outcomes achieved by independent counselling services in schools?
- The demands on the CAMHS service are so high that it seems inevitable that many more young people in significant distress will have to wait for help. How can the leadership in South Lanarkshire be sure young people with moderate to severe mental health difficulties are kept safe if there is a four-month waiting list for a specialist service?

4. There was a high level of commitment and skill seen in the Pupil Support and CAMHS service to promoting good mental health for young people

Areas to consider-

- Ensure the expertise and experience of experts is better harnessed within strategic and service planning activities to produce an improved pathway for children and young people experiencing mental wellbeing/ health issues- including those who internalise distress. Increased focus on early years interventions to promote resilience/ emotional intelligence. Support to children after experiencing bullying.

5. Social work services have become peripheral to mental health work with young people in South Lanarkshire which means that children and young people, and the wider multi-agency network, do not benefit from their perspective and skills.

Areas to consider-

- What is the Social Work role when a young person self-harms or is considering suicide; the lack of confidence of other agencies in Social Work's ability to assist with cases where concerns about lack of care do not exist.
- Do Social Workers understand the inter-play between Children's and Mental Health legislation; how can expertise in mental health work be increased within Children's Services?
- How can CAMHS services, which do not have a co-located social worker in the team, ensure they incorporate the social work perspective in their work?
- How do cases of high risk from mental health issues fit within established safeguarding procedures, as indeed, they do present differently.

Appendices

Appendix I. The Review Team *(senior managers who represented stakeholder organisations involved in the case but did not have a decision-making role in the case)-*

Lead Officer, Child Protection; Fieldwork Manager, Children and Justice Services, Social Work Resources; Consultant/ Lead Clinical Psychologist, NHS Lanarkshire; Quality Improvement Officer, Education Services; Detective Chief Inspector, Police Scotland and;.

The he Case Group (individual practitioners who were directly involved in working with Child N or had made decisions on her case)-

Children and Justice Service Social Worker; Counselling Psychologist; Children and Adolescent Mental Health Service (CAMHS), NHS Lanarkshire; Educational Psychologist; South Lanarkshire Education Services; Support Staff; Education Services, Depute Head Teachers; Community Youth Workers; Education Services.

Appendix II. Glossary of terms

ASSIST- Suicide prevention training

CAMHS- Children and Adolescent Mental Health Service

JAT - Joint Assessment Team

MAPPA-Multi-agency public protection arrangements.

GP- General Practitioner; NHS-National Health Service

CPC-Child Protection Committee

ICR-Initial Case Review

SCIE-Social Care Institute for Excellence

Appendix III. Documentation considered in this review-

Initial Case Review Forms A& B. Case records.

Getting it Right for South Lanarkshire's Children and Families 2017-2020 (integrated children's services plan).

Children and Young People's Mental Health Support Pathway (Practitioner Guidance) (April 2018).

South Lanarkshire's Business Plan 208-19.

Joint Assessment Team Minutes.

South Lanarkshire Public Protection Strategy; 2017-2018.

West of Scotland Child Protection Procedures

Assessment & Admission Protocol for Young People (under 18 years-deliberate self-harm/ mental health emergency)

TreatMeWell-bullying guidelines; 2018

Lanarkshire vulnerable children/ young people good practice guidance; 2012

SLCPC Self-evaluation Strategy & Activity Programme (2017-19).

SLCPC Annual Report 2017-18.

Multi -agency guidance on self-harm and suicide in young people; SLCPC