Significant Case Review

Executive summary

Child L

Conducted by South Lanarkshire's Child Protection Committee (2019)

Lead Reviewer: Dr Adam Brodie

TABLE OF CONTENTS

INTRODUCTION

The death of a child or young person is a tragic occurrence regardless of age or the circumstance. South Lanarkshire Child Protection Committee wants to extend their thanks to the family of Child L during this difficult time and for their assistance and understanding as the Review was progressed.

Thanks also are extended to the Lead Reviewer, the Significant Case Review Team and those multi-agency partners who took part in the Review.

1. WHY WAS THIS CASE CHOSEN TO BE REVIEWED?

1.1 The South Lanarkshire Strategic Significant Case Review (SSCR) Sub-Group chaired by the Independent Chair of the South Lanarkshire Child Protection Committee (SLCPC) became aware of the death of a 12 year old child (Referred to in Report as Child L) in autumn 2018.

1.2 The circumstances surrounding the death of Child L, were discussed by the South Lanarkshire SSCR Sub Group meeting. Having considered the criteria set in the National Guidance for Child Protection Committees Conducting Significant Case Reviews (2015) it was agreed the child's death met the criteria to proceed to SCR.

1.3 The scope of the Review was agreed as the three year period (2015 – 2018) of the child's life. The Review commenced in January 2019.

2. METHODOLOGY

2.1 There is a challenge in writing a report which protects, as far as possible, the privacy of all individuals concerned but provides sufficient evidence to support the findings. Every effort has been made to write as clearly as possible to explain the complexity and ambiguity of the system.

2.2 A hybrid model developed created by SLCPC was used for the Review and incorporates a local system referred to as "A Practical Approach to Conducting SCR's in South Lanarkshire" and elements of the Systems Model offered by SCIE[1]

2.3 The Review Team and Case Group

2.4 The Review was undertaken by Dr Adam Brodie, Consultant Addictions Psychiatrist. As Lead Reviewer, acting on behalf of South Lanarkshire Child Protection Committee, Dr Brodie had no connection to services directly provided to Child L.

[1] Social Care Institute of Excellence

2.5 The Lead Reviewer was supported by a Review Coordinator (Lead Officer Child Protection) and a Review Team whose membership was identified by the South Lanarkshire SSCR Sub Group from across the agencies involved in the case, who had not held any decision-making responsibility in relation to the child involved. Collectively, their role was to assist the Lead Reviewer in holding discussions with relevant staff known to the child and to contribute to the analysis of data and inform the final report.

2.6 Ownership of the final report lies with South Lanarkshire Child Protection Committee on behalf of the SSCR Sub Group and the South Lanarkshire Chief Officers Group (COG) Public Protection.

2.7 Review Team Membership included managers from Social Work Resources, Police Scotland, Education Resources and NHS Lanarkshire.

2.8 After a full multi-agency staff briefing had taken place, discussions were held with identified members of staff involved in the case across services. Staff were provided with the opportunity to bring an appropriate support person with them and were afforded the opportunity to view their recorded discussion ahead of submission to the Lead Reviewer.

2.9 **Involvement of Families**

2.10 The mother of Child L agreed to take part in the Significant Case Review and met with the Lead Reviewer and Review Coordinator (Lead Officer, Child Protection) with support of a Befriending Service.

2.11 **Review Questions**

2.12 Two sets of key questions were asked by the SSCR Sub group in order to (a) better understand the circumstances for the child and her family and its prevalence in the local areas and (b), how we understand and respond to significant harm in South Lanarkshire including the challenges faced in complex cases where mental health crisis is a feature.

3. THE FACTS

3.1 Child L was born 2005 and died in 2018, aged 12 years.

3.2 Police Scotland advised Social Work Resources about the death of Child L. The child's death was confirmed afterwards as suicide.

3.3 Prior to the death of Child L by suicide in 2018, the child/family had contact with Social Work Resources, Health, Child and Adolescent Mental Health Services (CAMHS), GP, Education, Police Scotland and Third Sector organisations.

3.4 Records show periods of domestic incidents, history of parents and extended family mental health issues, parents' substance misuse and destitution for the family. Following parental separation, there was little contact between Child L and Child L's father.

3.5 A comprehensive chronology was provided by agencies and key practice episodes [2] identified by the Review Team in considering evidence and outcomes.

4. KEY INFORMATION

4.1 Summary of Education Contacts and Concerns

4.2 Child L was reported as isolated from peers during primary school. The secondary school were made aware of the challenges faced by the family including parental mental health concerns. The inappropriate use of social media was reported by the mother as problematic, alongside parenting challenges in relation to behaviour of Child L at home.

4.3 Throughout Child L's first year and at the start of S2, Child L sometimes had difficult interpersonal relationships with other pupils; it was noted that the school did offer considerable support to both the mother and child, but incidents occurred when Child L was angry with other pupils as a result of perceived bullying in school and on social media (which was not able to evidenced fully by the school, resulting in a difference of views between the family and the school). Child L was discussed at the school Joint Assessment Team (JAT) meeting in respect of suicidal thoughts, feelings and behaviours as well as episodes of deliberate self-harm. At no time was reference made to applying the Getting it Right for Every Child (GIRFEC) principles in assessing the child's wellbeing throughout this period.

4.4 Summary of Social Work Resources (SWR) contact and concerns

[2] SCIE – Social Care Institute of Excellence

4.5 Since October 2016, SWR had received intermittent reports of issues relating to risk to Child L, either in relation to deliberate self-harm or via the actions of others. It was judged that these did not meet the level at which Child Protection processes or any initial assessment could be initiated. After significant concerns emerged including potential online sexual exploitation, possible contact by the mother of Child L in March 2017 with a person on Life Licence, acts of deliberate self-harm and suicidal thinking in September 2017, and following requests for support from Education Resources and CAMHS, it was agreed that Child L should be allocated a social worker.

4.6 The National Guidance for Child Protection in Scotland, 2014 (part 614) states; *"Children and young people can place themselves at risk of significant harm from their own behaviour. Concerns about these children and young people can be just as significant as concerns relating to children who are at risk because of their care environment*".

4.7 Both the National Guidance for Child Protection in Scotland (2014) and the West of Scotland Online Child Protection Procedures clearly state that; *"Some children and young people place themselves at risk of significant harm from their own behaviour. Where such risk is identified, as with other child protection concerns, it is important that a multi-agency response is mobilised and a support plan identified to minimise future risk".*

4.8 From February 2018, further concerns was raised by CAMHS including an alleged significant event (later retracted by the child) that led multi-agency case conference in August 2018. CAMHS were not present and did not submit a report. Concerns were raised regarding support for the mother who was struggling to cope. A further meeting was planned for early October 2018 but never took place due to the death of Child L.

4.9 <u>Summary of Health Contact and Concerns</u>

4.10 Child L was referred to the Child and Adolescent Mental Health Service (CAMHS) after emergency mental health assessment at the local hospital Emergency Department due to concerns about deliberate self-harm and suicidal feelings (records indicated that Child L had a first recorded episode of self-harm aged 9yrs) in September 2017. Allegations made by Child L's mother of online "grooming"; a strong family history of mental health issues for both parents, and completed suicide within the wider family was also recorded.

4.11 With further concerns emerging, including allegations of bullying. Child L took a deliberate overdose in November 2017. Thereafter Child L was seen by CAMHS regularly until June 2018, with CAMHS Intensive Treatment Team (CITT) input when needed during periods of identified increased risk.

4.12 Further appointments were cancelled by Child L prior to the suicide; only one was attended in late August 2018.

4.13 Summary of Police Scotland Contact and Concerns

4.14 At the age of 9 years, it was reported by Child L's mother that Child L had been involved in "grooming" via social media, and there had been a previous report in May 2013 of a domestic abuse incident.

4.15 In October 2016, there had been further reports of online "grooming"/sexual exploitation via social media; the family were advised on keeping safe, respective national Police agencies were contacted, and a notice of concern was sent to Social Work Resources. There is no record of this being formally considered as Child Sexual Exploitation, and in January 2018 – after Child L was found to be in contact with older youths via social media with sexual content an investigation by Police Scotland took place.

4.16 Police Scotland investigated Child L's deliberate fatal overdose of Child L's mother's medication in September 2018.

4.17 Summary of Interview with Mother of Child L (May 2019)

4.18 In May 2019, the mother of Child L met with the Lead Reviewer and the Review Coordinator (Child Protection Lead Officer), supported by staff from the Befriending Service. The mother advised a number of concerns in relation to her contact with agencies, both positive and negative. The issues raised about interventions and key events caused the mother considerable distress at the time of interview.

4.19 Child L's mother repeatedly reported during the meeting that she did not understand why her child had been taken out of class to work alone in the "base" at school. Although school staff are clear that this was action taken to support Child L, Child L's mother viewed this as "punishment", and repeatedly advised that Education staff needed increased awareness around the impact of bullying.

5. ANALYSIS

5.1 Impact of Professional Practice

5.2 Services clearly recognised that Child L was high risk with regard to deliberate self-harm/suicidal behaviours and in other key areas including alleged bullying and sexual exploitation. Despite placing themselves at harm, no child protection procedures were ever considered or invoked by services for Child L.

5.3 Exploitation and Sexualisation

5.4 There are a number of incidents recorded when Child L had been involved in inappropriate online contact with older males (whether adults or older young people) which involved sexual elements inappropriate for Child L's age and stage of development.

5.5 Maternal Vulnerability

All contacts report social isolation and a high level of maternal vulnerability due to the mother's own history affecting effective parenting and at times competing with Child L's needs. The mother reported feeling excluded from service working and information provision, with a sense of disempowerment and a lack of understanding of the consent process, in particular. Parental issues were recognised as significant by all staff involved.

5.6 Social Media

5.7 Negative issues with social media featured highly in staff discussions with the review team. These included concerns over sexual exploitation and online grooming, facilitating perceived bullying and harassment, and allowing negative events even out with school and face-to-face peer contact. Child L's inability to "escape" social media may have contributed to feelings of entrapment and hopelessness, ideation recognised as being associated with completed suicide.

5.8 Social Isolation

5.9 The family unit of Child L and Child L's mother was seen as socially isolated. There is the sense that the outside world was perceived as threatening to the family unit, rather than being a source of support, positive activity and opportunity. Befriending input provided social contact for Child L in a situation the mother viewed as safe, allowing the mother her own time. There appeared little other opportunity for both positive socialisation for Child L and respite for the child's mother.

5.10 Other Family

5.11 Child L's father was described as absent from the care arrangements for Child L, and it was reported that the maternal grandmother's views regarding care would sometimes conflict with that of the mother; little support appeared to be available for Child L and Child L's mother, and it is likely that paternal absence fed into Child L's mental health issues.

5.12 Relationships

5.13 Child L is reported to have witnessed significant violence in the parental relationship at a young age, followed by the relationship split between Child

L's parents – potentially modelling unhelpful interactions/relationships to Child L at a young age. It seems reasonable to assume that the absence of Child L's father in Child L's life following this may have led to the possibility of feelings of rejection and abandonment on the part of Child L.

5.14 Emotional Need

5.15 Agency staff felt that there was intermittent instrumental use of reports of sexual contact, suicidal feelings, and substance using behaviour by Child L to draw attention to Child L's negative emotional state, and Child L had reported to care-giving staff that Child L's family did not understand the extent and nature of Child L's distress. Child L appears to have had very few positive and wholly supportive relationships with others across the social milieu, with respect to having emotional needs met by other people generally in life.

5.16 Service Issues (Communication and Perception of Child Protection)

5.17 There are multiple reports of disconnects in communication between the services involved in the care of Child L, around information-gathering, care planning, treatment, and access to significant information. This was felt by all the services most involved in care. The multi-agency case conference arranged was not attended by all involved services, and there were issues around taking the lead in care, on clarity of roles and with respect to the focus for intervention. The perception of Child Protection procedures appeared to be that risk of harm from self would not trigger formal Child Protection, as would be the case if the young person was at risk from others; however, risk from others also intermittently occurred and did not trigger further formal Child Protection work.

6. FINDINGS

6.1 Child L displayed signs of low self-esteem, low mood, anger and distress. Parasuicidal thinking and behaviours occurred, with relatively frequent verbalisations of intent (occurring within and out with school) to fulfil these purposes. Child L also appeared to use communications involving sexualised speech for similar purposes, and on several occasions reached out to older males to attempt to address emotional need (particularly online), receiving sexualised responses in return. Peer relationships were poor quality, the mother and child family unit was socially isolated, and there were challenges to effective parenting, complicated by maternal mental health issues.

6.2 Whilst there were significant levels of service input to Child L in response to these issues, there were reported deficits by the services involved in collaborative working, information sharing, communication, and professional ownership/clarity of roles: and there was no jointly agreed consensus on care delivery. The third sector, in particular, felt that their service was working in effective isolation from other (statutory) services; emergency service staff reported systematic inabilities to access relevant information and to arrange appropriate immediate care inputs out with office hours; and there appeared to have been little or no helpful communication between services supporting Child L and adult services supporting Child L's mother.

6.3 Perceived bullying, reported by Child L and Child L's mother, was not recognised by the school as being present, and issues related to social media were unable to be managed effectively. Despite the level of concern, GIRFEC and Child Protection principles do not appear to have been fully considered in Child L's care. Child L's mother reported disempowerment and alienation from service working. All of these issues appeared to be related to care provision in general, rather than being limited to this one case alone.

6.4 Local and national evidence would appear to describe para-suicidality in young people as an increasing problem for services working with younger people. This is a pattern which appears unlikely to be restricted only to the care of Child L, and which could affect the care of other young people in the wider service environment.

6.5 Social media issues are a recently emergent problem, the increasing risk to young people of poor mental health and reflects a national picture, and the findings of this Review appear to be mirrored more widely in the available literature.

6.6 There are significant implications for services supporting, protecting and helping young people and their carer's. Reduced effectiveness of service provision due to the identified issues primarily risks further negative effects on therapeutic outcomes for service users, with the potential for the devastating effects on young people and their families poorer outcomes imply.

6.7 In addition, damage to service reputation and staff morale can further reduce the effectiveness of service working, resulting in challenges to recruitment and retention of staff and trust in services by those who use them,

6.8 Whilst Child Protection procedures could have been considered more fully in this case, it should be noted that these are not necessarily required to manage risk in care effectively, and that their absence does not necessarily imply a lower level of risk. Having consideration to the GIRFEC principles should be equally effective in providing a successful framework for maintaining the safety and wellbeing of a young person. Reflection is required on the issues highlighted in the Review in order to ensure that local systems appropriately identify risks and issues, and support young people and families most effectively.

6.9 Perceptions of risk (and the relevant risk factors) may vary between services and individual professionals, secondary to training and experience – and perhaps even more so in comparison to the views of service users and carers. This can affect the ability to engage successfully with people in crisis, and requires collaborative working. Families and carers should be involved in the care of a young person wherever possible, to improve outcomes for all members of a family unit. The young person should be kept at the centre of care to maximise successful engagement.

6.10 Formal and informal pathways for inter-agency communication require to be optimised for the most successful care delivery, in tandem with the views and wishes of the young person and their family.

6.11 Key issues in the care of Child L include effective service communication, which is well recognised in the available literature on service working; risk management issues relating to the appropriate recognition and support of families with a young person at risk; the awareness and appropriate use of the GIRFEC principles and Child Protection procedures; accurate recognition and effective support for parental issues; and consideration of how best to manage problems related to social media and the changing landscape of mental health problems in young people in the UK.

7. LEARNING POINTS

7.1 The Child L and Child L's mother, continue to disagree on the allegations of significant bullying of Child L at school with Education Resources.

7.2 The incidence and risk to young people from poor mental health and parasuicidal behaviours appears to be increasing in the UK.

7.3 The death of a child is a life-changing event for all who cared for that child; service staff are in no way immune to this. Whilst the majority of the burden of grief

remains with families, organisations have a duty to support both families and staff through this trauma.

7.4 Concerns exist around the appropriate, consistent use of the GIRFEC principles in care, and the awareness of when to invoke Child Protection procedures when harm from self exists.

7.5 Communication issues affected all services and the family unit, particularly around the reasons for behaviours and how best to address issues/risk in a wider manner.

7.6 Child L's mother experienced alienation and disempowerment in relation to service working, including her understanding of consent and misinformation provided from an external source which left the mother feeling she was never fully involved. This might have aided care and improved her own mental health issues.

7.7 Health and social work staff reported resource and collaborative working issues. Third sector input was possibly not as valued as it should have been. Staff morale was negatively affected by the problems highlighted during care delivery.

8. GOOD PRACTICE

8.1 Education staff highlighted the significant positive work and support carried out by the Pupil Support teacher and Home School Partnership worker.

8.2 Education staff recognised issues at transition to secondary schooling, and following expressions of poor mental health at school, that formal mental health assessment was required.

8.3 Health staff appropriately involved CAMHS, which recognised the need for urgent, intensive input for Child L

8.4 Social Work provided an allocated worker for Child L. Multi-agency case conference was progressed, due to the number of services involved.

8.5 Best Practice Example - Social isolation was correctly identified and addressed with Befriending Service input – which was later reported by Child L's mother as the most positive intervention

8.6 Child L was identified as at high risk by all services. The presence of social media was recognised as toxic to Child L's mental health by all services.

9. AREAS FOR DEVELOPMENT

9.1 Areas for development include consideration of the issue of bullying, when disagreement exists between family and statutory services; the risk of harm from self as it relates to GIRFEC principles, and child protection procedures; communication and inter-agency working issues; family involvement, maternal vulnerability, and consent procedures; social media issues and the changing landscape of mental health for young people in the UK as these relate to service working; and service response to the death of a young person during care delivery.

Published January 2021