



Children's Safeguarding Board Practitioner Briefing

Briefing Number 2: Rachel's Story

Suicide in children and young people is an extremely distressing subject to explore, and this introduction comes with a warning that readers may find some aspects of this briefing upsetting. However, in order to find out how we, as agencies working together, can best support our children and young people; we need to examine this area in some detail, with the help of one young person's story.

Rachel's Story

Rachel's story is written with the kind permission from Rachel's father for agencies to learn what went wrong and to explore how to improve safeguarding practice; with a view to Rachel's experience never happening to any young person again.

Rachel's a 17 year old girl who lives with her father and brother. She has a very close relationship with her father and her younger brother whilst her mother lives elsewhere and, with whom, she rarely keeps in touch. Her home address is situated on the Cambridgeshire border though her health provision comes under a different county. Rachel attends college in Hertfordshire and has good relationships with her tutors and particularly confides in one of her tutors about how she feels. She also has a part time job at the local pub, which she enjoys and is a sociable young person having many friends. Her father described Rachel, prior to Christmas 2017, as being her normal "effervescent self".

In January 2018 Rachel's father noticed that she seemed "distant" whilst in the car and he recalled that they never argued as such and were always able to talk to each other. Rachel's father made web searches onto Mumsnet to try and find out more about his daughter's behaviour and whether this was "normal teenage angst". As her father was still worried he persuaded Rachel to see the doctor, as a routine appointment. Rachel was reluctant but went to see the GP (General Practitioner).

At the GP surgery, Rachel explained that she feels depressed but cannot fully explain the reasons why. The GP suggested that Rachel could make a self-referral to CHUMs (a tier two provision for mental health). As soon as they got home Rachel and her father made the referral to CHUMs on the website. After not hearing for a quite a while they both tried again making a referral to the second local CHUMS on the website.

Rachel recalled that she had experienced feeling something similar to this when she was in year 10 whilst attending a school in Bedford; where she remembered some instances of being bullied. Rachel will say that she uses drink and drugs (cannabis) to help her to sleep and occasionally has used cocaine, though will not tell her father about this. She worries about general things in life but is able to speak to 'her Dad' about it, generally either in the car when travelling or in the kitchen at home.

During the past year her father recalls only one incident when he saw superficial cuts, described as "paper cuts", to Rachel's hand which he asked her about.

The CHUMs worker contacted her by phone and ascertained that she takes cannabis to sleep and some cocaine along with tablets and drinks but only socially. The CHUMs worker asked if Rachel would attend a drugs group, to which Rachel replied "no". The CHUMs worker suggested that she go to the Inclusion service (a local adult substance misuse agency) for help with her substance misuse and wrote a letter to Rachel closing her case. Around the same time the second CHUMS service tried, unsuccessfully, to contact Rachel. Her father acknowledged that Rachel felt "disappointed" that CHUMs would not help her.

Rachel's father described Rachel as being a healthy eater and always carried a bottle of water around with her, but by February she had stopped eating and was not drinking as much. Her father used to make her wraps to eat at lunch time, but Rachel had stopped eating them. Rachel seemed to become more 'fatigued' and as a result her father called the GP to ask for her to have some blood tests to rule out anything untoward. Her father recalled that Rachel was not at all happy about this and he thought that was because of her fear of needles. It later transpired that Rachel's concerns were due to her substance misuse being found out.

There was only one occasion that her father remembered where Rachel had mentioned something that was odd. She asked her father if they could have a chat, in the kitchen, and she said that she had been thinking about "Bad things and that", though her father did not know what this meant and Rachel did not say anything else.

By February Rachel's mood had deteriorated and at times she had taken to her bed. Her father, was extremely worried and took a "very reluctant" Rachel back to the doctors and Rachel saw a second GP. Her father explained what had been happening and he was asked to leave the room so the GP could speak to Rachel alone. Some time, later Rachel came out, from seeing the GP, with a piece of paper with CAMH's number written on it. After seeing Rachel the GP sent an 'Urgent referral' letter by fax to CAMH (Child and Adolescent Mental Health Service) regarding Rachel being in 'low mood, severe fatigue' and having 'suicidal thoughts'. The letter also indicated that Rachel denies any self-harming behaviour and that her appetite is good. Her father was not informed of how Rachel was feeling (suicidal thoughts) nor of the urgent referral made by the GP to CAMH. Both Rachel and her father tried to contact the CAMH telephone number and left messages and details of how to contact Rachel. Unfortunately no one from CAMH responded.

The out of county CAMH triaged the GP's letter and the clinician on the duty tried to contact Rachel on two separate telephone numbers that were either unobtainable or continually ringing. The clinician tried to ring the GP surgery but could not 'get through'. Rachel's father noted that on the GP letter to CAMH, from the coroners pre-hearing, that the land line telephone number headed at the top of the letter was not his/ Rachel's home number and that the dialling code was for a Letchworth phone number and not Cambridgeshire.

The GP referral to CAMH was discussed within 'the single point of entry' (SPoE) meeting and it was ascertained that Rachel was already open to Bedfordshire CHUMS which was considered the best support for her. The letter of that decision was sent to the GP declining an assessment with CAMH (March time) but explaining an appointment would be available with CHUMs shortly. Unfortunately Rachel was not open to the second CHUMS service as the letter had suggested.

Around February time Rachel's father contacted the college to explain to them how Rachel was feeling and to ask for some help for her at college. Rachel explains to her college tutor (pastoral support) that she feels 'low' and is taking drugs but explained that her dad is taking her to see the GP. The tutor asks if she had had any suicidal thoughts, Rachel replied that she had not and 'could never do that to her dad or her brother'. The college makes a referral to CASUS (Cambridgeshire Child and Adolescent Substance Use Service) for support with her drug use and suggests getting some over the shop counter remedies to help her sleep, such as Nytol. Her father recalled that the college were extremely supportive of Rachel and to help Rachel had asked her to work with them on a project – this was a cover story so her friends did not know that Rachel was seeking help from the college.

At the start of March the CASUS worker phoned Rachel and had a discussion around her drug use. Rachel explained that she was worried what would be found (drug use) if she agreed to have a blood test taken at the GP surgery, but the CASUS worker reassured her that the GP would only be testing for drugs with her permission and it was more likely that the blood test was to test for something else. With Rachel's consent the CASUS worker agreed to book a time to see Rachel at the college. Rachel agreed for her father to take her for the blood test.

Her father took Rachel for the blood test and he noted that she was quite tearful, he thought because of her fear of the needle.

A short while later her father rang the GP surgery to ask about the blood test results. He got through to the first GP, that they had seen before. The GP explained that the blood results were fine, though there was no mention of the previous meeting between the second GP and Rachel. Her father asked why CAMH had not seen Rachel at which point her father said the GP explained that CAMH have huge waiting lists. Rachel's father asked if he should look at private counselling for Rachel, however, the GP advised not to go down this route. Rachel's father informed Rachel that her blood tests were fine and in response Rachel appeared disappointed and said to her father "how are we going to know what's wrong then".

During the second week of March, Rachel had been experiencing headaches and was at home in bed. On the Thursday, a work day in the late evening, her boyfriend came around to Rachel's house as he had received a text message from Rachel and he was worried about her. Rachel's father checked Rachel's bedroom and called her place of work but Rachel had called in sick. Rachel's father and boyfriend found Rachel's body in the back garden and called an ambulance. Full cardiac life support was given but Rachel's body failed to respond. The Police on the scene, regarded Rachel as a 17 year old and therefore as an adult and her body was sent to the mortuary. This meant that the rapid response procedures for unexpected child deaths, which include suicide, were not carried out meaning that none of the agencies who worked with Rachel were made aware of her death and in some instances it was left for her father and her father's friend to tell them of her death and of the circumstances.

Evidence gathered from the family home showed that Rachel was forward planning for life and had written on the calendar about going to the gym. However, there were drawings gathered of her suicidal thoughts with different methods of suicide depicted. Police also found searches on her laptop where she had looked for suicide.

The GPs letter explaining to Rachel that they were no longer pursuing CAMH and that they were re referring her back to CHUMS was found in her bedroom by her father two weeks after Rachel passed away.

Rachel's Inquest took place during January 2019 and the coroner ruled that there was evidence that Rachel had planned to take her own life and stated that 'there was no intention of agencies to mislead or demoralise [Rachel] – this was the consequences of misinformation and structural difficulties'.

What can we learn from Rachel's case?

Since Rachel's death the out of county CAMH and the CHUM's services have made significant changes in a number of areas of their service provision for children and young people:-

- The out of county CHUMs is now commissioned by the out of county CAMH. CHUMS have more workers in post and CAMH have allocated a number of additional resources
- Both CHUMS services liaise with each other and to make a referral, a young person, must have the consent of either a parent or an agency. The website has been redesigned so that only one service can be referred to by a young person.
- Administrators record all SPOE meetings and there are templates and guidance reminding practitioners to contact family members and other agencies for information
- A number of training sessions have been provided to GPs and there are Webinars available
- CAMH has employed liaison officers to work closely with GP practices regarding mental health concerns for children and young people
- Automatic letters have been reviewed and the language changed, where possible copies of the letters will be sent to both the young person and to parents

County and Commissioning Borders

- Neither of the CHUMs service knew they were contacting Rachel nor were their electronic recording systems shared to see what work had and was being completed with her. *Families accessing different services across counties should not impact on the services that they receive and it is important that agencies contact and liaise with each other to ensure the safety of the child.*

The Jigsaw Puzzle of Sharing Information and Making Assessments

- Each agency and the family had a little bit of information that they knew about Rachel. Her father and GP were concerned about her mental health whilst; the college, CHUMS, CASUS and CAMH all prioritised the substance misuse issues that they perceived as being the main issue from; asking Rachel about her drug and alcohol use. Each agency had their own assessments and assessment criteria though all of the information that each had was not shared
- Assessments by some of the health agencies were made over the phone and in isolation, with no other agency information in relation to their work with/ knowledge of Rachel being considered. None of the agencies had 'all of the information' about Rachel and her life in order to be able to make an 'informed risk assessment'.
- *As practitioners we should be sharing information regarding any identified safeguarding risks with those agencies whom we know are working with the child / family. Sharing Safeguarding Information leads to informed risk assessments, holistic intervention planning and effective support for the young person / family.*

Time scales and expectations for service delivery

- CAMH have time scales for assessments (between 2 to 10 weeks) and treatment. In hindsight had the services known what they know now about Rachel's case she would have been given an appointment to be seen within 2 weeks as an urgent referral.
- Both CHUMs and CAMH are services under pressure from the amount of mental health referrals for children and young people. *It is important that the best use of resources are made and issues surrounding case-loads and staffing are escalated to management and if necessary to the local safeguarding boards.*
- CAMH wrote to the GP surgery to say that Rachel's case had been moved to a routine appointment from the urgent referral that the GP had made. *As a practitioner working with a young person if you are not happy about the service being provided from either your own or another agency consider escalating your concerns.*

Clarity of letters sent by agencies

- CAMH received the letter from the GP, which was marked as 'urgent'. The letter gave little detail as to why the case was deemed as urgent and contained positive factors that Rachel was not self-harming and had an appetite. *Remember when making referrals to any agency ensure that there is a full analysis of the case, risk factors are highlighted and say what you as the referrer want to happen to support the young person.*
- The out of county CHUMS service sent a letter to the GP stating that Rachel's case was open to them and they were working with Rachel. This letter was incorrect and sent in error. *Always check letters for service user details and that they are sent with the correct information and to the correct agency.*
- *When sending letters to young people and their families be careful about the language used in the letter and make sure that the letter explains what is happening with their case and not in a negative fashion.*

Recording

- Some of the records written within the agencies were limited and did not give a full explanation of or behind key events and Rachel's father did not know where a landline telephone number for him came from as he had not supplied this information.
- *As practitioners we need to ensure that records are kept up to date giving a rationale for the work completed with a young person and make sure that all details about the young person and their family are correct.*

Professional Curiosity

- The majority of the professionals involved focused only on Rachel's 'drug use', which she was open about to varying degrees with the different workers. That said no one seemed to ask the question about how she really felt or if they did, they did not pursue the line of enquiry further (i.e. Professional Curiosity). For Rachel maybe talking about drugs and her drug use was far easier than to talk about the difficult topic of feeling depressed and suicidal.

The Lived Experience of the Child

- Receiving a referral online and speaking to a child on the phone limits our capacity as professionals to see the child and the wider picture of their; appearance, non-verbal communication and home/college life. For Rachel, it may have been easier to speak on the phone about certain things and easy to cover up or not to mention the real issues that were bothering/concerning her. Did any of the agencies ask Rachel 'what is life like for you right now'?

Protective Factors

- *As part of a holistic risk assessment and intervention plan when working with children and young people any protective factors for that child should be identified and utilised to safeguard the child.* In Rachel's case her father was the protective factor yet agencies failed to involve him or alert him to the fact that she had suicidal tendencies.
- Rachel was just seventeen and would probably have said that she wouldn't want her dad to know about what she had discussed with any agency. *However, in terms of child protection and safety of the child, disclosing important information should always be considered and noted on records as to why information had / had not been shared with family.*
- A safety plan completed with Rachel, her family and the agencies that worked with her may have given additional support for Rachel and put in place plans to help her with low mood, eating, sleeping and self-harm / suicidal thoughts.

Knowledge and Understanding of Roles and Responsibilities

- CHUMS, at the time, was a new service provision and they were unaware of all the agencies and support available for children and young people. CHUMS signposted Rachel to the 'Inclusion service' to support her drug and alcohol misuse. However Inclusion was an 'adult' drug/alcohol service and CASUS would have been the correct referral route for children and young people. *Practitioners need to be aware of what support is available for children and young people and sign post to the correct agencies for that individual / family*
- The out of county CAMH has a SPoE (single point of entry) and an on call duty psychiatrist who is available speak to professionals regarding their concerns about a particular child for advice and referral routes. Agencies could have contacted the SPoE with their concerns had they known that the service was available.

- The police personnel who attended the family home after Rachel had committed suicide did not follow the child death overview procedure and Rachel's body was taken to the morgue instead of the emergency duty department. This resulted in none of the agencies, who knew /had been working with Rachel, being informed about her death in line with the CDOP procedure.
- *Practitioners need to explain to children, young people and their families what their roles and responsibilities are and what certain acronyms, within their service, mean.* In Rachel's case her father knew nothing about what CAMH was nor what service they could provide

Supportive Websites

<https://calmharm.co.uk/> for those young people worrying about self – harm

<https://kooth.com/> Free, safe and anonymous online support for young people

<https://www.childline.org.uk> for young people and children Helpline 0800 1111

<https://www.keep-your-head.com/cyp> mental health support website for Cambridgeshire and Peterborough young people

Further Information

Safeguarding Board Website: <http://www.safeguardingcambspeterborough.org.uk/children-board/>

Safeguarding Training: <http://www.safeguardingcambspeterborough.org.uk/availabletraining/>

- Resolving Professional Differences (Escalation) Policy:

http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/escalation_policy/

- Supporting Schools in responding to Suicides in Teenagers: A multi-agency guide for Practitioners

<http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/self-harm-2/>