Serious Case Review
Overview Report in respect of

Chris

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Nobody wanders aimlessly, alone, revelling in the blissful stillness.

The golden ball of fire smiles, genies dance in the radiant sky, leaving trails of mist in their wake.

Spontaneously powerful packs pour from the gates which held them hostage, adults attempting to tame them. Over the shrill bell that ends their torture they roar with laughter, shattering the silence –

Nobody shrinks impulsively into the safety of the walls. Fear rises in her as the thunderous noise approaches. She's hyperventilating, pure terror courses through her veins…They pass her by, indifferent to their impact.

Safer, she breathes. Smooth silence settles once more.

Chris

"Anxiety" – a short story written by Chris and published in 2017

Being traumatised means continuing to live your life as if the trauma were still going on – unchanged and immutable – as every new encounter or event is contaminated by the past.

Van der Kolk – The Body Keeps the Score 2014

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Executive Summary

At the heart of this Serious Case Review (SCR) is the appalling legacy of child sexual abuse and the response by agencies to this abuse and to the complex mental health conditions that can follow. Chris's life, and that of her sister and parents, illustrate the pernicious nature of child sexual abuse and the devastating impact it can have on the lives of children and families.

This SCR seeks to understand the lived experience of Chris, and her experience of service intervention, from the age of 6. During early adolescence, Chris disclosed she was the victim of sexual abuse from at least 6 years old. Chris self-harmed from, at least, the age of 13 years. Self-harm continued throughout her life becoming extensive and long standing. She suffered from difficulties in emotional regulation, depressive symptoms eating difficulties, anxiety and shame. She often expressed a wish to die and made several attempts to take her own life. Her identical twin sister (Sam) also alleged she had been sexually abused. Over time it was understood that the sexual abuse included allegations of repeated and extensive abuse, and the twins spoke about being abused in each other's presence by the same alleged perpetrator. Sam's pattern of self-harm, emotional, social, educational and mental health difficulties were of similar intensity as Chris's. Sam took her own life when she was 16 and Chris took her own life five months later, when she was 17.

As identified in relevant guidance[1], it is not the purpose of a SCR to conclude issues such as predictability or to hold organisations or individuals to account; there are separate processes for this purpose that must be followed. The purpose of SCRs is to focus on a child and family, often in extremely tragic circumstances, to try and understand and make sense of their experiences of multi-agency services and consider what these experiences might tell us about the health of the multi-agency safeguarding system and determine what might be needed to strengthen the way children are safeguarded.

An array of interventions were provided during Chris's life; there are examples of highly committed practitioners/clinicians/teachers and examples of good practice. As with any case that is the subject of a SCR, there are also examples where improvements in practice and service provision are needed.

Key learning has been identified in this SCR and recommendations are made. This SCR does not conclude that, had these things been in place, Chris would be with us today. As Joiner[2] recognises, there are limits to the interventions provided to people intent on taking their own lives, people have ultimate autonomy including a freedom to occasion their own death if they are really committed to do so. That said, the learning is substantial, and it is hoped that by translating this learning into changes in service provision, children will be less likely to take their own lives and be better supported to reach their potential.

This SCR considers relevant legislation, policy, practice and procedure. It reflects on research, literature and national guidance and it draws learning from the extensive experience, and wealth of knowledge, held by those who work within the multi-agency safeguarding arena.

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1 *Working Together to Safeguard Children* 2018 & *Child Safeguarding Practice Review panel: practice guidance* DfE 2019.

2 *Why People Die By Suicide*. T. Joiner (2007)

The independent reviewer had the privilege of meeting Chris's parents on several occasions; their experiences and perspectives are reflected throughout.

This SCR contains a detailed narrative and as a result the report is lengthy. Cambridgeshire and Peterborough Safeguarding Children Partnership Board (CPSCPB) decided to provide this detail for two reasons. Firstly, it has been provided to enable the reader to make sense of Chris's life experiences and the significant learning that has emerged. Secondly, Chris's parents were deeply concerned about events and decisions during this time; out of respect to the family these events have been thoroughly explored.

1 Reason for this review

Chris was aged 17 years when she sadly died after walking onto railway tracks and was hit by a train, she died instantly from her injuries. Chris was a white British child who, at the time of her death, was living intermittently between an inpatient unit and with her boyfriend. Tragically, Chris's identical twin sister (Sam) had died five months earlier after taking an overdose of prescription medication at home.

After the death of Chris, CPSCPB[3] held a Rapid Review to consider the circumstances of her death. At the time, another young person was known to have died after taking her own life and it was known that Sam had also died. It was decided that a Thematic Multi-Agency Learning Review would be undertaken to explore what lessons could be learnt about the tragic deaths of the three girls. Subsequently, information was received from multi-agency partners which suggested that child sexual abuse was key to understanding the life experiences of Chris and Sam and, after consulting with parents who were involved at an early point in the review[4], CPSCPB concluded that the SCR[5] threshold had been met. The National Child Safeguarding Review Panel were advised and separate SCRs commissioned.

2 Purpose and methodology

The purpose of a SCR is to learn lessons through a systems analysis of the single and multi-agency work undertaken to assess and support children[6] and their families. The methodology used in this SCR has been informed by an approach which endeavours to understand professional practice in context by identifying systemic factors that influence the nature and quality of work with families. By using one case the aim is to get to systemic patterns, which are generalisable beyond this particular case, providing what is called a 'window on the system'[7].

The aim of SCRs is to provide a proportionate and meaningful account of what happened from the perspective of the child and to add reflection and learning into the local safeguarding

[3] Changes in statutory guidance subsequently led to the Board becoming a Safeguarding Partnership.

[4] Involving parents as early as possible in practice reviews is in line with best practice recommended by The National Child Safeguarding Review Panel.

[5] New arrangements of LSCB's led to Local Safeguarding Partnerships being formed in Sept'19 and over the following year SCRs became Child Safeguarding Practice Reviews. As Chris had died when the old arrangements were in place, it was concluded that this should be a SCR.

[6] In line with legislation, the term child, or children (applied to all who are under the age of 18) will be used throughout

[7] Vincent CA, 2004, *Analysis of clinical incidents: a window on the system not a search for root causes,* QUALITY & SAFETY IN HEALTH CARE, Vol: 13, Pages: 242-243, ISSN: 1475-3898

system by asking: Why did things happen in the way they did? The goal is always to ascertain which factors aid good practice and which hinder it in order to develop and enhance the safeguarding of children. Solutions then focus on re-designing the system in order to make it harder for professionals to safeguard poorly and easier for them to do it well.

2.1 Process of review

A key aspect of the model is for an independent reviewer to work with a review team to plan and organise the key tasks, participate in the meetings, read key documents and analyse the data in order to produce the findings. In this case an independent reviewer, Bridget Griffin[8], worked alongside the CPSCPB Head of Service and representatives from the main services involved. These representatives were independent, in that they had no direct involvement with Chris or her family and no management responsibility for the services that were provided during the period under review.

Independent agency reports and an integrated multi-agency chronology informed this review. The independent reviewer had access to a range of other relevant documents which included witness statements provided to the Coroner (these witness statements were not read by panel members). The independent reviewer had access to extracts of letters, diary entries and social media communication written by Chris; these have been read in an attempt to understand and reflect Chris's voice within this review. Several panel meetings were held and focus groups were convened with representatives from key services, which included a consultant psychiatrist, to analyse the data and discuss the emerging findings.

2.2 Involvement of families & practitioners

2.2.1 Parental perspectives

A vital part of SCRs is to work with families to understand their perspectives. Chris's parents have been involved throughout this SCR. Parents shared several documents and spoke freely about the areas of service provision that were of concern to them, as well as sharing their views about what worked well. It is important to note that in SCRs it is not always possible to fully triangulate parental perspectives. Where triangulation has been possible, this has been made clear. Otherwise, when parental comments are referenced, these should be interpreted as their viewpoint.

Parents were keen to point out that it was extremely hard to make sense of the various services and treatments and their efforts to navigate it all, and advocate for their daughters' needs whilst providing care, required a level of resources that many families do not have. Aside from the financial, educational and social resources it was clear that the emotional resources needed were immense. Grateful thanks are extended to Chris's parents for the time, commitment and patience they willingly gave in being part of this SCR. Their steadfast commitment to make a difference for other children to improve their outcomes, and to prevent other families from suffering such unbearable loss, cannot be commended highly enough.

[8] CQSW, BA (Hons), MA (Tavistock & Portman NHS Foundation Trust), Accredited SCIE Reviewer

2.2.2 Practitioner involvement

Another important aspect of a SCR is to engage practitioners in the review process. Panel members met with practitioners who knew Chris or who provided a service to Chris and her family. These practitioners were invited to share their views about the services provided to Chris, to identify single and multi-agency learning and to make recommendations to CPSCPB about what changes may be needed to strengthen the way services meet the needs of children in the local area. It is clear that practitioners and clinicians were deeply committed to Chris; they worked hard to try and support her and were deeply saddened by her death. These practitioners engaged well in this SCR process and offered several insights into service provision based on their wide experience of partnership working in Cambridgeshire and Peterborough.

At an early point, several focus groups with practitioners were planned. These included multi-agency focus groups aimed at learning from practitioners who had worked with Chris, separate focus groups to learn from the wider multi-agency workforce and a focus group with children.

2.3 Limitations of the review

The main part of this review has been conducted during the COVID-19 pandemic; this has had a significant impact on the speed at which this review has been concluded. In addition, it has meant that the planned focus groups with practitioners and children could not go ahead. CPSCPB will determine how these groups are involved in the future.

3 Chris

The independent reviewer has read the Joint Witness Statement to the Coroner prepared by Chris's parents which contains a pen portrait of Chris; parents have given permission for this to be shared. The following is a short summary:

Chris was colourful and loud, funny and kind, and she had an outgoing personality that lit up any room. She had many close friends and she was loving, generous and fiercely loyal.

Before her illness she was a confident, intelligent, active, friendly, sparky child with a great future ahead of her; she was expected to do extremely well academically. Chris enjoyed an array of activities including horse riding, beach holidays, snowboarding and music festivals.

Chris was also a child who suffered enduring pain and deep distress as a direct result of the abuse she suffered and the significant mental health difficulties that followed. After her twin sister's death, parents feared that nothing could fill the gap that Sam's death left in her life: *The abuse may have broken Chris's mind but losing Sam broke her heart.*

4 Summary account of events, agencies' involvement & analysis

4.1 Early years – help seeking behaviour

When Chris was 6 years old, her school identified that she and her sister were exhibiting *sexually inappropriate behaviour* and took steps to manage this behaviour in school. No referrals were made to other agencies and the information was not passed to the next school. When aged 11 years, Chris and Sam took a routine psychometric test (covering areas such as emotional wellbeing / attitude to learning) which revealed exceptionally low scores. Parents were told their daughters' results were the lowest ever recorded in the school but there appeared to be little action taken in response and parents said they were not supported to understand what they could do to help Chris. Due to the passage of time, it has not been possible to understand the reasons for the lack of action taken by involved practitioners during these early years. There was a need for professionals to be curious about what may have been the lived experiences of the sisters that might explain these low scores and provide a response. Responding to children's help seeking behaviour, and providing children with the help they need, is discussed in Sc5.

4.2 Early Adolescence – self-harm and disclosure: May 2016 – Jan 2017

Chris was 14 years old when she took a significant overdose at home and was admitted to hospital. She told hospital staff that she had self-harmed around her mons pubis area[9] and allowed this area to be examined; it was recorded that she had *quite extensive self-harming wounds around her labia area.* Chris was provided with a number of appointments with a mental health practitioner in Child and Adolescent Mental Health Services (CAMHS). The first appointment took place promptly and regular appointments followed. Fluctuating moods, shame, disgust, restricting food, self-harm (over a number of years) and emotional dysregulation was noted. After her presentation at hospital, a referral was made to Cambridgeshire Children's Services (CS) by the Acute Trust. CS concluded that as CAMHS were involved, and parents were supportive, there was no role for CS and no further action (NFA) was taken. The location of Chris's self-harm was not detailed in this referral. It is the view of the Acute Trust that this would have been verbally shared with CS and CAMHS; there are no records to show that it was shared with CS, but there are records to show that the on-call CAMHS clinician was aware of the self-harm in this general area[10].

Whilst it is accepted that Chris's symptoms fell into a range of generic trauma presentations; the specific area of self-harm, coupled with these symptoms, meant that Chris's presentation was suggestive of child sexual abuse (CSA). Agencies needed to share all the information available, consider that Chris may be the victim of CSA[11], and provide a multi-agency response. Understanding the symptoms of CSA, and providing children with the protection they need, requires a multi-agency approach informed by an understanding of relevant research and guidance. This is discussed in Sc5.

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9 The term 'mons pubis' is used by the author; it is not a direct quote.

10 Self-harm in 'bikini area' is recorded in a letter sent by CAMHS to GP at this time.

11 Cuts to this area is an unusual presentation and needs to be explicitly shared with multi-agency partners to not only consider CSA but also to consider (for all girls) whether they have been the victim of female genital mutilation (FGM)

Chris was placed on a waiting list for psychiatric review and family therapy; she continued to be seen and assessed within CAMHS where safety planning and risk mitigation took place. In hindsight, after reviewing the notes from these early sessions after Chris had died, parental views are that Chris's symptoms fell firmly in the range of symptoms associated with Borderline Personality Disorder (BPD) but that an *unwillingness* to diagnose BPD in adolescence, and the lack of a BPD care pathway and approach, meant that Chris was not provided with the help she needed at this point to prevent her difficulties escalating.

As detailed in relevant guidance[12], the diagnosis of BPD is a contentious area; the reliability and validity of diagnostic criteria have been criticised as has the construction itself. Therefore there is a reluctance to make a diagnosis of BPD, particularly in adolescence, as the brain is still developing and there is understandable concern about the potential stigma attached to having this diagnosis. At this point, it was still early days in the involvement of CAMHS and Chris had not been seen by a psychiatrist which meant she did not have a diagnosis at this time. The view of CPFT[13] is that, at this time, Chris was provided with appropriate services in recognition of her possible context of trauma. That said, the importance of an early diagnosis of BPD is covered in the relevant guidance[14] and is discussed in Sc5.

In June 2016, Chris disclosed to a school friend that she had been the victim of abuse from the age of 6 years. She was clear that this was perpetrated by someone outside of her immediate family. A strategy meeting took place and a joint investigation was agreed; a police investigation commenced and CS completed a Single Assessment. CAMHS and school were not invited to the strategy meeting and there was no consideration of a child protection medical[15]. At the start of the investigation, Chris was electively mute. When answering questions put by the local police force, she wrote a note disclosing some details of the abuse and said she wanted to write down the details of the abuse with support from a friend.

Due to the passage of time, it is not possible to fully determine what took place at this time. However, it appears that some principles contained with the ABE[16] guidance were not followed. Firstly, whilst this guidance is clear that Visually Recorded Interviews (VRI) are the preferred means of gaining evidence in these circumstances, it is also important to take into account the victim's preference. Chris's request to make a written statement did not appear to be explored at the time or subsequently. In addition, the guidance emphasises the need for careful planning which includes the involvement of CS and key agencies/professionals, including mental health professionals. Chris was known to CAMHS, it was important to involve clinicians to consider how Chris may have been supported to seek justice at this point and over time. At the time of the initial investigation, parents said they were told that Chris could

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12 *Borderline Personality Disorder. The NICE Guidance on Treatment and Management.* National Collaborating Centre for Mental Health commissioned by The National Institute for Health and Clinical Excellence. The British Psychological Society & The Royal College of Psychiatry 2009

13 Cambridgeshire & Peterborough NHS Foundation Trust

14 *Borderline Personality Disorder. The NICE Guidance on Treatment and Management.* National Collaborating Centre for Mental Health commissioned by The National Institute for Health and Clinical Excellence. The British Psychological Society & The Royal College of Psychiatry 2009

15 Recent developments in Cambs Constabulary have included a wider adoption of holistic medicals and increased awareness and action to ensure medicals take place.

16 *Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures*. Ministry of Justice 2011

not access therapy. Whilst this is compliant with ABE[17] guidance, once it was established that Chris was not prepared to undertake a VRI, the advice needed to be revised in line with established guidance[18].

Both the police and CS appropriately referred the family to an Independent Sexual Violence Advisor (ISVA)[19] service in July after the disclosure and parents said this referral was welcomed. There was a delay of several weeks before an offer of support was made by which time parents said Sam and Chris were adamant they did not want to see anyone to talk about the abuse. The reasons for the delay are not known.

A joint Sc47 (Children Act 1989) [20] assessment was completed within required timescales and CS closed their involvement on the basis that parents were supportive and there were no risks that the girls would have any future contact with the alleged perpetrator. The details of this assessment were not shared with CAMHS and there was no consultation about closure of the case. As the alleged CSA had primarily occurred out of area, the criminal investigation was passed to the relevant police force. Five months after the disclosure, the out of area police force informed parents that the case was closed. Parents informed Chris of this decision; they told the independent reviewer that on hearing this: *The girls felt completely invalidated.*

The reason for not undertaking an active criminal investigation was recorded as due to evidential difficulties: *the girls had declined to provide their evidence by means of a video recorded interview and did not support wider investigation, this position was supported by their family.* This had been shared with CS two months previously but there had been no contact with the girls or their parents by CS or the local police force since the initial investigation. In part, this lack of contact seemed complicated by the involvement of two police forces, where there was a differing interpretation of the policy about which police force needed to take up the role of family liaison. In addition, the out of area police force asked the local police force to conduct enquiries with 3rd parties, who Chris had spoken to about the alleged abuse, but there is no evidence that this was taken forward. As a result, what seemed to happen was that an emphasis was placed on the girls and their parents for being responsible for decision making in relation to the criminal investigation. The views of victims and families are an important consideration and, where there is no agreement to proceed with a VRI, this can limit how far an investigation can proceed. However, there were other reasons why this investigation did not proceed and this included the lack of contact with Chris and her family by the local police force and CS and the limited involvement of multi-agency partners in the careful planning that was needed.

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17 ABE guidance clarifies that therapy should not be provided if a VRI is imminent.

18 *Provision of Therapy for Child Witnesses Prior to a Criminal Trial Legal Guidance, Sexual offences*: The guidance makes it clear that the best interests of the witness are paramount when deciding whether, and in what form, therapeutic help is given.

19 The ISVA Service is provided by a local charity. ISVAs are specialist support workers whose job is to provide assistance to individuals who have been the victims of sexual offences. The role was introduced in 2006 as part of a Home Office-led initiative to improve outcomes for victims of these crimes

20 Sc47 of the Children Act 1989 sets out the statutory duties of local authorities/county councils to take action when a child is suffering or at risk of significant harm.

This was a complex CSA matter; information available suggested that the CSA had started in infancy and persisted over several years. Research[21] suggests that the impact on the girls and their parents of secrets, deceit, betrayal, lies, and feelings of shame, guilt and anger were far reaching and would have long term implications on Chris's mental health and on relationships within the family. Whilst CAMHS clearly focussed their interventions on attempting to address this early trauma, a multi-agency response was needed which was informed by guidance about how justice might be sought over time. Relevant issues about the multi-agency response to CSA, and the support needed by parents who care for traumatised children, is explored in Sc5.

A therapy session took place the day after the disclosure, Chris remained mute. Safety planning was discussed and shared with the school; this was good practice. However, there was no contact with CS about their involvement and there had been no multi-agency planning to conclude how Chris and her family would be supported, or how justice could be sought over time. This is discussed in Sc5.

In September 2016, four months after Chris's suicide attempt and three months after her disclosure, Chris was seen by a trainee GP in CAMHS who was supervised between sessions by a consultant psychiatrist. She was prescribed an anti-depressant. The lack of direct involvement by a psychiatrist was important to parents as they had become increasingly concerned about Chris's mental health and wellbeing. Whilst CAMHS have clarified that it is standard practice for there to be a period of assessment before a child is seen by a psychiatrist, it is also accepted that there was a shortage of psychiatrists in CAMHS at this time.

There was consistent involvement by the Family Therapy (FT) team over this period with parents. This gave space for parents to talk about the impact of CSA. Parents said Chris was *less tense now the secret was out*. Chris did not attend FT at this time but spoke to her CAMHS therapist about feeling much better, she was observed to be bright and reactive. She was asked about whether she wanted to talk about the CSA and although she declined, opportunities were consistently offered - this was good practice.

A few weeks after being told that the police had closed their investigation, Chris was excluded from school after reports had been received from pupils that Chris was frequently talking about suicide and had made a suicide attempt at school. At this time, parents said she spoke to them about wanting to know what was wrong with her and said she felt no confidence that she could be helped.

In December 2016, a joint meeting with the FT, the trainee GP and parents, took place to jointly consider the needs within the family; this was good collaborative practice. However, at the time, Sam was also receiving services from CAMHS. Aside from the FT team, the CAMHS clinicians working with Chris and Sam were not involved in formal meetings that considered the needs of the twin sisters and the family. There had not been joint formal consideration of the impact of child sexual abuse on the sisters and the implications for care and treatment,

[21] Such as: *Understanding the complexity of child sexual abuse: a review of the literature with implications for family counselling* S.V. Hunter. The Family Journal: counselling and therapy for couples and families, vol. 14 no. 4 2006 Sage

particularly: the impact of the co-abuse, the age it began, the lack of justice achieved, the relationship between the sisters and how this trauma may have effected their relationship. This required a joint focus on the implications for treatment informed by an understanding of CSA. This was an unusual situation, there was a scarcity of research about the sexual abuse of twins and no relevant guidance in place to assist clinicians in their work. The importance of collaboration within CAMHS is discussed in Sc5.

A few days later, following her suicide attempt at school, it was decided that Chris should be admitted as an inpatient when a place became available.

4.3 Admission and 12 month stay in Inpatient Unit (1): Jan 2017 – Feb 2018

Towards the middle of January 2017, Chris was admitted to a local NHS Tier 4 (T4)[22] inpatient unit. The plan agreed with Chris and parents was for a three week stay for assessment to see if she was able to engage to begin to address her past trauma, and to consider longer term admission if successful. It was concluded that if she was unable to talk about the abuse, or if inpatient care made her feel worse, she would be discharged to the community. This plan reflected research that inpatient stays for adolescents should be as short as possible[23].

On admission, a referral was made to CS who made contact with parents and CAMHS. Parents wanted support in caring for their daughters at home but were unclear about what CS were able to provide and there was a lack of clarity within CS about what could be provided. As a result, NFA was taken. There was a need to provide a multi-agency response to Chris and her family, to seek Chris's views and to proactively plan for Chris's discharge. In the absence of parental consent, it is not possible for CS to provide services in these circumstances. At the time, there was a lack of clarity about the role CS would take up when working with children with significant mental health needs and this impacts on obtaining informed consent from parents, and on multi-agency working. The importance of understanding the impact of CSA, working together to support children and families, empowering children to speak out and enabling parents to make informed choices about service intervention, is discussed in Sc5.

During the first few weeks of her stay, Chris engaged well with the staff/therapists. Parents found staff to be *very kind, helpful and professional,* they felt that a good relationship was established and that their views and opinions were heard and valued. There was collective involvement of clinicians and therapists within the T4 unit and within CAMHS, the systemic impact of trauma on Chris and her parents was identified and flexible attempts were made to address this trauma. Chris said she wanted to talk about the abuse but could not do so without chain smoking and cutting throughout; she said that this was partly why she did not want to talk to the police. There was a need for a multi-agency approach to support Chris in seeking justice over time, this emerged as key learning and is discussed in Sc5.

At the end of February 2017, a probable diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD) was made. Acknowledging a child's trauma by placing this at the core of service intervention/treatment enables a clear message to be heard by children that their symptoms

[22] Tier 3 (T3) is the term commonly applied to CAMHS community services and Tier 4 (T4) is the term commonly applied to inpatient care. Care in T4 units was funded directly by NHS England not from local Trust budgets (until July 2021).

[23] As reflected in: The *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (July 2019)

are a result of the trauma they have suffered and places a trauma informed approach as central to care and treatment. This approach was consistently seen in Chris's treatment by CAMHS and within the local inpatient unit.

The treatment focus on Chris's trauma continued to be an inherent component of the care provided in the inpatient unit and Chris's voice was heard throughout interventions. Whilst Chris found it difficult to engage in therapy, a flexible approach was taken which provided opportunities for Chris to engage with trusted adults. Initially, Chris engaged well with her allocated therapist but she was aware that this this therapist would shortly be leaving and was worried about forming a trusted relationship in therapy that would end after a few weeks. She was unable to form a relationship with the next therapist but did form trusted relationships with a number of staff members, in particular her key nurse (KN) who received supervision from the consultant psychiatrist and clinical psychologist. Whilst parents said they had been concerned that this member of staff was not a trained therapist, the approach by the unit that enabled Chris to engage with a trusted adult of her choosing was in line with the principles of a trauma informed approach.

Chris was encouraged to write a therapeutic diary, she was escorted on therapeutic walks and engaged with EMDR[24]. A CAMHS Care Coordinator (CC) was allocated who established a positive relationship with Chris. Chris's difficulties in engaging with therapy continued to be responded to by providing flexible and creative approaches to enable Chris to engage in therapeutic opportunities. At this time Sam had been discharged from CBT[25] in the community and was regarded as 'hard to engage'.

A short time later, Sam took an overdose of medication and was admitted to an out of area inpatient unit. The local inpatient unit quickly established liaison with the out of area inpatient unit to co-ordinate leave for the twins so that they could be at home together. Family therapy was coordinated which allowed Sam and Chris to attend together and liaison took place between Chris's community and inpatient psychiatrists; this was all good practice.

After a couple of months, in a 1:1 with her key nurse, Chris spoke about 'family secrets' within the wider family (about the CSA she had disclosed and her mental illness). She said she found it difficult to keep these 'secrets' but also that it was difficult to talk about the CSA in therapy and in her immediate family. In part, this had been influenced by parental understanding from the initial stages of the criminal investigation that they should not talk about the CSA with their daughters or within the wider family. These were complex issues; CSA typically traps victims in silence, self-blame and fears of not being believed. Supporting parents to care for traumatised children is discussed in Sc5.

Chris continued to be given the maximum flexibility that safety plans would allow; this was in line with a treatment plan that was based on building resilience and achieving risk sensible decision making. On occasions, Chris was permitted unescorted walks which encouraged

[24] Eye Movement Desensitization and Reprocessing (EMDR) therapy is an interactive psychotherapy technique used to relieve psychological stress. It is an effective treatment for trauma and post-traumatic stress disorder (PTSD).

[25] Cognitive behavioural therapy is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems.

agency and autonomy. On one unescorted walk, Chris was believed to have been seen walking on the railway tracks near to the unit. She returned to the unit and denied she had been on the tracks. Staff requested British Transport Police (BTP) to review CCTV footage to determine whether she had been there in order to inform risk mitigation and safety planning. The BTP agency report to this SCR acknowledged that this did not happen as it should have and this has been escalated to senior management. Consequently, improvements to CCTV at the crossing have been planned to enable joint risk management.

By this point, Chris had been an inpatient for 12 weeks. Section 85 of The Children Act 1989[26] sets out the responsibilities of Local Authorities in relation to children who are living in hospital provision for over 12 weeks. A referral to CS was needed at this time but was not made; this was an oversight. The perspective of clinicians was that there was a history of CS not taking a proactive role in the multi-agency network in these circumstances and this may have been a contributory factor influencing partnership working at the time; this is discussed in Sc5.

Regular family therapy sessions took place and there was a flexible approach to these sessions characterised by an open invitation to all family members; on occasions parents attended alone, on other occasions Chris watched the sessions supported by another therapist, on occasions Chris attended with her parents or attended alone, and on occasions Sam attended. It was clear that these sessions enabled family members to give voice to their feelings about the abuse the girls had suffered and the impact on their relationships.

There were times when Chris expressed anger and frustration about her parents. She often spoke about her former nanny and it was clear this was an important attachment figure. Parents considered Chris living with her nanny and considered moving to be in closer proximity to her. However, for various understandable reasons, these options were not pursued. Over time, Chris spent holidays with her former nanny and these went well.

In May 2017, Chris took an overdose of medication and received treatment at a local hospital. A few weeks later, after returning to the ward following a difficult home leave, Chris absconded and was restrained by police and returned to the inpatient unit. Chris's diary graphically portrays the trauma she experienced during this restraint. Police made a detailed referral to CS, who concluded there was no ongoing role as Chris was an inpatient. At the

[26] Section 85 of the 1989 Children Act places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and / or likely to exceed 12 weeks. The intention behind the legislation is to provide a 'safety net' for vulnerable children living away from home where the child is not Accommodated under Section 20 and where the child is not subject to the usual processes of Care Planning and review by an Independent Reviewing Officer. The legislation is aimed particularly at ensuring the safety and support needs of disabled children and their families. These children are at increased risk of Significant Harm within every category of abuse due to their increased level of dependency on others. The institutions required to comply with this notification policy includes psychiatric units including private and voluntary sector units including those that treat young people for dependency on drugs or alcohol.
Note: The Children and Young Persons Act 2008 amends Schedule 2 Part 1 of the 1989 Children Act and clarifies the sort of services appropriate for 'accommodated' children away from home (s.85) including financial help to promote contact, advice, counselling and help for children to holiday with their family as well as the provision of advocacy services.

time, the role of CS under Sc85 (Children Act 1989) was not fully understood. Relevant issues are explored in Sc5.

At the beginning of June 2017, following a further episode of self-harm, Chris was detained under Sc136 of the Mental Health Act (1983) and, a day later, under Sc2 (MHA 1983) A diagnosis of Complex Post Traumatic Stress Disorder[27] (CPTSD) and Emotionally Unstable Personality Disorder (EUPD)[28] was made. The importance of making a diagnosis of EUPD/BPD in patients over 14 years is supported by relevant guidance[29] and a multi-agency approach is endorsed. Parental perspectives are that a treatment pathway should be in place in CAMHS that recognises the unhelpfulness, and the potential for decline in mental health and wellbeing, of inpatient treatment that is of any significant duration. This is supported by the relevant guidance and is raised as a learning point in agency reports and discussed in Sc5.

Family therapy, EMDR and other therapeutic opportunities continued to be offered to Chris and there continued to be a plan to discharge Chris over the coming weeks. At a CPA meeting, a few weeks after the diagnosis of CPTSD and EUPD, the diagnosis returned to CPTSD. Parents challenged this change of diagnosis and stated that, in their views, this diagnosis in isolation did not entirely fit her symptoms. From the point of view of the clinical team, it is acknowledged that there are no clear set of markers which denotes one diagnosis; rather overlapping symptoms which may be seen in multiple diagnoses. It was the view of the consultant psychiatrist that there should be a focus on Chris's trauma although it has since been acknowledged that it would have been better if a more consistent diagnosis had been achieved.

One month later, Chris was discharged from Sc2 (MHA 1983) and reverted to voluntary inpatient treatment. The inpatient unit facilitated contact between the twins, provided joint family therapy and coordinated leave arrangements to maximise contact between the sisters – this was all good work. During the summer months, Chris was regarded as relatively stable although she continued to self-harm. At this time, Chris spoke in detail about the sexual abuse to her KN, who was supervised by senior clinicians. It is understood that Chris did not want police or parents informed of the details she disclosed and these wishes were honoured. This was an important episode that required careful thought, informed by the safeguarding leads, about how to proceed. On this occasion, this did not happen. It is understood that since this time, extensive work has taken place to strengthen this area of safeguarding practice. The importance of children being fully supported to seek justice over time is discussed in Sc5.

Chris's relationship with the KN was observed to be characterised by an *intense disordered attachment* and attempts to discharge her prompted a crisis. Parental views were that she should be discharged home with outreach provided by the inpatient unit. From reviewing the

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[27] Complex post-traumatic stress disorder (CPTSD; also known as complex trauma disorder) is a psychological disorder that can develop in response to prolonged, repeated experience of interpersonal trauma in a context in which the individual has little or no chance of escape. CPTSD is associated with chronic sexual, psychological and physical abuse or neglect.

[28] EUPD is also known as: Borderline Personality Disorder.

[29] *Borderline Personality Disorder. The NICE Guidance on Treatment and Management.* National Collaborating Centre for Mental Health commissioned by The National Institute for Health and Clinical Excellence. The British Psychological Society & The Royal College of Psychiatry 2009

documents during this SCR it appears that whilst there were plans to discharge at this time, there were concerns about Chris's significant mental health needs and the support available to parents in meeting these needs. The inpatient unit discussed with parents the need for CS involvement under Sc85 (CA 1989) and that a referral would be made to CS by Sam's inpatient unit. This referral was not made; the reasons for this are unclear.

It is perhaps at this time that the involvement of CS was most needed; there was a view that Chris could not go home, parents were struggling to manage the different approaches to their daughter's treatment between the inpatient units which was making care at home very difficult, and the support parents needed to provide safe care at home needed to be explored. This required a joint CS and CAMHS assessment which included shared decision making and a multi-agency scaffold of support. At the time there was no multi-agency framework in place to facilitate this kind of approach. Supporting parents who are caring for traumatised children, and the need for a multi-agency approach, is discussed in Sc5.

In August 2017, Chris took a large overdose at the inpatient unit and was admitted to the local hospital. After a period of treatment she recovered and returned to the unit. During the following month, her sister Sam began a phased discharged from the out of area inpatient unit and spent increasing amounts of time at home. Over the following months, Chris's discharge continued to be considered. EMDR and family therapy continued and there were signs that Chris was showing less anger; she was engaging in therapy and starting to talk about recovery. Chris engaged well with the education provision within the inpatient unit, and she started at a private school in the local community. Close work took place between the school and the inpatient unit to support her integration; staff provided training to the school to support them to meet her needs and safety plans were jointly constructed between Chris, parents, the school and education staff at the unit. This was excellent joint work.

Over the following weeks, there was a decline in Chris's mental health and in October 2017, during an unescorted walk from the inpatient unit, Chris went missing. She was found lying near a local railway line by her father and inpatient staff, with a ligature tied around her neck. After attempting to run away, she was restrained by police and taken to the local hospital. During assessment at the hospital, Chris absconded and was again restrained[30]. A detailed referral was sent to CS by police. This referral outlined police involvement with Sam the day before[31] and their involvement with Chris. CS made contact with the inpatient unit; no 'safeguarding concerns'[32] were raised by the inpatient unit and as parents said they did not need support from CS, there was no further involvement. This was an opportunity to provide a multi-agency approach to Chris's care and support parents. The absence of an agreed multi-

[30] Chris needed to be restrained at hospital on a number of occasions over this timeline. The Trust has since reviewed methods of restraint and have changed restraint practices to provide a child centred restrictive intervention approach: *Restrictive intervention and therapeutic holding for children and young people.* Cambridge University Hospitals NHS Foundation Trust Version 1; Approved February 2020

[31] Sam had been reported missing to police by parents the day before, parents had been attempting to find her without success and were concerned about her safety. She was found by police in a distressed state and returned home.

[32] Since this time, work has been completed to strengthen the confidence of clinical staff to be more confident in expressing views with partner agencies about the support children & families need.

agency approach, and the resultant lack of clarity in CS and in children's mental health services about the role CS might take up in these circumstances, is discussed in Sc5.

Chris was detained under Sc3 (MHA 1983) and over the following weeks frequently self-harmed and tied ligatures. Chris asked to return home stating she had got *worse and worse* since admission. Parents supported her requests stating that little had improved for Chris since admission and there were few episodes of self-harm at home.

The CPFT agency report identifies that prolonged admission in inpatient units can increase risk and this can include developing unhelpful behavioural strategies around self-harm and suicidality, as well *as losing hope for any concrete future.* Relevant NICE guidance supports this view, particularly in relation to children who have a diagnosis of BPD. In addition, children who are detained under Sc3 (MHA 1983) come under Sc117 (MHA 1983)[33]. This legislation details the legal duty of health and social services to provide after care services at the point of discharge to prevent future admission. Relevant issues are discussed in Sc5.

At the next CPA (Care Planning Approach) meeting, discharge was planned to take place two months later. It was noted that Chris was engaging with her KN but not with other therapeutic relationships although continued attempts to seek her engagement were made. Chris continued to attend the community school and spend time at home. It was noted that since the last CPA meeting, her self-harm had continued which included tying 65 ligatures whilst on the unit. After running away from an escorted walk, Chris was restrained by police. This was the 4th restraint by police, and it was becoming clear to staff and parents that sight of uniformed officers resulted in panic and disassociation.

4.4 Continued inpatient care & second opinion: Dec 2017 – Feb 2018

Chris, now 16 years old, had been an inpatient for 10 months. At the request of parents, a second opinion was sought by the inpatient unit. A diagnosis of EUPD – borderline type was made, and it was recommended that Chris was discharged from Sc3 (MHA 1983) as soon as possible. Home leave increased and active risk assessments and safety planning with Chris and her parents took place. Whilst it was acknowledged that Chris remained at high risk, it was accepted that incidents of self-harm happened most often whilst on the ward.

In December 2017, it was found that Chris had stockpiled medication in her room on the ward and this was removed by her KN. Subsequently, Chris made threats to kill her KN and spoke about being scared she would hurt her family. The breakdown in the relationship with her KN was very significant for Chris and, for complex reasons, this became a difficult issue to manage for all concerned. Chris was deeply affected by the ending of this relationship and how this relationship ended. Difficulties in interpersonal relationships[34] is a feature of BPD and can include a pattern of unstable and intense interpersonal relationships, alongside alternations between extreme idealization and devaluation and fears of abandonment. Relevant issues about the diagnosis and treatment of BPD are discussed in Sc5.

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33 https://www.mind.org.uk/media-a/6156/leaving-hospital-2020.pdf

34 *Attachment and personality disorders: a short review* Nicolas Lorenzini, MSc, MPhil and Peter Fonagy, PhD, FBA University College London and Anna Freud Centre, London, UK (2013)

Due to an increase in the risks to Chris and others, a decision was taken to move Chris to a Psychiatric Intensive Care Unit (PICU). Parents opposed this decision requesting that she was discharged home with support or transferred to an alternative unit attached to the inpatient unit where Sam had been. Parents were extremely concerned about the impact of this move on Sam's mental health but felt that a move to an inpatient unit that Sam and parents trusted, and where good working relationships had been formed between the staff and parents, would mitigate these risks. A discussion took place between Chris's psychiatrists in the community and the inpatient unit and later, with Sam's former psychologist at the out of area inpatient unit. It was concluded that it may cause problems with Sam's care if Chris was admitted to the inpatient unit suggested by parents. Parental perspectives are that their views were not given sufficient weight at this time and that this decision had a long-lasting impact on their daughters' mental health and family wellbeing.

Parents continued to request that Chris was discharged home asking for support with her care, particularly at night. However, few services were available to provide the high level of support needed in the community; there was not an established practice or agreement between services for providing overnight support, there are limits to the crisis support available within CAMHS and there are no services available in the local area that can provide residential care in these circumstances. These issues are discussed in Sc5.

Chris said she did not want to return home although the reasons are not completely clear it was recorded that she was concerned that she could not keep herself safe at home and was afraid she might hurt her parents. As a result, a referral was made to CS. This referral set out Chris's current circumstances, was clear about the duties of CS under Sc117 (MHA 1983) and requested that alternatives to home were considered by CS. CS contacted parents who said they were keen to have support in managing the care of Chris and Sam across the different clinicians.

This referral was accepted and family members engaged with CS. However, there remained a lack of clarity within CS about their role in supporting the sisters and their parents. The benefits of a multi-agency approach were not understood and as previously stated, there was no multi-agency framework in place that would have supported this work. A parallel plan of CS seeking alternative supportive accommodation for Chris was proposed. This was an important juncture; there was a need for CS to make a thorough assessment of family life and parenting capacity, advocate for Chris (informed by an understanding of her mental health needs) and support parents. The concept that CS had access to local resources that would be an 'alternative to home' needed to be challenged and sources of support and safety in the kinship and community needed to be explored. In addition, Chris's needs fell under The Equality Act (2010), there was a need to fully explore parental requests for night-time support. There is little evidence to suggest that this kind of proactive role was taken up.

4.5 Transfer to an out of area inpatient unit (2): Feb 2018 – Apr 2018

Over the next few days, Chris continued to spend time at home and appeared relatively settled on the ward. However, there remained concerns about the safety of Chris and staff; Chris continued to self-harm, tie ligatures and was not compliant with boundaries whilst on the ward. It was still felt that the unit was no longer appropriate and that she would not be

safe at home. As a result, active attempts continued to find a bed in an alternative unit. A bed became available in a privately run Low Secure Unit (LSU) some distance from home[35] and arrangements were made for her admission. At this point, Chris was electively mute. Parental views were that Chris did not meet the criteria for admission to this unit and that there should have been concerted efforts to support Chris's return home. The view of the coroner was that this transfer was a judgement call made in a context of finite resources. The limitations of the support in place to enable Chris to return home may have contributed to this judgement call.

Chris's parents and inpatient staff were aware of her trauma when she saw uniformed officers and/or when she heard sirens/saw blue lights. Parents persistently asked for non-uniformed officers to assist in her move and asked that sirens/blue lights were not used. These requests were not responded to; on the day, Chris was restrained by uniformed officers and travelled in a secure ambulance that used sirens and blue lights. Members of staff from the local inpatient unit accompanied her and provided care during the journey. Records from the out of area inpatient unit indicate she was showing signs of acute trauma on arrival. It is understood there were no existing protocols/guidance that would have supported the secure officers and ambulance crew to provide a different response to Chris on this day; relevant issues are discussed in Sc5.

The distress of Sam on this day, directly related to her sister's move, is detailed in police reports who responded to an emergency call from parents. The need for clinicians to formally collaborate about the care of siblings is an area of learning identified in agency reports and is discussed in Sc5.

The following day CS made contact with the LSU inpatient unit and with parents. The original plan had been to admit Chris for a 12 week stay but it was suggested by the LSU unit that discharge was unlikely in the next 2-3 months and, given her presentation on arrival, it was more likely to be long term. Mother was tearful, she described the very difficult transfer of Chris and of Sam's restraint and arrest on that day. She expressed her deep concern for Sam's mental health and wellbeing in relation to the continued separation of the sisters and expressed fears that parents may lose Sam as a result. She was concerned about the unit rules, that the family were unable to regularly visit Chris, and noted that parents did not have support from kinship or family in the care of their daughters.

There was a need for CS to advocate for Chris and Sam and, with the involvement of CAMHS, seek to improve relationships between parents and the unit staff. A trusted relationship with the family needed to be built and there needed to be proactive involvement in planning for Chris's discharge. The position taken by CS appeared to be characterised by a lack of agency in taking up a role in these circumstances. In addition, a further barrier may have been that CS/social workers did not feel able to exercise authoritative practice; particularly in relation to the decisions of mental health professionals/clinicians or represent Chris's rights for advocacy and a tribunal service under Sc3 (MHA 1983). Related issues are discussed in Sc5.

[35] The availability of T4 beds is recognised as a challenge across the UK and this can mean that there are limited options and children can be placed some distance from home.

Chris remained an inpatient in this unit for approximately 9 weeks. On admission, Chris was mute. It was decided by the responsible clinician (the inpatient consultant psychiatrist) that Chris should not have access to paper or pens to communicate unless she was engaged in therapy. Parents and the CAMHS community psychiatrist questioned this approach, but this approach remained in place. Chris remained mute for the entire period of this LSU admission.

Parents described extremely difficult relationships with the unit staff and said this came as a shock to them when compared to the relationships with the local inpatient unit which, despite some disagreements, were characterised by respect and collaboration. Equally, it was clear that unit staff experienced a relationship with parents that on occasions featured conflict and tension regarding treatment decisions. Parents asked for support from community CAMHS and the local inpatient unit to improve this communication; they asked for the needs of the siblings and the family to be considered and requested a review of Chris's treatment. The local inpatient unit would not have had the authority to intervene. There was liaison between the CAMHS psychiatrist and the inpatient unit, but as decision making ultimately lay with the consultant psychiatrist at the inpatient unit, this did not result in any changes.

Apart from restricted eating, Chris only self-harmed once (on the day of her admission) and complied with the boundaries set. Parents' views about this period of inpatient care are that their views were ignored, that there was no collaboration about Chris's care and treatment (including her educational needs), no consideration of Sam or consideration of how clinicians might jointly consider the needs of the siblings. It is clear that there were difficult and protracted negotiations about a range of issues that involved frustration and upset on both sides. It is understood that significant changes have been made by this inpatient unit to improve collaboration with patients and parents.

One month prior to her discharge, a social worker (SW) visited Chris to ascertain her views about her current inpatient stay and discharge. Chris communicated in writing to all questions posed. She expressed her unhappiness at the unit, communicated her desire to go home to be with her parents and her sister, 'where she felt safe', and asked for support in being discharged. This was a clear account of Chris's wishes and feelings but there was little evidence that any action was taken in response. Relevant issues are discussed below and in Sc5.

4.6 Discharge from inpatient unit (2) & return home: Apr 2018 – Aug 2018

As time went on, in the absence of evidence that the threshold for compulsory admission was met, discharge planning was started. CS records detail the communication that took place at this time between the responsible clinician (the inpatient consultant psychiatrist) and CS. In this communication, it was recorded that this psychiatrist spoke about parents being *confrontational* and *very intrusive* regarding Chris's care. It was recorded that *mental health professionals are concerned that parents don't want to take any professional advice in terms of management and [are] working against the clinical team.* There were a range of other comments which inferred negative judgements about parents. These comments needed to be triangulated with the evidence; the reference to concerns being held by *mental health professionals* needed to be thoroughly explored (to clarify what this meant and who this was

referring to[36]). Professional challenge should have been a feature of the communication that took place and these concerns should have been openly discussed with parents. This did not appear to happen. In the absence of this, statements such as these can be read as statements of fact which can invade thinking over time and can lead to fixed thinking[37] which has implications for how views about families are formed and judgements made both in the short and long term.

CS had previously agreed to consider supported lodgings for Chris if a return home was not viable (although the view of CS was that in the first instance efforts needed to be made to meet Chris's needs at home). This was prompted by the views of some clinicians that this was a feasible alternative to living at home. It is important to clarify that there are no local resources offering supported accommodation that would have been suitable and as a result this was not an option. After consultation with Chris's care coordinator, who accurately stated that care by family in the community had not been thoroughly tested, CS concluded that Chris should return home; this was an appropriate decision. Views that CS may hold the potential key to a local placement resource that can successfully meet the needs of children with significant mental health difficulties should be challenged and extensive attempts to support children and parents should be made. The importance of CS understanding their legal duties under Sc117 (MHA 1983) and supporting parents who provide care to traumatised children, is discussed in Sc5.

In April 2018, the CS assessment was concluded. The assessment identified that both girls were noted to have emerging BPD traits and listed concerns from *mental health professionals*[38] that parents could be *obstructive - restricting access to appropriate support* and *undermining treatment and care planning*. It was also recorded in this assessment that parents wanted *specialist mental health support* and support at times of crisis. There was a view expressed that *their challenge of mental health services was understandable in the context of the traumatic moves between and increased security of Chris's placements*. CS concluded that parental engagement needed to be tested in the community and a CiN[39] meeting was arranged. The CS assessment was not shared with parents or with multi-agency partners, it is unclear why this did not happen - it was later confirmed at the inquest that CS held no concerns about the parenting received by Chris.

The need for authoritative practice[40] characterised by; advocating for a child and family within mental health services, proactive involvement in care and discharge planning and risk

[36] Coroner's findings established that these comments related to a single professional – this was not established at the time

[37] One of the most common, problematic tendencies in human cognition … is a professional failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture. Fish, Munro and Bairstow (2009), *Learning together to safeguard children*. Pg. 9

[38] Quote from CS records. Note: it is important to highlight that during the inquest it was established that these concerns were held by a single clinician (the out of area psychiatrist) the importance of accurate recording and triangulation of evidence is discussed later.

[39] Children in Need (CiN) are defined in law under Sc17 of the Children Act 1989 as children who are aged under 18 and need local authority services to achieve or maintain a reasonable standard of health or development/need local authority services to prevent significant or further harm to health or development. CiN meetings take place to meet these needs.

[40] In summary: Authoritative Practice is characterised by starting with the needs/voice of a child, includes respectful challenge and uncertainty, considers the needs of parents and sees these needs from their point of view without

management, did not appear to be understood or facilitated by CS at the time. This is linked to the lack of understanding about their role under Sc85 (CA 1989) and Sc117 (MHA 1983) and is discussed in Sc5.

Four days before discharge, Chris was permitted unescorted leave from the unit in the company of parents. This was the first time this had been permitted by the unit and as a result gave little opportunity for Chris and her family to prepare for her discharge. It is unclear why this happened, it could be that the difficult relationships between unit staff and parents may have been a contributory factor.

Discharge plans included the involvement of the Intensive Support Team (IST), the continued involvement of the CAMHS care coordinator, EMDR therapy, out of hours support from the local inpatient unit and review by the CAMHS consultant psychiatrist but there appeared to be no comments about education provision. Once Chris was discharged, parents paid for private tutoring at home and Chris was later supported in taking her GCSEs at the local inpatient unit. This was a flexible approach to promoting resilience and achieving positive outcomes. However, there had been no advice provided by involved professionals about the need for an Education Health and Care Plan (EHCP). Established practice at the time did not recognise the importance, or facilitate the completion, of EHCPs for children with significant mental health needs. Relevant issues about EHCPs are discussed in Sc5.

In the middle of April 2018, Chris was discharged. The collaboration achieved by CAMHS and the local inpatient unit with Chris and parents, and between the local inpatient and community clinicians, was consistently good. The local inpatient unit were flexible and creative in the way they adopted an agile inclusive approach to meeting Chris's needs and collaborating with parents. The approach that was enacted was a good example of joint working and how flexible, trauma informed therapy and approaches can be provided.

The community psychiatrist found it difficult to engage Chris in a meaningful relationship although Chris engaged with other support provided by CAMHS.

A CiN meeting took place, CS were clear that there was no ongoing role for the service as parents were working well with mental health clinicians/practitioners and were regarded as able to advocate for Chris's needs. Chris said she did not want further contact with CS at this time and it was assessed that there were no child protection concerns about Chris or Sam. The need for a multi-agency response to support children and families where there are significant mental health needs; including the role of advocacy, family support, authoritative practice, joint risk management and safety planning has been raised previously and is discussed in Sc5.

Chris continued to engage in treatment and collaboration with parents continued to go well. Chris engaged with IST (Intensive Support Team) for a short while. IST offered support to parents, but parents declined. Parent's perspectives were that they felt unsure about how the team would be able to support them and that, at this point, the array of professionals

collusion and "recognising that there is no single professional who has a monopoly of knowledge of skills to bring to the case". *Authoritative Child Protection Child Abuse Review Vol. 22*: 1–4 (2013) Ed. P. Sidebottom

involved was overwhelming. Parents were constantly vigilant about the risks to both daughters and it was noted by the CAMHS psychiatrist that mother was exhausted. There had been no exploration of their requests to receive night-time support as part of the Sc117 (MHA 1983) discharge planning and the limitations of suitable crisis support within CAMHS, coupled with Chris's fear of uniformed services, left the parents caring for their daughters at home in relative isolation.

During the following few months, there were signs that Chris's mental health was improving. Chris continued with EMDR and had formed a trusted relationship with this clinician who expanded their sessions to include trauma informed dialogue. This was a particularly good example of a flexible trauma informed approach.

Chris applied to a local 6th form college, parents said Chris found this college to be unwelcoming. With the active support of the Council's Senior Transitions Advisor, a place in a more welcoming state 6th form was secured. Subsequently, Chris passed six GCSEs and was accepted onto A-level courses which was a remarkable achievement. Relevant issues about the availability of further education options in the state sector for children with complex mental health needs are discussed in Sc5.

In July, after an unlawful restraint by police due to mistaken identity, Chris sought support from the inpatient unit who responded promptly. Chris continued to see the EMDR therapist but was unable to re-engage in the EMDR treatment to cure her fear of police. The therapist adapted the approach and instead used *mentalizing.* Mentalization Based Therapy (MBT)[41] is an evidence-based psychotherapeutic approach for BPD. Again, the flexible approach to Chris's needs by this clinician was commendable. There is no bespoke treatment pathway for BPD in the local CAMHS and whilst it is understood that MBT and CAT[42] are both available, the absence of a bespoke pathway risks an inconsistent approach to the treatment of BPD in adolescence.

4.7 Sam's tragic death: September 2018

At the beginning of September 2018, Sam tragically died at home after taking an overdose of medication. Chris was understandably distraught, she made contact with the local inpatient unit and immediate support was provided. Chris was electively mute.

An urgent meeting took place at the inpatient unit the following day, including involved clinicians, to decide on what could be offered to Chris. It was acknowledged that this was an extremely difficult time for Chris and her family and careful thought was given to the best options for Chris. It was concluded that inpatient care may not be in her best interests as detaining her could escalate risk due to her feeling even more hopeless about the future. Chris was clear that she did not want to be admitted. It was agreed that the most helpful therapeutic approach was to support Chris by reducing, as much as possible, access to

[41] Mentalization-based therapy (MBT) is a type of long-term psychotherapy. Mentalization is the ability to think about thinking. It helps to make sense of thoughts, beliefs, wishes and feelings and to link these to actions and behaviours.

[42] CAT stands for Cognitive Analytic Therapy; a collaborative programme for looking at the way a person thinks, feels, and acts, and the events and relationships that underlie these experiences (often from childhood or earlier in life).

dangerous methods (of self-harm) and to give her people to talk to so that she could be helped through this difficult time.

With the agreement of Chris and parents, it was concluded that the trusted relationships that had been formed by the CAMHS care coordinator and the EMDR therapist were of central importance and this therapy would continue. A highly supportive safety plan was agreed which included comprehensive liaison with the 6th Form College, who agreed to a flexible and creative approach to meeting Chris's needs. Ultimately Chris decided that she did not want to continue attending this college and was encouraged to continue with her established babysitting (which she enjoyed) and to work towards childcare qualifications within the inpatient education provision. Excellent collaboration was achieved by the education staff at the inpatient unit between Chris, her parents, and the 6th Form College.

A complex strategy meeting took place with CS and multi-agency partners. It was decided that CS would undertake a single agency Sc47 (CA 1989)[43] investigation because of Sam's death. It was decided that this should be a single agency investigation as there were no criminal concerns to be addressed. Whilst it is appreciated that agencies were concerned about the risk of Chris taking her own life, it is unclear on what grounds the Sc47 (CA 1989) threshold had been met. This is discussed in Sc5.

Multi-agency meetings continued to take place. At this time, an internal CS email referred to comments (made by *mental health practitioners*[44]) about parenting. These comments inferred negative judgements about parenting which included a statement: *mother likes to direct and take charge of professionals and is selective about what intervention the family will engage in – therefore the girl's voices are not heard and what is seen is the behaviours.* This was a very serious statement which had the potential of being interpreted as meaning that mother's actions were linked with the girls' mental health difficulties. In the first instance, this needed to be openly discussed with Chris and her parents by the 'mental health practitioners' and triangulated with the evidence. As previously highlighted, in the absence of challenge, these statements can be unintentionally read as statements of fact and have implications for how views about families are formed and judgements made and can be damaging to families. This is discussed in Sc5.

In response to a discussion with parents, British Transport Police (BTP) updated CAMHS on the actions and safety plans in place in the community. It was agreed that if Chris were missing and if it was believed that Chris would make her way to the Railway Line to take her own life, urgent contact should be made with BTP[45].

Over the following weeks, Chris received a high level of support from the inpatient unit and from CAMHS. Chris talked in therapy about not being more or less suicidal than before Sam's

[43] Sc47 of the Children Act 1989 sets out the statutory duties of local authorities/county councils to take action when a child is suffering or at risk of significant harm.

[44] It has not been possible to clarify what or who was meant by the term 'mental health practitioners'.

[45] There was a different policy in place in the inpatient unit – this policy required contact to be made with local police in the first instance – this has been thoroughly explored by the coroner and findings have been made.

death but now knew her own suicide was possible. Safety plans were frequently reviewed and shared.

4.8 Third admission to inpatient care: September 2018

Two weeks after Sam's death, parents found a suicide note at home written by Chris and made contact with the CAMHS on-call clinician and the inpatient unit. At this point, Chris's CPTSD and eating difficulties were regarded as being under control but it was recognised that Chris was experiencing a severe bereavement reaction. Chris agreed to be admitted as an informal patient. The CPFT agency report[46] raises the question of whether this admission could have been averted with the right access to respite support and more options in home treatment and crisis management. The lack of community services for emerging personality disorder in under 18s is also mentioned.

As part of a risk management plan, Chris was admitted as an informal patient and the inpatient unit collaborated closely with the CAMHS clinicians/practitioners and with Chris and her parents. Opportunities for trauma informed therapy were consistently provided and safety plans were regularly reviewed, updated and shared. Chris said she did not want to live at home, due to her parents' distress and complicated by memories of Sam. Flexible arrangements were in place that allowed Chris to stay with her boyfriend at night and return to the inpatient unit during the day. Maximum opportunities were provided to promote freedom and autonomy in order for Chris to build a life outside the inpatient unit. Risk sensible decisions were at the heart of the decisions that were made. These were unusual arrangements in unusual circumstances that required an extra-ordinary response. With the consent of Chris and her parents, this was provided jointly by the inpatient unit and CAMHS.

Chris was explicit in stating that she did not want the ward to be in contact with her boyfriend and said it was sufficient that her parents were in contact with him. There were concerns that Chris's boyfriend, who was an adolescent, was being expected by parents to oversee the risk management plans. After discussion with parents, the view of the inpatient psychiatrist was that there was no indication that this arrangement raised safeguarding issues that required the wishes of Chris and parents to be overridden.

By this point, CS had decided that there was no further role for the service. It had been concluded there were no safeguarding concerns, Chris had independently (through staff at the inpatient unit) expressed her wish not to have contact with a new SW and parents did not see a role for CS. Subsequently, during communication between the inpatient unit and CS, concerns were raised with CS about Chris staying with her boyfriend, parental reliance on the boyfriend to monitor her medication and keep her safe, and concern that parents were supplying Chris with alcohol. CS were asked to assess these matters including assessing the capacity of Chris's boyfriend to keep her safe; CS agreed to keep the Sc47 (CA 1989) investigation open.

Whilst these concerns did not meet the threshold for continued involvement under Sc47 (CA 1989) and use of this statutory instrument in these circumstances is unhelpful, these concerns

[46] This report was appropriately informed by the views of CAMHS clinicians.

needed to be addressed. Careful thought and intervention, to determine the needs of Chris and the needs of her boyfriend, was needed. This should have been characterised by a collaborative approach led by CAMHS and the inpatient unit with continued involvement of CS to support and oversee the action taken to address the concerns. It is appreciated that there is a justifiable concern that clinicians leading these kind of enquiries may risk alienating children and their parents. However, the risk of passing concerns to CS to resolve can result in CS being perceived as a threat to family life and thereby reduce the possibility that consent for their continued involvement will be forthcoming. Relevant issues are discussed in Sc5.

Persistent, but unsuccessful, attempts were made by the new SW to engage Chris. In the absence of concerns that met the threshold for continued involvement under Sc47 (CA 1989), coupled with the lack of engagement by Chris and an absence of parental consent, CS subsequently closed their involvement on the basis that they had no ongoing role. It did not seem that CS took an active role in analysing the concerns that had been shared, or in advising partners about how these concerns should be addressed. As a result it appears that the concerns about the wellbeing of Chris's boyfriend and the safety of Chris, in these circumstances, were left unresolved. In the absence of a clear pathway that defined the roles and responsibilities of the multi-agency network, the multi-agency response was muddled. Relevant issues are discussed in Sc5.

Chris continued to say that she found it difficult to stay at home because memories of her sister dominated the house. Flexible care arrangements continued to be provided which were underpinned by regular risk assessment and safety planning. A therapist revisited the question of whether Chris wanted contact to be reinstated with the police relating to the CSA. It was good practice that the therapist kept the option of seeking justice open although Chris declined on the basis that she did not trust that anything would be done. Parental views are that Chris's fear of police was a significant inhibiter but if an option of speaking to another non-uniformed professional had been offered, Chris may have reconsidered this.

On the night of Sam's funeral, Chris took an overdose and two months later took a further overdose shortly after her 17th birthday; she received treatment and recovered. The flexible arrangements to keep her safe continued, underpinned by close collaboration between Chris, her parents and mental health practitioners. Chris was consistently clear that she would take her own life (it being a matter of *when, not if*). She continued to grieve the loss of her sister whilst on the ward. This was an extremely difficult time, the question of whether Chris should be detained under the MHA (1983) was regularly considered alongside the views of Chris and her parents. It was concluded that compulsory admittance risked increasing her suicidality and self-harm. There was extensive work undertaken to manage these risks whilst promoting Chris's sense of empowerment and investment in the future. Chris went on holidays with her parents and attended several rock concerts with them, all without incident.

Chris attended an appointment with the adult personality disorder team to start her transition to adult services, but this appointment did not go well, and Chris told her care co-ordinator that she had no faith that she would be provided with adequate support. The following days were challenging for Chris, she continued to grieve the loss of her sister.

4.9 Chris's tragic death: January 2019

In January, the existing plans continued to be in place. On the day of Chris's death, in line with these plans, she had spent the morning with her parents then returned to the inpatient unit and planned to stay with her boyfriend that evening. There was no indication to staff or parents that her suicide risk was increased on this day. Chris engaged well with staff, she was said to be bright and responsive. Staff noticed she had a mark on her arm which appeared to be inflamed and, after negotiation, Chris allowed this to be examined. Chris said that some days previously she had used a lighter to burn her arm and the examination revealed that the wound was infected and required medical examination by a doctor. The duty doctor was contacted who was unable to attend until later that evening. Chris refused to attend A&E but agreed to wait to see the doctor, before she left the unit to stay with her boyfriend overnight, if she could have a cigarette.

Chris was an informal inpatient who had the right to leave the hospital should she choose to do so, although this was always the subject of risk assessment. It was decided that if agreement was not given to this request, Chris may leave the unit without the required treatment. This was a risk sensible decision. However, there was an established smoking policy in place that prohibited patients from smoking on hospital grounds[47]. In the past, staff had used their discretion around this policy and made exceptions that allowed patients to smoke within the hospital grounds or be accompanied by staff. On this day, it is understood that there was a miscommunication between staff about where Chris should smoke and Chris left the hospital grounds. She made her way to the local railway line where she tragically died after being hit by a train.

A number of accounts have been scrutinised by the coroner about these events and it is clear that lessons have been learnt about what may have prevented Chris's suicide on this day. It is important to note that no blame has been attributed to inpatient staff about their actions on this day; it has been recognised that systemic factors influenced decision making and parental views, that it was a tragic situation where unfortunately everyone had incomplete knowledge, except Chris herself, have been acknowledged.

It is understood that action has already been taken by relevant agencies/services to address the learning that has been identified. The coroner has made additional findings about the future action that is needed. The detail of these findings has been made available to CPSCPB; it is neither appropriate nor proportionate for this SCR to re-examine the facts of this day. The findings of the coroner have been reviewed to fact check with this SCR and CPSCPB will be guided by the coroner about relevant learning and maintain oversight of implementation.

[47] The Coroner has sent a 'Letter of Concern' to the Royal College of Psychiatry about the NHS- wide smoking policy/potential risks for inpatients who are suicidal.

5 Systems analysis & learning

At the start of this SCR, CPSCPB set a number of broad areas that the review should address:

- How can children with very high-risk behaviour be effectively safeguarded in the community?
- How might we better support children, young people, families, practitioners, and agencies?
- How can an effective partnership be achieved between professionals, services, children, young people, family, kinship, and community?

The following section answers these questions by summarising the learning that has emerged and making recommendations to CPSCPB. As stated, a key requirement of SCRs is to understand how a child's experience of services might provide a window on the health of the wider system. In order to do this, the local context is considered alongside national research and guidance. It is perhaps unsurprising that there are no simple answers and no quick fixes. In line with systems thinking and analysis, the following sections interlink with each other, as do the recommendations. Implementing changes in one part of the system will not affect the systemic changes that are needed.

Key Learning

The independent agency reports written for the purposes of this SCR identified single agency learning, this learning will be taken forward by agencies and oversight provided by CPSCPB. The learning set out in the following section identifies the multi-agency learning that has emerged and picks up the key areas of single agency learning that have a bearing on multi-agency working

5.1 Good Practice

The care and treatment provided to Chris by the local inpatient unit and CAMHS are impressive examples of how working in a trauma informed way, which places the child at the heart of decision making, can be achieved. The following are some examples of the excellent work which appeared to be led by the local inpatient unit in conjunction with CAMHS.

- Work of the inpatient unit that focused on trauma informed treatment.
- Trusted relationships that were nurtured by the inpatient unit and CAMHS.
- Sources of safety that were identified and nurtured.
- Flexible and creative approaches to care, treatment, and therapy.
- Understanding Chris's trauma.
- Respectful relationships that were formed with parents by the inpatient unit and CAMHS.
- The excellent work of the inpatient education provision including the collaboration achieved with the community school, the 6th Form College, Chris and parents.
- The standard of education provision and the flexible approach to meeting Chris's educational needs.
- Working together with parents as equal partners.
- Promotion of contact between Chris and her twin sister.
- The standard of FT that was provided and the consistency and flexibility of provision.

- The risk sensible decisions that were made, and the overall standard of risk mitigation and safety planning.
- The outpatient care provided by the inpatient unit.

5.2 Child Sexual Abuse

The heart of the learning in this SCR is about how children can be protected, and supported to recover, from child sexual abuse. In order to understand Chris's needs, it is important to start with what has been learnt about how services responded to Chris's help seeking behaviour in her early years.

The sexual abuse and sexual exploitation of children is a serious issue which has significantly negative emotional and developmental consequences which can last throughout childhood and into adulthood. Prevalence studies for England and Wales suggest that some 15% of girls and 5% of boys experience some form of sexual abuse before the age of 16. However, sexual abuse is a hidden crime and many of those who experience it do not report their experiences for several years, if at all. In fact, it seems that only around 1 in 8 cases of child sexual abuse reach the attention of statutory services, which means far more children are being sexually abused than we are currently safeguarding. There is considerable evidence that children who are victims of sexual abuse are not identified by professionals and that there is an over reliance on children to tell people what is happening to them. Adults, who suffered CSA in childhood, have talked about what would have helped them speak out[48].

Professionals rely too heavily on children to verbally disclose abuse.

Children are unlikely to tell someone that they are being sexually abused, particularly when the perpetrator is known to them. Therefore, parents, professionals and the public must understand and know how to respond to the signs and symptoms of child sexual abuse[49].

5.2.1 Responding to children's help seeking behaviour

It is a core ambition of the safeguarding system that children feel able to talk to family, friends, and professionals about any concerns they have. This concept of help seeking behaviour is important. It is a developmental task which develops over time and is supported by the response of parents/adults. Children who are abused are likely to have underdeveloped help seeking behaviour or are actively discouraged or prevented from seeking help through threats, intimidation, or suggestions of impact on family. It is essential that professionals respond to children's help seeking behaviour. The research evidence suggests that children will "test out" the response of professionals before making more serious allegations of harm.

[48] NSPCC Practice Briefing. Child Sexual Abuse 2013

[49] *Multi-agency response to child sexual abuse in the family environment*: joint targeted area inspections (JTAIs) Published 4 February 2020

Teachers are the professionals to whom children will most commonly disclose, but the disclosure process can be helped or hindered by the way in which any professional engages with a child about whom concerns exist[50].

It is of vital importance that any child who is exhibiting sexualised behaviour, outside the normal range for their age and development, is responded to by an approach informed by an understanding of sexual abuse and an appreciation of children's deep reluctance to speak out about abuse. How adults react will frame a child's understanding of what they are trying to communicate. Therefore, any language used that may communicate the behaviour is *inappropriate* or wrong, and/or reward and punishment behavioural management techniques aimed at stopping the behaviour and used in isolation, risk perpetuating feelings of shame and deepening the silence that shrouds CSA.

Rates of verbal disclosure are low at the time that abuse occurs in childhood. However, children say they are trying to disclose their abuse when they show signs or act in ways that they hope adults will notice and react to[51].

5.2.2 Responding to the symptoms of sexual abuse

The young people said they wanted: someone to notice that something was wrong; they wanted to be asked direct questions; they wanted professionals to investigate sensitively but thoroughly[52].

Chris was 14 when she was admitted to hospital after taking an overdose and it was noted she had self-harm wounds in her labial area. She attended appointments at CAMHS where a variety of symptoms associated with trauma were noted. A referral was made to Children's Services by the Acute Trust, but the quality of the referral was not sufficient for CS to be clear as to the level of risk that was being assessed by the hospital. Equally, CS could not see what role they would take up in circumstances where a child was suffering mental health difficulties and so the referral was logged but no further action was taken. There was a need for the Acute Hospital, CAMHS and CS to consider whether Chris had been/was the victim of CSA.

The Children's Commissioner's report on CSA[53], associated research[54] and guidance[55] available at the time, detail the symptoms of sexual abuse. Chris's symptoms fell firmly within this range: *The consequences of child sexual abuse can include depression, eating disorders, post-traumatic stress, and an impaired ability to cope with stress or emotions (Allnock et al*

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50 *Key messages from research on identifying and responding to disclosures of child sexual abuse* Debra Allnock, The International Centre: Researching child sexual exploitation, trafficking, and violence (University of Bedfordshire) Pam Miller and Helen Baker, NSPCC September 2019

51 *Key messages from research on identifying and responding to disclosures of child sexual abuse* Debra Allnock, The International Centre: Researching child sexual exploitation, trafficking, and violence (University of Bedfordshire) Pam Miller and Helen Baker, NSPCC September 2019

52 *No one noticed, no one heard: a study of disclosures of childhood abuse*. London: NSPCC 2013

53 *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action* November 2015 Children's Commissioner

54 Such as: *Impact of Child Sexual Abuse: A Review of the Research*. Browne and Finkelhor
Family Violence Research Program and Family Research Laboratory, University of New Hampshire
The American Psychological Association1986 Vol. 99, No. I, 66-77 0033-2909/86/

55 Such as: Royal College of Paediatrics and Child Health (RCPCH) (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*. London: Royal College of Paediatrics and Child Health (RCPCH). *Child maltreatment: when to suspect maltreatment in under 18s Clinical guideline*. NICE July 2009

2009). Self-blame, self-harm, and suicide are commonly mentioned as consequences of sexual abuse[56].

Key learning: It is vital that the children's workforce understand this evidence base, hold in mind the possibility that a child may be the victim of sexual abuse, frame responses to children underpinned by an understanding of trauma informed practice and provide opportunities for children to speak out.

A range of complex and interacting individual, relational, and social barriers may prevent children from disclosing abuse, to professionals or anyone else……..the disclosure process can be helped or hindered by the way in which any professional engages with a child about whom concerns exist[57].

5.2.3 Responding to disclosures of child sexual abuse

Practice in this area is too police-led and not sufficiently child-centred. Too often, health agencies are not involved at all[58]

Police often led decision-making in cases of sexual abuse: *This was because of a lack of confidence and ability to challenge within the rest of the partnership. We saw too much silo working and, in most of the work we saw with children, not enough involvement from health professionals due to children's social care and the police not consistently involving health partners in decision-making. This meant that decisions were made without all of the information and that children were then left at risk and/or without medical treatment.*

It takes great courage for children to speak out about sexual abuse: the response to the disclosure of sexual abuse by Chris mirrored findings in the joint area targeted inspection into sexual abuse[59]. There was a focus on achieving the evidence needed to pursue the investigation through a visually recorded interview; this focus is understandable as VRIs allow for special measures to be put in place such as avoiding the need for victims to repeat this evidence in court. However, in the passage of time, once it became apparent that Chris did not want to complete a VRI, alternative means of giving evidence needed to be pursued. It is the view of the police that this would have been discussed at the time but there are no records of this and parents do not recall any alternative ways of giving evidence being discussed at the time or subsequently. A number of principles contained within the Achieving Best Evidence[60] guidance did not appear to underpin the work that took place. Whilst initial consultation with parents and the girls took place, this did not continue over time. The absence of joint planning between the two police forces involved, and the lack of multi-

[56] *No one noticed, no one heard: a study of disclosures of childhood abuse*. NSPCC 2013

[57] *Key messages from research on identifying and responding to disclosures of child sexual abuse* Debra Allnock, The International Centre: Researching child sexual exploitation, trafficking, and violence (University of Bedfordshire) Pam Miller and Helen Baker, NSPCC September 2019

[58] *Multi-agency response to child sexual abuse in the family environment*: joint targeted area inspections (2020)

[59] *Multi-agency response to child sexual abuse in the family environment*: joint targeted area inspections (JTAIs). Feb 2020

[60] *Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures*. Ministry of Justice 2011

agency partnership working, suggested that the importance of seeking justice over time was not understood.

This was a critical juncture. The response by services at the time was fragmented and very shortly professionals and services from across the multi-agency network withdrew in a misguided belief that they had no ongoing role. Responsibility to meet Chris's needs was left solely in the hands of her parents and mental health professionals.

5.2.4 Enabling children to speak out.

Children and non-perpetrating parents and family members are not supported well enough.

We are particularly concerned about misconceptions we saw around what support can be offered and when; for example, whether therapeutic support for victims is available during a police investigation or ongoing trial or not.

The lack of appropriate professional challenge among agencies in relation to child sexual abuse was particularly evident[61]*.*

The impact on victims and families of child sexual abuse is devastating. Children who disclose sexual abuse need professionals to come together to provide support to them and their families, and provide services based on a sound understanding of sexual abuse informed by research and guidance. Multi-agency services have an important part to play in supporting and challenging each other about the services that are provided.

5.2.5 Achieving justice over time

Disclosure is best understood as a process which is influenced by relationships and interactions with others and may extend over a considerable period of time[62]*.*

Shortly after being told that the criminal investigation was closed, Chris was admitted to an inpatient unit. Relevant research points to a critical finding that trusted adults need to find ways to invite genuine disclosure[63]. This was achieved whilst Chris was an inpatient when she spoke in detail about the abuse with a trusted adult. Whilst it is understood she did not want police involvement at this time, the therapeutic importance of justice for victims needed to be better considered in consultation with safeguarding leads.

Key Learning: Service developments across the multi-agency network should include raising the awareness about the importance of seeking justice for children who have alleged CSA and how this might be promoted and enacted over time; these developments should include

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61 *Multi-agency response to child sexual abuse in the family environment*: joint targeted area inspections Feb 2020

62 *Key messages from research on identifying and responding to disclosures of child sexual abuse* Debra Allnock, The International Centre: Researching child sexual exploitation, trafficking, and violence (University of Bedfordshire) Pam Miller and Helen Baker, NSPCC September 2019

63 *Understanding children's non-disclosure of child sexual assault: implications for assisting parents and teachers to become effective guardians*. N. M Wagner 2005

informing and supporting children and their parents/carers. A further issue that should be included in this work is the importance of seeking criminal injuries compensation[64]. Whilst it is accepted that no amount of money can ever compensate victims for the abuse they have suffered it can represent a form of acknowledgement that they have been believed and that what happened to them was wrong. The importance of this, in the healing journey for victims of abuse, should not be underestimated.

5.2.6 Providing a trauma informed response[65]

The Independent Inquiry into Child Sexual Abuse[66] is clear that of greatest importance to survivors is a relationship where they feel heard, listened to, understood, believed, and not judged by a caring, empathetic professional. As identified in the strategic direction statement by NHS England[67]; when providing services to children who have been the victim of sexual abuse a trauma informed approach is needed that appreciates the devastating impact of CSA, and one that is centred on the needs of the survivor to build a trusting relationship with those who can help. For Chris, this was mostly achieved.

What has happened to you? As previously stated, Chris's presentation fell firmly within the range of symptoms suffered by children who have been sexually abused. Whilst it is acknowledged that there are no diagnoses that adequately reflect the effects of developmental trauma as a result of abuse/adverse childhood experiences, the traumatic stress field has adopted the term complex trauma or Complex Post Traumatic Stress Disorder (CPTSD) to describe the experience of multiple, chronic, and prolonged developmentally adverse traumatic events most often of an interpersonal nature (such as sexual abuse). CPTSD is a relatively new diagnostic term[68] which was not in wide use at the time.

It is argued that diagnoses per se are not as important as the approach that is enacted. And of critical importance is the meaning the diagnosis has for a child/young person. Chris asked, '*what is wrong with me?'* Whilst it is understood that Chris did not agree with this diagnosis, acknowledging her trauma by placing this at the core of the formulation and treatment approach enabled a clear message to be heard by Chris that her symptoms were not as a result of something that was inherently wrong with her but as a result of the trauma she had suffered. This had the potential of empowering Chris to envisage a future where she could be helped.

Taking a trauma informed approach in our work can enable this shift away from asking "What is wrong with you?" towards an orientation of "What has happened to you?", enabling the possibility of survivors of abuse being seen by themselves and others as just that – survivors. With this change in ethical orientation a child or young person's responses to trauma are seen

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64 https://www.gov.uk/government/organisations/criminal-injuries-compensation-authority

65 A trauma informed approach is currently being developed within CPSCPB within a contextual safeguarding approach.

66 Independent Inquiry Child Sexual Abuse 2020

67 *Strategic Direction For Sexual Assault And Abuse Services - Lifelong care for victims and survivors*: 2018 – 2023 NHS England

68 CPTSD was first described in 1992 and was included in the WHO International Classifications of Diseases (ICD- 11) in 2011, 2012 & confirmed in the 2018 edition. However, there are no NICE guidelines for CPTSD.

as understandable and courageous attempts to survive which were absolutely necessary at the time[69].

Key Learning: Research, literature and guidance about child sexual abuse has been available for some time. The Independent Inquiry into Child Sexual Abuse commenced in 2015, since this time there has been some substantial additional research and new national initiatives such as the work completed by the Centre of Expertise on Child Sexual Abuse. In 2018, NHS England published a five-year strategy[70] to provide lifelong care to survivors of sexual abuse and this year the government launched a national child sexual abuse strategy[71]. A number of local initiatives are now in place, in line with the national findings, to strengthen all parts of the system to "*protect children from these abhorrent crimes"*[72] and provide victims and their families with the services they need.

Whilst this strategy appears to be a comprehensive document, parental views are that it does not go far enough to address concerning issues previously identified by the Children's Commissioner[73] in response to the Poppi Worthington case[74]. These issues surround the burden of proof needed in cases of CSA; it was the view of the Children's Commissioner that the burden of proof should be lowered in cases of CSA arguing that the current system is not "*fit for purpose*". Indeed, it appears that the strategy does not address this. It is an important issue that is particularly poignant for Chris's parents as the burden of proof needed to convict the alleged abuser appeared to impact on the initial police investigation and the subsequent investigation that has taken place since the tragic deaths of their daughters.

Recommendation 1: The CPSCPB should take the learning arising from this SCR and ensure that it is reflected in the work on CSA currently being undertaken by the partnership. This work should be embedded across the partnership and the CPSCPB should monitor its impact on children.

Recommendation 2: The CPSCPB should write to the National Panel, National Police Chiefs' Council (NPCC), HMG: Home Office and Ministry of Justice, the Children's Commissioner and Association of Directors of Children's Services (ADCS) about the concerns raised within this review about the burden of proof required in CSA cases and consider how the partnership can support this important national work going forwards.

[69] *Trauma – informed approaches with young people*. Research in Practice Front Line Briefing 2018
[70] *Strategic Direction For Sexual Assault And Abuse Services - Lifelong care for victims and survivors*: 2018 - 2023
[71] *Tackling Child Sexual Abuse Strategy* 2021 HMG
[72] Priti Patel Home Secretary quoted in *Tackling Child Sexual Abuse Strategy* 2021 HMG
[73] https://www.childrenscommissioner.gov.uk/2016/01/27/we-must-learn-from-the-tragic-death-of-poppi-worthington
[74] Poppi died as a direct result of sexual assault by her father.

5.3 Working Together - responding to children who are at high risk

Disclosures from young people about suicidal thoughts and concerns about self-harm should be taken seriously and prompt an immediate multi-agency response[75].

There was little multi-agency involvement during the period under review. This reflects the national picture in relation to children who are at high risk of harm as a result of their mental health difficulties and/or as a result of exploitation. The difference between working with children who are at risk of harm from exploitation and those who are at risk because of their mental health needs is that service provision for the former group of children is generally left in the hands of Children's Services (CS) and the latter with CAMHS.

The most consistent learning identified by all agencies was the need to provide a multi-agency joined up approach to meeting Chris's needs. Concerns were highlighted by all involved agencies that this was not a feature of the work; this led to silo approaches and a fragmented knowledge of Chris and her lived experiences. On occasions when there were opportunities to provide a multi-agency response, these opportunities were not utilised and had wide ranging implications on how Chris's needs were understood and met.

Several referrals were made to CS, the majority of which resulted in no further action on the basis that there was no role for the service. Part of the reason for this stemmed from a lack of clarity about what referrers were asking CS to provide and there seemed to be a general misunderstanding about relevant legislation, associated research and guidance. In terms of CS, their legal role under Sc117 (MHA 1983) and Sc85 (CA 1989) was not well understood or established, and multi-agency working with children who are at high risk as a result of their mental health needs was not usual practice.

Attempts were made by CAMHS to secure the involvement of CS under Sc17 (CA 1989)[76] and Sc47 (CA 1989)[77]. Under Sc17 of this legislation, consent is required for CS involvement and parents were ambivalent about the involvement of CS. As a result, CS were only briefly involved. There were several reasons for this; there was a lack of clarity within CS and across the multi-agency network about the role they would take up in these circumstances, there did not seem to be an acknowledgement that Chris's mental health needs came under The Equality Act (2010) and therefore she was entitled to an assessment for services that are available for children who have complex needs in relation to their disabilities. This lack of clarity, together with the stigma that can be felt by families when CS are involved in family life might contribute to why consent may not be forthcoming.

Under Sc47 (CA 1989) consent is not required for undertaking initial enquiries and the initial safeguarding assessment and there were occasions when CS were involved under this legal

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[75] *Teenagers: learning from case reviews briefing: Summary of key issues and learning for improved practice around working with teenagers* NSPCC February 2021

[76] Section 17 of the Children Act 1989 states that it is the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as it is consistent with that duty, to promote the upbringing of such children by their families.

[77] Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard a child.

framework. However, aside from CS involvement after Chris had disclosed CSA, the reason for their subsequent involvement under Sc47 was unclear.

As evidenced in relevant research [78] [79] [80], considerable stress is experienced by families when Sc47 (CA 1989) is used and, especially when working with adolescents, this can result in alienating children and disempowering parents who are responsible for their care. A seminal review of child protection in England[81] highlighted an imbalance in child protection work, with a focus on technical solutions, rules and procedures rather than recognising the importance of the skills needed to engage with families. This review states that the emphasis should instead be on *building strong relationships with children and families with compassion.* It seemed that the absence of a locally agreed multi-agency approach under the preventative agenda, coupled with misunderstandings about relevant legislation, guidance, and research (about when and how to provide effective support for children and families in these circumstances) may explain why attempts were made to achieve multi-agency working under a higher threshold of statutory intervention. The impact of this conundrum on children and families and on multi-agency working requires attention.

It is important to refer to an added component that may have influenced multi-agency involvement at this time. This relates to how multi-agency working is achieved with young people who have a diagnosis of BPD. As identified in relevant guidance: *Many young people with borderline personality disorder have needs that span health, social care, and education. Coordinating a multi-agency response for these young people is often exceptionally difficult. Often, the presence of one agency in the care of the young person reduces the likelihood of involvement, or in some cases precipitates the withdrawal, of another* agency. *Withdrawal by one agency when the young person has identified needs that are their responsibility is unhelpful[82].*

Finally, an important area that has arisen is the issue of how authoritative practice[83] is facilitated and enacted across the multi-agency multi-disciplinary workforce. In this case, this applies to challenging each other about service provision. This is an issue that repeatedly emerges in SCRs as far back as the Lord Laming Inquiry[84].

The implications for how children are protected and supported to recover from CSA have been discussed, as has the need to provide a multi-agency response to children who are

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78 *Rethinking child protection strategy: child protection and assessment*. Devine L and Parker S ESRC evidence briefing 2015

79 *That Difficult Age: developing a more effective response to risks in adolescence*. E. Hanson & D. Holmes. Research in Practice. ADCS Dartington 2014

80 *Reimagining child protection*. Featherstone, White and Morris, 2014

81 Department for Education*: The Munro Review of Child Protection: Final Report. A child-centred system.* Presented to Parliament by the Secretary of State for Education by Command of Her Majesty May 2011

82 *Borderline Personality Disorder. The NICE Guidance on Treatment and Management.* National Collaborating Centre for Mental Health commissioned by The National Institute for Health and Clinical Excellence. The British Psychological Society & The Royal College of Psychiatry 2009. P.370

83 Authoritative practice places the child's needs as paramount and involves challenging service provision on behalf of the child.

84 The Victoria Climbie Inquiry: report of an inquiry by Lord Laming. Crown copyright 2003

exhibiting high risk behaviours as a result of their mental health needs. This approach should be led by CAMHS with multi-agency services taking up a proactive role in service provision.

Other areas of particular note that need multi-agency collaboration, decision making, planning and support are:

- Consideration of the specific needs of children who meet the diagnostic criteria for BPD / CPTSD or similar within the context of a multi-agency approach.
- Use of a robust planning framework that places the child at the centre and includes regular review by the multi-agency network, child and family (such as the CETR framework)[85].
- Collaborative decision making across the multi-agency network including joint ownership and approach to addressing any safeguarding concerns, which includes triangulation of the evidence, challenge of fixed views and transparent discussions with parents.
- The involvement of police forces and ambulance services in discussions about providing a trauma-informed response/approach to children in these circumstances.
- Collaboration across agencies to achieve parity of provision for children with complex mental health needs which includes finding creative ways to support parents in providing care at home – with specific reference to overnight support.
- Consideration of specialist local residential accommodation for children who are discharged from T4 when it is not possible for children to return home.
- Recognition that providing services to children with complex needs and their families can be challenging and can lead to anxiety which affects the collaboration that is achieved. Provision of psychological safety[86] for professionals is therefore an important consideration.

Key Learning: As stated, there is no national approach, framework or guidance that supports multi-agency services to provide a joined-up approach to children with significant mental health difficulties. A great deal of national activity has taken place in the last few years in response to the growing concerns about children who are at risk of harm/are harmed through criminal and/or sexual exploitation. This activity and associated guidance[87] has not included children who have significant mental health difficulties, despite the high risk of harm.

Several recommendations have been made in the various single agency reports, provided for the purposes of this SCR, about how this might be locally achieved. There is clearly a desire for this area of work to be developed and recommendations are made.

There are a number of encouraging changes that have taken place in service provision since the period under review, these include:

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[85] A Care, Education & Treatment Review (CETR) is: a meeting about a child or young person who has a learning disability and/or autism and who is either at-risk of being admitted to, or is currently detained in, an in-patient (psychiatric) service".

[86] The notion of psychological safety was first introduced by organizational behavioural scientist, Amy Edmondson and includes creating a team environment characterised by trust, sensible risk taking, creativity and mutual respect for each other's roles and responsibilities.

[87] *Working Together to Safeguard Children* 2018 HMG.

- An effective agreement between the local inpatient unit and CS in relation to CS's duties under Sc85 (CA 1989) and Sc117 (MHA 1983).
- Multi-agency consideration about how overnight support could be provided was raised during the coronial proceedings and a commitment was given to address this.
- A Children and Young People's Mental Health and Emotional Wellbeing Board has been established including partners from the multi-agency network and the voluntary sector.
- Regular Complex Case Meetings involving senior leads from Children's Social Care, NHS England and senior clinicians within mental health to discuss complex T4 cases and to support discharge planning.
- Monthly meetings with CS and health safeguarding leads (acute, community and primary care) to address the needs of vulnerable children, facilitate early professional resolution and to discern emerging themes.
- Weekly complex case meetings in the local inpatient general adolescent unit to provide a holistic approach to meeting needs & supporting discharge planning.
- Significant work in progress to co-produce a safeguarding children policy with parents and children in CAMHS.
- Regular safeguarding supervision across T4 and CAMHS services has been embedded, resulting in improved multi agency working.
- Partnership working with police has now been strengthened by involvement of a Mental Health Policy Co-Ordinator to improve practices regarding risk management and discharge planning.
- Adolescent Teams were created in Children's Social Care in 2018 for young people who met social care thresholds whilst Young People's Workers continued to work with adolescents within the Early Help sphere. It was recognised that there needed to be a more joined up approach for vulnerable and at-risk young people, so the *Strong Families Strong Communities: achieving best outcomes for children and young people strategy*, has recently been endorsed across the early help partnership.

These are very promising developments; the question that arises is how these new initiatives will be brought together to provide a fully integrated multi-agency scaffold of care, informed by the learning in this SCR, so that the needs of children with complex mental health needs and their families can be met.

Recommendation 3: **CPSCPB to request that the National Child Safeguarding Panel undertake a national review about multi-agency service provision to children who are at risk of harm as a result of their mental health needs.**

Recommendation 4: **CPSCPB to be a key stakeholder in the future developments of more closely integrated health and care systems to develop an aligned multi-agency approach to children with complex mental health difficulties, including children who are living in an out of borough resource. This work should be undertaken in collaboration with children, young people and parents**.

5.4 Meeting children's educational needs

For most of the key period under review, Chris received education at the local inpatient unit. Chris was registered with a private school in the community and the inpatient unit worked extensively to support this school. The practice of the inpatient education service has already been commended in a number of key areas. However, as identified in SCR (Sam)[88], Chris required an EHCP to ensure her needs were met and their similar experiences of trying to find further education provision within the state sector suggests that the principles of The Equality Act (2010) are not understood by local further education providers.

Since this time, a revised EHCP strategy has been implemented in Cambridgeshire that recognises the rights of children with significant mental health difficulties and their entitlement to an EHCP. Some considerable work has taken place to raise awareness within schools about this entitlement and the importance of EHCPs; this is an excellent development.

Recommendation 5: CPSCPB to request a review by the Education Directorate to determine how schools and colleges comply with their legal duties under The Equality Act (2010) to meet the needs of children with complex mental health needs.

Recommendation 6: CPSCPB to make representations to the Department for Education (DfE) to encourage a national approach to meeting the needs of children with mental health needs who are entitled to an EHCP, founded on the good practice demonstrated in Cambridgeshire.

5.5 Meeting children's mental health needs

5.5.1 Think siblings & family

Providing services to families requires an approach that situates the family at the heart of service intervention. Thereby, the family and its interconnected and interrelated needs can be understood, and services provided that hold this unit in mind. The Family Therapy Team clearly held this in mind and there were several other examples illustrating how the local inpatient unit and CAMHS clinicians worked hard to try and achieve an approach that considered the interrelated needs within the family. However, this was not demonstrated across the system.

An example of this was the very different treatment approaches in place to address Chris and Sam's eating difficulties. Whilst it is understood that approaches were formulated to meet their individual needs, these different approaches needed to be followed by parents when their daughters were on home leave (often together), and this compounded the complexities of providing care at home. This was recognised by the family therapy teams although this did not result in a formal coming together of the two inpatient treatment teams to consider the needs of the siblings, or to hold the family in mind.

In Chris's case, it is important to note that there were occasions when informal opportunities were pursued by the consultant psychiatrists to foster engagement with the clinicians treating

[88] Cambridgeshire and Peterborough Safeguarding Children Partnership Board Serious Case Review Sam

Sam, and it is commendable that the inpatient unit worked hard to achieve collaboration with the out of area inpatient unit to coordinate joint leave, arrange visits between the units and to provide family therapy. Nevertheless, the need to formalise this approach to achieve collaboration routinely and consistently amongst clinicians/professionals, when more than one sibling is receiving a service, is identified in agency reports and requires further work.

5.5.2 Think CSA & Think Twins

It is clear that the local inpatient unit and CAMHS placed CSA/early trauma at the heart of their interventions. However, throughout multi-agency records and within the reports submitted for the purpose of these SCRs, there was very little reference to the fact that Sam and Chris were identical twins. The agency author for the Children's Service notes no reference in the records about this and highlights the lack of attention across the agencies to the relationship between the twins*: It is not clear if partner agencies were exploring this dynamic and how it may have affected the girls' individual mental health. Assessments might have usefully drawn on research in this area.*

Whilst it is accepted that all children should be regarded as unique individuals, and there is evidence that to regard twins as one unit is detrimental to their mental health and development, it was unclear how agencies paid attention to the specific relationship that exists between identical twins or thought about the possible implications for service intervention. Of particular note was how the influence of being an identical twin was considered in terms of the girls' psychological makeup.

Importantly, the impact of CSA on the relationship between the twin sisters and the specific nature of this abuse needed to be actively considered. Early police records identified that the allegations included the girls as both victims and witnesses of CSA alleged to have been perpetrated by the same abuser. Chris and Sam were at a critical developmental age when the abuse was alleged to have started. How the grooming behaviour of the alleged perpetrator and the abuse itself affected their psychological development, their response to care and treatment and the relationship between them in the past, and currently, did not appear to feature in assessments and service intervention and it was unclear how the implications for treatment and care were formally considered across the different treatment teams.

Research suggests that the relationship between identical twins involves both intensity and complications and that understanding each step of an identical twin's journey through their developmental stages and significant life events, and understanding the challenges of twin attachment and separation, needs to be understood within the context of understanding the psychology of identical twins.

It is important to recognise that there is little research available about twins who have experienced sexual abuse, not least those who have experienced co-abuse, and the lack of such an evidence base would have hindered practitioners/clinicians in their work. The

research that is available suggests: *Rates of major depression, conduct disorder and suicidal ideation were higher if both co-twins were abused*[89].

Key Learning: There is no doubt that the challenges presented in enacting a think family, siblings and twins approach were considerable. The complexities of commissioning arrangements, the involvement of multiple clinicians/members of staff in various services/inpatient units, the absence of an integrated multi-agency approach and the scarcity of relevant research would have had a significant impact. Various agency reports recognise this as an area of learning, specific reference is made to the need for professionals involved in the community team to meet together at intervals in order to: *gain a co-ordinated understanding of the issues affecting the family, communicate this with them, foster spontaneous, prompt and flexible communication between clinicians in both inpatient and outpatient teams and hold formal joint planning meetings with teams and families*. Early work taking place in CPFT to develop a Think Family approach (in conjunction with families) and design a safeguarding policy (that promotes trust and transparency with families) are promising developments.

There is a clear desire to learn from the experiences of Sam and Chris and their parents to strengthen how a think siblings, twins and family approach will be formalised and become embedded in practice. This is an area of learning that applies to mental health services and multi-agency partners and should be included in the work that will take place to build a multi-agency scaffold of care.

5.5.3 Gaps in service provision

The CPFT agency reports and Serious Incident reports, highlight the limitation of home treatment options/crisis team and the impact this can have on providing limited options around tier 4 admission and timing of discharge. The work of the inpatient unit and the flexible ways in which these services were provided meant that, in effect, a number of these gaps were filled in a way they were not filled for Sam. This included outreach/outpatient support provided by the local inpatient unit, permission for parents to contact the inpatient psychiatrist at times of crisis and the consistent provision of creative and flexible trauma informed therapy. Aside from some treatments recommended for BPD that were not widely available at the time, Chris was provided with good opportunities to engage in therapeutic relationships. This included the work of the inpatient unit and CAMHS.

Since this time, some promising new service developments are emerging within CPFT. A multi-disciplinary Crisis Assessment Team for children and adolescents is currently being developed; this team will provide services to children in crisis who are living at home and who are not already receiving a CAMHS service. However, this team would not provide a service to children in Chris's circumstances. There is an ambition to expand home treatment options with a view to preventing inpatient admission/facilitate early discharge, this service has the

[89] *Early sexual abuse and lifetime psychopathology: a co-twin–control study.* S. Dinwiddie, A. C. Heath, M. P. Dunne, K. K. Bucholz. Psychological Medicine. Vol 30, Issue 1. Cambridge University Press: January 2000

potential to fill existing gaps for children in Chris's circumstances but there are no firm plans in place.

Key Learning: As a result of the care and treatment provided across the local inpatient unit and CAMHS Chris did not have the same experience of the service gaps that other children, such as Sam, contended with. Gaps in crisis/home treatment services for children with significant mental health needs compromise a child's treatment, recovery and well-being. This is of particular importance when considering the research and guidance on BPD (see below) which is clear that inpatient stays of any significant duration are unhelpful. Proposals to bridge this gap by providing a crisis team and home treatment team are promising.

5.5.4 Borderline Personality Disorder (BPD)

Chris's diagnosis changed a number of times over the period under review. Towards the latter stages, the plans in place for Chris to transfer to the adult personality disorder service suggested that the diagnosis of BPD, made in June 2017, best fitted Chris's symptoms. The Coroner concluded that the two main causes of her death were her serious mental health disorder (variously diagnosed as BPD, CPTSD and Mixed Disorder of Conduct and Emotions)[90] related to allegations of prolonged CSA in earlier childhood and the recent death of Sam (who also suffered from BPD).

This SCR has grappled with competing views about the ethicality and efficacy of making a diagnosis of BPD in children/young people; this dilemma is reflected nationally. The CPFT agency reports do not directly address this dilemma but the absence of a care pathway and relevant resources may suggest the local position is that it is not in a child's best interests to make this diagnosis. Whilst it is commendable that aspects of the evidence-based treatment for BPD were considered and adopted in Chris's treatment[91], the potential reluctance to diagnose BPD at an early point, and the absence of a care pathway, are relevant issues.

It is understood there is a reluctance to make a diagnosis of BPD in adolescence as the brain is still developing and there is understandable concern about the potential stigma attached. It is also understood that there should be consideration of the meaning of a diagnosis to a child and that an approach, rather than a diagnosis per se, is the primary issue. These are valid moral issues. From a parental perspective the diagnosis of EUPD/BPD was helpful; it fostered greater understanding of Chris's mental health needs and importantly served as a means of empowerment in caring for their daughter. Available guidance[92] sets out the evidenced based treatment pathways and approaches that should be in place for BPD and includes clear guidance about the limitations, and potentially negative consequences, of inpatient admission for any significant duration and includes cautionary notes about the use of medication.

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[90] The coroner recorded it was inappropriate for the diagnosis to keep reverting to mixed disorder of conduct and emotions.

[91] Such as Mentalization-based therapy (MBT)

[92] *Borderline Personality Disorder. The NICE Guidance on Treatment and Management.* National Collaborating Centre for Mental Health commissioned by The National Institute for Health and Clinical Excellence. The British Psychological Society & The Royal College of Psychiatry 2009

For reasons mentioned above, CPFT have said that there is a reluctance to make a diagnosis of BPD within local CAMHS and that there is not a national consensus in guidance and research, or about the ethics, of making a diagnosis in adolescence. This means that bespoke treatment pathways are not in place and it is understood there are no coherent plans to address this; this reflects a national picture.

Entering an ethical debate is beyond the scope of a SCR. However, it is the statutory responsibility of SCRs to be clear about what may have prevented services from providing what a child needed/needs and it is also the job of a SCR to consider what relevant research and guidance is available about a specific area of practice. There is a wealth of such research and guidance on BPD. The recent position statement from the Royal College of Psychiatry[93] was informed by 71 pieces of guidance and research. This states that, where indicated, a diagnosis of BPD should be given as early as possible and that evidence based treatment pathways, approaches and provisions, should be available. This chimes with a consensus statement written by adults who are diagnosed with a personality disorder[94].

Key Learning: The NICE guidance, and the recent position statement by the Royal College of Psychiatrists, reveals an evidential base for the diagnosis and treatment of BPD in adolescence. However, the national picture shows considerable variation in service provision. There appear to be no local plans to develop a treatment pathway or approach for adolescents and this reflects a national picture. It is difficult to understand what lies beneath this, whilst resources and capacity clearly play a critical part, it seems likely that a well-intentioned reluctance to make an early diagnosis of BPD may have a significant bearing on the lack of treatment or plans to tackle this important issue.

The CPFT Serious Incident Report[95] recommends that the diagnosing policy and lack of community services for emerging personality disorder in the under 18's should be reviewed.

Recommendation 7: **As part of established partnership governance arrangements, CPSCPB to support and oversee the service developments in CPFT arising from the single agency learning about service delivery that have been identified. The learning in this SCR should play a key part in informing these service developments**.

Recommendation 8: In recognition of the variable national and local approaches to the diagnosis and treatment for adolescents with BPD/BPD traits the CPSCPB should, using this review and other available research, facilitate a dialogue with Commissioners (CCG and NHS England) and service providers to ensure that the most informed and child centred treatment is made available.

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93 *Services for people diagnosable with personality disorder*. Royal College of Psychiatrists Position Statement January 2020

94 *Shining lights in dark corners of people's lives*. The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder. Centre for Mental Health, Royal College of Nursing, BASW, Royal College of General Practitioners, The British Psychological Society, Anna Freud National Centre for Children & Families, Mind, Barnet Enfield, and Haringey Mental Health NHS Trust 2018

95 Cambridgeshire & Peterborough NHS Foundation Trust Serious Incident Investigation Report 13.11.19

5.6 Hearing the voice of parents

There is no doubt there were occasions when parents advocated for Chris's needs in a way that, at times, was felt to be confrontational by professionals and there were times when parents questioned the advice that was given or rejected a particular service. Parents were well able to research/inform themselves about evidence-based practice and about legal or procedural matters that apply to the children's workforce and make decisions on behalf of Chris. This was their legal and moral duty as parents and was the equal duty of professionals/clinicians. When Chris was at the out of area inpatient unit the inpatient psychiatrist described the position taken up by parents as; *sabotaging* and on occasions this psychiatrist regarded parents as not being compliant with professional advice or influencing Chris's engagement with certain services. This view was not shared by other professionals and was not evidenced in the relentless care and treatment that parents undertook and complied with.

It is important to consider the day-to-day life of the family; the repetitive cycle of trauma and pain felt by parents when caring for their daughters and the helplessness felt in being unable to alleviate the suffering of their loved ones. In this case, what we know about the alleged CSA was that it started in infancy and continued for many years. It is known that the violating acts involved in sexual abuse sit alongside the psychological damage caused in a multitude of ways; including the powerful grooming messages repetitively delivered by perpetrators to trap their victims in self-blame and silence. In this case, another important component identified by police during the early investigation was that the disclosures made by Chris suggested that she was both the victim of sexual abuse and the witness of her sister's abuse.

Abused and/or neglected children who have been exposed to on-going trauma over a prolonged period of time, carry brain and body responses consistent with their traumatic experiences. A growing body of scientific research identifies the way in which the neuro-biological impact of early abuse impacts children resulting in traumatised children developing different neurological patterns to their non-traumatised counterparts[96]. Exposure to stress chemicals such as adrenaline and cortisol can also have a long-lasting impact on traumatised children's ways of understanding themselves and the world around them. Additionally, the intersubjective nature of the way in which children make sense of the world means that traumatised children develop 'mirror neuron patterning' that colours their understanding of the intentions of the adults who are caring for them; as a result they may interpret the positive intentions of safe and loving parenting figures as potentially abusive and threatening[97].

Research [98] [99] [100] shows that the impact on parents of parenting a child who has experienced trauma can be similar to that of the child's response to trauma. Living with a sad, angry,

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[96] *Neuroscience and the Future of Early Childhood Policy: Moving from Why to What and How.* J. Shonkoff & P. Levitt 2010). Neuron. Science Direct Volume 67, Issue 5, 9 September 2010, Pages 689-691

[97] *Grasping the Intentions of Others With One's Own Mirror Neuron Systems.* Iacoboni, Molnar-Szakas, Gallese, Buccino, Mazziotta, Rizzolatti (2005) Available at http//www.plosbiology.org/article/info

[98] *Reparenting the Child Who Hurts.* C. Archer & C. Gordon. Kingsley Publishers, London

[99] *The Cost of Caring: Secondary Traumatic Stress.* Fostering Communications 2004.Vol. XVIII No.3

[100] *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat The Traumatized*. C.Figley Routledge Psychosocial Stress Series

sometimes aggressive child who is clearly in pain, who is regularly engaged in extreme self-harm and making attempts to end their lives, is traumatic. The nature and extent of the behaviours are not single incidents, but ongoing lived experiences that saturate every facet of family life, often for many years. Traumatised children are frequently described as hyper-vigilant; parents may also become hyper-vigilant. They may have internalised a belief that, if they let their guard down, disaster may follow. Like their children the response to living with this level of trauma may be to develop one or more of the trauma responses: flight, fight, or freeze[101].

Professionals should work to understand the profound and pervasive impact of abuse on children and the consequent impact on families. Parents/carers need long-term, consistent and empathetic support and understanding if they are to meet their children's needs in the short and long-term. Professionals need to assist parents to safeguard their feelings of self-worth and self-esteem by valuing them and the contribution they have made, and continue to make, to their children's lives. Teaching parents about the neurobiological impact of trauma is also important alongside respecting the critical place parents occupy in being the key repair agent in their child's recovery.

There needs to be an acceptance that parents are often doing the best they can in very difficult circumstances and an understanding that parental fear and pain may be communicated by anger and frustration directed at professionals, which needs to be responded to in a non-blaming / non-judgemental way. This is the basis for developing a trusting relationship between parents and professionals and allows for a reduction in the sense of isolation that parents of traumatised children may feel. The issues raised in this SCR, about the lack of transparent communication with parents, damage trusted relationships and fuel feelings of a lack of trust in services and parental isolation; this ultimately impacts on children.

The approach to parents of traumatised children that is needed was embodied in the work completed by the FT team and was demonstrated by a number of professionals/clinicians. However, this was not replicated across the system.

Key Learning: SCR (Sam) includes a section about working in respectful partnership with families. This SCR has identified a further area that requires attention relating to how agencies and professionals engage in a respectful, supportive manner with parents who are caring for traumatised children. This includes consideration about the communication that takes place between professionals/clinicians; the need to challenge fixed views and to consider how information is shared and recorded that may confer judgement, without the necessary triangulation of the evidence and/or without an understanding of relevant research. The CPFT SI report helpfully recommends the need for parental psychoeducation, and this should include information and guidance about caring for traumatised children. The CPFT agency report identifies a need for a systemic response to helping families deal with the aftermath of CSA and that mental health services should not be left alone to try and address the powerful issues that emerge.

[101] Parental views are that their response was to fight.

Recommendations: No specific recommendations are made in this section and the following section. The work outlined in recommendations 1 & 3 should be underpinned by an informed understanding of how parents of traumatised children can be best supported and include consideration of what might get in the way of building trusted relationships.

5.7 Hearing the voice of Chris

Chris often expressed her views about a range of practitioners, services, interventions, diagnoses and treatments. This report has illustrated examples of when her views were respected and when on occasions, for various reasons, they were either overridden or unheard. As this report draws to end, it is felt important to represent the views of Chris about her parents / family life and the alleged CSA.

The independent reviewer has seen extracts of Chris's therapeutic diaries and treatment notes which express Chris's views. It is important to be mindful of what a child would want to be in the public domain about their intimate private thoughts, or about family life. It is clear that Chris was sometimes angry with her parents and that the girls often did not want to be in the same room with parents during family therapy. There are records referring to; parental difficulty in having *transparent conversations, setting boundaries,* of a *disordered attachment* with parents, Chris's feelings that parents were intrusive and there were times when there was a need for practitioners to try and achieve a fair balance between hearing the wishes and feelings of Chris, and the views of parents.

In Sam's SCR, it has been observed that triangulation (in relation to BPD) may have played a part in the relationships and questions have been raised about how this was considered. In addition, there is well-established research and literature about adolescent brain development, and the process of re-organisation that occurs across family relationships which can feature misunderstandings and conflict as the adolescent child moves into a position of seeking independence and autonomy away from parental care and control.

It is important to note that Chris was an inpatient for, at minimum, 18 months. As a result, Chris was an adolescent whose life, and all that she communicated, was under close professional observation. Based on what is known about adolescent development and relationships, it is therefore perhaps unsurprising that review of the records reveals differences in how Chris spoke about her relationship with parents at different times, and that views about this relationship varied across professionals. It is perhaps also unsurprising that at times her relationship with parents was described as poor; *she could be verbally and physically abusive to them despite their best efforts to provide care and understanding*[102]. On other occasions, she was described as being able to speak to her parents when she needed support and that she felt safe when she was at home with Sam and her parents.

[102] Quoted from the Witness Statement to the coroners court (Consultant psychiatrist at local inpatient unit at the time of Chris's admissions)

"I am so happy right now, words literally can not explain this feeling, I'm going home to the people I love so much, even if we may fight sometimes, they all mean the world to me and being apart from them has been the hardest time ever."[103].

So the question that remains is: What would Chris want to be said in this SCR about her views? She may want it to be said that she was understandably angry about the abuse she suffered and may have been angry with her parents about this, that her parents' desire to protect her sometimes felt controlling and intrusive, and parents did not always get it right. But in the view of the independent reviewer she would also want to remind readers that she also spoke about how safe she felt at home, that she loved her parents and Sam, that she enjoyed many family holidays and activities and that on the last day of her life dad bought her the red hair dye that she wanted, and together they went horse riding.

And lastly, from reading an extract from a letter Chris wanted to send to her alleged abuser, it is clear that Chris would want the final word to state her views about the alleged abuse she and her sister suffered, and for this to be heard:

> "You completely ruined life for me and my sister. The first 5 years were pretty good, but the last 10 have been hell. You caused all of this; it is your fault……. Sadly, I will never get to hurt you, but that doesn't mean my sister won't do it, we both hate you more than anything else…. My suicide is all your fault, never forget that."

[103] A post on social media by Chris when discharged from the out of area inpatient unit.

Glossary

A&E	Accident & Emergency
ABE	Achieving Best Evidence
ADCS	Association of Directors of Children's Services
BPD	Borderline Personality Disorder (also called EUPD)
BTP	British Transport Police
CA	Children Act 1989
CAMHS	Child and Adolescent Mental Health Services
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CC	Care Coordinator (CAMHS)
CCG	Clinical Commissioning Group
CCTV	Closed-Circuit Television
CETR	Care, Education and Treatment Review
CICA	Criminal Injuries Compensation Agency
CiN	Children in Need are defined in law under Section 17 of the Children Act 1989
CPA	Care Program Approach. (*A regular multi-disciplinary team meeting held for each inpatient approximately every 6 weeks*).
CPFT	Cambridgeshire & Peterborough NHS Foundation Trust
CPSCPB	Cambridgeshire and Peterborough Safeguarding Children Partnership Board
CPTSD	Complex Post-Traumatic Stress Disorder
CS	Children's Services
CSA	Child Sexual Abuse
DfE	Department for Education (HMG)
EHCP	Education, Health and Care Plan
EMDR	Eye Movement Desensitization and Reprocessing
EUPD	Emotionally Unstable Personality Disorder (also called BPD)
FGM	Female Genital Mutilation
FT	Family Therapy
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HMG	Her Majesty's Government
ICD	International Classification of Diseases
IST	Intensive Support Team
ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspections
KN	Key Nurse
LSCB	Local Safeguarding Children Board

LSU	Low Secure Unit
MBT	Mentalization Based Therapy
MHA	Mental Health Act (1983)
NFA	No Further Action
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPCC	National Police Chiefs' Council
NSPCC	National Society for the Prevention of Cruelty to Children
PICU	Psychiatric Intensive Care Unit
PTSD	Post-Traumatic Stress Disorder
RCPCH	Royal College of Paediatrics and Child Health
Sc	Section
SCR	Serious Case Review (*now called Child Safeguarding Practice Review*)
SCR (Sam)	Serious Case Review for Chris's sister Sam
SI	Serious Incident (*report*)
SW	Social Worker
T4	Tier 4 NHS funded mental health treatment services (*usually inpatient settings*)
VRI	Video Recorded Interview
WHO	World Health Organisation