Serious Case Review
Overview Report in respect of

Sam

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I gave up on myself years ago. I was told it's all in my head, it's not real, it'll pass, it's just a phase, it's just stress.

But it's not all in my head, it's everywhere. My body is ruined trying to cope. It's not my head, it's my life.

It is real. It's me. It will never leave unless I do.

It doesn't pass, it's not a phase. It gets worse with every exhausting day, hour.

Sam (March 2018)

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; the response by agencies to this abuse and to the complex mental health conditions that can follow. Sam's life, and that of her sister and parents, illustrates the pernicious nature of child sexual abuse and the devastating impact this can have on the lives of children and families.

This SCR seeks to understand Sam's lived experiences, including her experience of service intervention, from the age of six. During early adolescence, Sam disclosed she had been the victim of sexual abuse from at least 6 years old. Sam self-harmed from the age of 9 years and this continued throughout her life becoming extensive and long standing. She suffered from difficulties in her interpersonal relationships, emotional dysregulation, depression, eating difficulties, anxiety and shame, and often expressed a wish to die. Sam's identical twin sister (Chris) 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 sisters spoke about being abused in each other's presence by the same alleged perpetrator. The pattern of Chris's self-harm, emotional and mental health difficulties were of similar intensity as Sam. 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 decide what might be needed to strengthen the way children are safeguarded.

An array of interventions were provided during Sam'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, Sam would be with us today. As T. 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 doing so. That said, the learning in this SCR 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 Sam'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 Sam's life experiences and the significant learning that has emerged. Secondly, Sam'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

Sam sadly died after taking an overdose of medication at home, she was aged 16 years. Sam was a white British child who lived at home with her mother and father and her identical twin sister, Chris. Tragically, Chris died five months later after taking her own life.

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 Sam and Chris 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.

In order to understand the depth and entirety of the learning that has emerged, Sam and Chris's SCRs should be read together.

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 endeavours to understand professional practice in context, 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 purpose 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

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3 Changes in statutory guidance later 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 and Sam 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? Do patterns reoccur? If they do, what can be done? 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 experienced 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 Sam or her family and no management responsibility for the services that were provided during the period under review.

Independent agency reports and an integrated chronology informed this review. The Independent Reviewer had access to a range of other relevant documents, including witness statements provided to the Coroner; these witnesses statements were not read by panel members. 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 perspective – extract from pen picture presented to the Inquest

Sam was a truly wonderful, strong young woman who started out with all the advantages life could possibly give her, with intelligence, good looks and a loving personality. She was born mentally and physically healthy and should have been able to look forward to a long, successful happy life:

***Of course all that advantage was stolen from her by eight years of sexual abuse and society's failure to support her and help her win the battle she bravely fought against the resulting mental illness**.*

But of course we, her Mum and Dad, loved her with all our hearts. We will cherish memories we have, both happy and sad, and we will miss her until the day we die.

A vital part of SCRs is to work with families to understand their perspectives; Sam's parents were invited to give their views during several meetings with the Independent Reviewer. They 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 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.

[8] CQSW, BA (Hons), MA (Tavistock & Portman and MHT), SCIE accredited reviewer.

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 Sam'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.

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 provided a service to Sam and her family. These practitioners were invited to share their views about the services provided, to identify single and multi-agency learning and 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 Sam; 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 Cambridge 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 Sam, 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 Sam

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

Sam was a beautiful young woman, who enjoyed an array of activities including horse riding, beach holidays, snowboarding and music festivals. She was intelligent, quick witted and sporty. She was empathetic and kind and went out of her way to give comfort to those who were hurting; she was fiercely loyal to her friends.

Sam's key nurse at an inpatient unit, with whom Sam had a close trusted relationship, described Sam as possessing many strengths. She was described as intelligent, articulate, and artistic and someone who demonstrated care, empathy and sensitivity to her peers. She was seen to extend warmth, affection and humour toward those she felt close to and had a number of strong interests which she pursued as a source of relaxation and enjoyment.

Sam 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.

4 Summary account of events, agencies' involvement & analysis

4.1 Early years – help seeking behaviour

When Sam was 6 years old, she was living in another part of the country. Her school identified that she was exhibiting *sexually inappropriate behaviour* and took steps to manage this behaviour in school. At 9 years, Sam was referred to the local Child and Adolescent Mental Health Service (CAMHS) by her GP as she was pulling out her hair, eyelashes and eyebrows causing bleeding and was referred for Cognitive Behavioural Therapy (CBT)[9].

Sam was diagnosed with trichotillomania[10] and engaged with a series of telephone appointments with the therapist. Parents said that Sam wanted the sessions to continue but after her symptoms appeared to resolve, the sessions ended. This is in line with what would be expected when delivering treatment focussed on a resolving a specific issue. However, there was a need for professionals to be curious about what may have been the lived experiences of Sam that might explain the *sexually inappropriate behaviour* and the trichotillomania. Responding to children's help seeking behaviour, and providing children with the help they need, is discussed in Sc5.

Sam and her family subsequently moved into the Cambridgeshire and Peterborough area.

When aged 11 years, Sam was attending a private school close to her new home. A routine psychometric test (covering areas such as emotional wellbeing / attitude to learning) revealed exceptionally low scores for Sam and Chris. Parents were told their daughters' results were the lowest ever recorded in the school. Sam was referred to the senior school counsellor; parents said they were told they could not be involved in this work and no history was requested. There is no information available about the type of counselling provided but it is known that this was the second time Sam had received counselling / therapeutic intervention. Parents said she did not experience this counselling as helpful and did not want to continue. During this time, Sam started to self-harm although this did not come to light until later.

4.2 Early Adolescence – self-harm and disclosure

Sam was 13 years old when school raised concerns about her self-harm. Sam had formed a trusted relationship with a counsellor at the private school who unfortunately left the school. The GP advised parents to refer to a local charity for counselling. Sam engaged with this counselling but told her parents that she did not find this helpful and stopped attending.

Sam's self-harm continued; four months later she was seen by her GP who noted cut marks on her legs and abdomen. Parents then returned to the GP and discussed Sam's self-harm, analgesia use, suicidal thoughts, and of finding a noose in her bedroom. A few days later, at the request of parents, the GP referred Sam to the local CAMHS.

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[9] Cognitive Behavioural Therapy focuses on changing the automatic negative thoughts that can contribute to and worsen emotional difficulties such as depression, and anxiety. Through CBT, these thoughts are identified, challenged, and replaced with more objective, realistic thoughts.

[10] Trichotillomania is diagnosed in children who have established a recurrent behaviour of hair pulling that is causing them significant distress. To meet the criteria for the disorder they must have made repeated attempts to decrease or stop the behaviour.

Two weeks later, Sam (now age 14) was found to be extensively self-harming at home and contact was made with CAMHS; a CHOICE[11] assessment was promptly completed. The assessment identified a range of symptoms; low self-esteem, anxiety, low mood, self-harm, emptiness, anger, social anxiety, negative self-beliefs, poor sleep, binge eating and thoughts of death and suicide. Notably the assessment included the phrase "*She denied any abuse*". It was recorded that Sam *refused talking therapy* – including Cognitive Behavioural Therapy (CBT)[12]. A diagnosis of depression was made.

Referrals were made to psychiatry, to consider medication, and to the Eating Disorder Service (EDS). Sam was seen approximately two months later by EDS. She was assessed by the psychiatrist and prescribed anti-depressant medication. Sam's parents became increasingly concerned about Sam's moods which – despite the medication - *would swing rapidly and her self-harm appeared to be getting worse.* Sam told her parents that she wanted to understand "*what is wrong with me?"* Understanding the possible symptoms of sexual abuse, supporting children to speak out and trauma-informed approaches are discussed in Sc5.

Two months later, Sam was admitted to hospital with a lacerated arm (caused by self-harm) that required stitching. It was noted that she had a long history of self-harm and that she was on a waiting list for CBT and Family Therapy. Her next appointment with the EDS psychiatrist was brought forward and she was referred to the Intensive Support Team (IST).

A referral was made to Children's Services (CS) by the hospital. Apart from sharing information the reason for this referral, and the outcome that was expected, was unclear. Reassured by the involvement of CAMHS, a decision was taken that there was no role for CS and no further action (NFA) was taken. This emerged as a pattern throughout multi-agency involvement and is discussed in Sc5.

One month later, IST discharged Sam from their service after seeing her on 4 (out of a possible 5) occasions. Sam cancelled the last planned visit, parents said she told them she did not find IST's involvement helpful. During the same time, Sam's identical twin sister was admitted to hospital after taking a significant overdose. A referral was made to CS for Chris, CS were reassured by the involvement of CAMHS, and no further action (NFA) was taken.

In June 2016, Chris disclosed to a school friend that she had been the victim of sexual abuse from the age of 6 years. She alleged that this was perpetrated by someone outside of her immediate family. A strategy meeting and a joint investigation took place; a police investigation commenced, and CS completed an assessment. CAMHS and school were not invited to the strategy meeting and there was no consideration of a child protection

[11] A CHOICE assessment is a quick and easy way to determine what items or options an individual will choose to engage. This helps an individual understand the available options and provides them with a degree of investment in the outcome. It also provides a measure of relative preference.

[12] 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.

medical[13]. Due to the passage of time, it is not possible to be clear about why these things did not happen.

At the start of the investigation, Sam indicated that she had also been the victim of CSA. At this point Chris was electively mute. When answering questions put by the local police force, Chris 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. Both Sam and Chris said they did not want to undertake a Visually Recorded Interview (VRI) at this time.

Again, due to the passage of time, it is not possible to determine fully what took place. However, it appears that some principles contained with the ABE[14] guidance were not followed. Firstly, whilst this guidance is clear that VRIs are the preferred means of gaining evidence in these circumstances, it is also important to take into account the victims' 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. Both Sam and Chris were known to CAMHS, it was important to involve clinicians to consider how the girls 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 Sam and Chris should not discuss the abuse in therapy and that they should not talk to their daughters, or other family members, about this abuse for fear of it may compromise the criminal investigation. Whilst this is compliant with ABE[15] guidance, once it was established that Sam was not prepared to undertake a VRI, the advice needed to be revised in line with established guidance[16].

Both the police and CS appropriately referred the family to an Independent Sexual Violence Advisor (ISVA)[17] service in July after the disclosure and the 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.

CS completed an assessment within required timescales and 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

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[13] Due to the passage of time it is unclear why a medical was not considered although it may be that the disclosure was regarded as relating to historical abuse and therefore a medical & requests for forensic material were not felt to be needed, as it was unlikely to identify any evidence that could be used in a criminal investigation. Recent developments in Cambridgeshire Constabulary have included a wider adoption of holistic medicals and there is now increased awareness and action to ensure medicals take place.

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

[15] ABE guidance clarifies that therapy should not be provided if a VRI is imminent.

[16] *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.

[17] 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.

primarily occurred out of area, the criminal investigation was passed to the relevant police force.

4.3 A period of relative stability

Following this period, whilst Sam's moods were up and down, she experienced a period of relative stability for approximately six months. Sam attended all her appointments with the CAMHS psychiatrist. She was described by her psychiatrist as: *feeling much better - bright in mood – gave good eye contact and was bright and reactive* - on occasions *happiness – no plans to end life – no plans to self-harm*. Episodes of self-harm were described as *habitual – not driven by suicidal thoughts*.

In line with established plans, Sam transferred to a state school where she settled in quickly. Over this period, the family were waiting for the police to confirm what action they would be taking, and parents made regular requests to the police for an update.

Almost six months after the disclosure, the out of area police force informed parents that the case was closed. Parents informed the girls 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 Sam 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.

This was a complex CSA matter; information available suggested that the CSA had started in infancy and persisted over several years. Research[18] suggests that the impact on Sam, Chris 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 Sam's mental health and on relationships within the family. A multi-agency response was needed which was informed by guidance about how justice might be sought over time. There have been considerable changes in the multi-agency response to sexual abuse since this time. However, there remains

[18] 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.

work to be done to strengthen the protection and support for victims of CSA. Relevant issues about the multi-agency response to CSA and the support needed by parents who care for traumatised children are explored in Sc5.

At the time of disclosure, parents had informed the EDS psychiatrist about *long-term significant sexual abuse*. At the time Sam was seeing a private psychologist who, at Sam's request, was working with Sam on her hair-pulling. There was a long waiting list for CBT in CAMHS and Sam was reported as being reluctant to engage in therapy. These factors provide a partial explanation for why individual therapy was not provided within CAMHS, but it is also important to note that police advice to parents at the time was that Sam could not access therapy until the VRI interview had been completed. These are valid factors that would have influenced why therapy was not provided. That said, it is important to highlight the research that emphasises the value of providing suitable therapy as close as possible to a traumatic event. This is discussed in Sc5.

4.4 Decline in mental health / wellbeing & escalation of self-harm

A month after the disclosure parents attended a family therapy session, Sam and Chris decided not to attend. This session, and sessions thereafter, provided an important opportunity for parents to talk about the impact of CSA on family wellbeing. The consistent work completed by the family therapy team for the duration of the period under review was good practice. However, by this point, various clinicians and teams within CAMHS were now involved with Sam and Chris. There had not been joint formal consideration of the impact of child sexual abuse on the sisters and the implications for care and treatment, 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 impacted their relationship. This required a joint focus on the implications for treatment informed by an understanding of CSA[19]. This was an unusual situation, there was no formal guidance in place and little relevant research to guide clinicians in their work. The importance of collaboration within CAMHS is discussed in Sc5.

Within a few days of the girls being told about the decision by police to take NFA, Sam was seen by her GP when she spoke about having suicidal thoughts. Chris was admitted to hospital after a significant suicide attempt when she was recorded as: *non-verbal*. A referral was made to CS by the hospital; the referral stated that the criminal investigation was not pursued as *the girls did not want to go through with VRI interview* and that parents did not want additional help from CS. As a result, CS took no NFA. 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.

A few weeks later, Sam attended hospital after suffering from a panic attack at school and was found self-harming. A 4th referral[20] was made to CS which resulted in NFA. Sam returned to school the following day. There had been little communication between the mental health

[19] This was particularly important given that the girls had been both the victim and witness of CSA.

[20] When counting the separate referrals that were being made in relation to Sam and Chris this was the 5th referral related to the siblings.

service and the school, or vice versa, by this point. The need for close communication and liaison between schools and clinicians to plan for children's needs, and mitigate risk, is an important theme and is discussed in Sc5.

Over this period, Sam attended her first session of CBT within CAMHS[21] and engaged well with the therapist, although it is understood that Sam did not want to talk about the abuse she had suffered. After three sessions of CBT, the sessions ended. Parents said Sam wanted to continue seeing the therapist but had not felt able to identify a specific goal to work towards in these sessions. Parents said that at the ending of this therapeutic relationship Sam felt *invalidated, abandoned and hopeless.* Short term, focussed CBT is the nature of this treatment modality. Trauma-informed approaches and providing therapeutic services to children who are the survivors of CSA, is discussed in Sc5.

CAMHS recognised that Sam was displaying striking fluctuations of mood from periods of confidence to times of absolute despair, an unstable self-image, with fears of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. This information, together with the knowledge about Sam's CSA, suggested that it might have been helpful to have a detailed working formulation which included potential emerging personality traits as part of a wider formulation which also included developmental trauma / abuse to inform the management of Sam's care and approach. Diagnoses, treatment pathways and therapeutic approaches are discussed in Sc5.

Sam's twin sister was voluntarily admitted to a local CAMHS inpatient unit in January, and in February a decision was taken that she would remain an inpatient for a further 6 weeks. The next day, Sam was admitted to hospital after consuming alcohol and taking a large overdose of medication. Although aspects of treatment and risk management were considered between clinicians, the impact on Sam's mental health of her sister's admission to hospital did not appear to be formally considered across the treating clinicians. Clinicians were contending with an unusual situation of providing concurrent care and treatment to siblings with significant mental health needs, and there was no local guidance or framework in place that would have informed how coordination of treatment, advice, care planning and risk mitigation might be achieved. There is a need for this work to be strengthened, and this collaboration should include risk management and mitigation across tier 3 (T3) and tier 4 (T4)[22] mental health services at pivotal points of risk. This is discussed in Sc5.

A decision was taken to admit Sam to an inpatient unit. Taking a decision to admit a child to an inpatient unit is a serious step; clinicians are required to consider the advantages, disadvantages and risks of admission from the point of view of the child. Parents do not recall any discussion had with them about how these advantages, disadvantages and risks were considered and believed it was an entirely positive move. Before Sam was admitted, it was decided she should return home with support provided by the Intensive Support Team (IST). The involvement of IST was declined after Sam refused to meet the IST worker at home. Sam said she had found the earlier involvement of this team unhelpful, and the view of parents

[21] Due to demand outstripping capacity, there was a long waiting list for CBT in the local area.

[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).

was that the role of the team was unclear. Parents were also concerned about the involvement of multiple professionals / varied treatment approaches. NICE[23] guidance details the therapeutic approaches that should be adopted when providing treatment to patients with Borderline Personality Disorder (BPD). Relevant issues about BPD, inpatient admission, and the absence of alternatives to T4, are discussed in Sc5.

Another referral was made to CS by the acute trust. CS took a decision to take NFA, the reasons for this decision have been discussed earlier. This decision was not challenged by the acute trust or by CAMHS, the reason for this lack of challenge is not clear but it is perhaps fair to reflect the perspective of clinicians that the frequent referrals resulting in a lack of response can lead to a despondency that nothing will be done regardless of how many referrals are made. There was no local framework in place to guide the multi-agency response in these circumstances, this is discussed in Sc5.

4.5 Inpatient admission & treatment

Sam was admitted to an NHS inpatient unit out of the local area. Parents spoke to the Independent Reviewer about the challenges posed by their daughters being inpatients in units some considerable distance apart; in terms of practicalities of the daily 120-mile round trip between the units and in terms of the different treatment approaches / regimes within the different units.

The availability of T4 beds is recognised as a challenge across the UK and this can mean that children can be placed some distance from home. It is clear that collaboration was achieved across the T4 family therapy teams to enable Sam and Chris to attend family therapy sessions together and home leave was coordinated to allow the girls to have time together. However, this collaboration was not in place across the system. As stated, these were unusual circumstances that would have been challenging for the clinicians involved. Routine collaboration across T3 CAMHS and T4 units when treating siblings/twins is an area of learning identified by the Cambridge and Peterborough NHS Foundation Trust (CPFT) and is discussed in Sc5.

During the first 6 weeks of inpatient care, Sam engaged well at the unit and with the assessments completed. Overall, her mood was described as good. Sam told staff that she wanted *to understand the root cause of her difficulties and would like to have a diagnosis in order to make sense of this*. Other than Sam restricting her eating, there were very few incidents of self-harm during this time. After six weeks, a decision was made that Sam should remain on the unit for a further 6 weeks to allow Sam to engage in therapy, parents agreed with this recommendation. Sam was upset by this decision and wanted to return home. Relevant issues about diagnoses, and implications for care and treatment, feature across the timeline and are discussed in Sc5.

Sam's mood and behaviour rapidly deteriorated; her eating was of significant concern and her self-harm increased. A diagnosis *of severe depressive disorder without psychotic*

[23] *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.

symptoms and eating disorder of a binge-restrict type was made. Sam was repeatedly clear that she wanted to be discharged. On a number of occasions, the unit pursued a mental health assessment (MHA) under the Mental Health Act (1983) as a means to achieve compulsory treatment. This was opposed by parents on the basis that, with the right care plan and approach, Sam would cooperate with treatment. The Approved Mental Health Practitioners (AMHPs) agreed that MHAs were not needed. Routine consideration of the need for compulsory mental health treatment is a requirement of mental health staff, particularly in inpatient units, to ensure every effort is made for a patient to receive the care considered necessary and to ensure their safety and wellbeing. It is positive that good collaboration occurred between the AMHPs and parents.

During her inpatient stay, Sam attended a number of family therapy sessions at the inpatient unit where her sister was living. This was a very positive example of collaboration between the different mental health teams (T3 & T4). The family therapy provided in the community for parents during this challenging time that gave space to explore the devastating multi-dimensional impact of CSA on the family was particularly good practice.

Sam spoke about the sexual abuse she had suffered to a nurse. Sam had a trusted relationship with this nurse, and this was an important juncture. Prior to this point, Sam had not wanted to speak about the abuse and resisted suggestions that her mental health difficulties were linked to this significant early trauma. Sam's community CAMHS Care Co-ordinator was informed, although parents were not informed and there was no discussion with the police, CS or with the designated safeguarding team by the inpatient unit. It is not entirely clear why these steps were not taken. At the time, Sam was extensively self-harming and needed an operation to remove objects that she had inserted in her deep self-harm cuts. It is possible that this skewed the focus away from this serious matter. Parental views are that they should have been told[24] and that had they known they would have been able to reaffirm their belief about the abuse and would have asked Sam if she wanted to change her mind about police involvement. In addition, parental views are that Sam would have assumed that they had been informed and may have felt invalidated and upset that parents (who were visiting daily) did not acknowledge this important juncture. Responding to children who are the victims of CSA by providing opportunities for them to speak out, to seek justice and for suitable therapy to be provided, requires close collaboration with children, parents/carers and within and across the multi-agency network. This is discussed in Sc5.

Sam's mental health, including significant episodes of self-harm, continued to be of concern and her reluctance to engage in treatment prompted a decision to initiate a MHA. At this time, the relationship between staff at the inpatient unit and parents was fraught with contention. Parents said they were frustrated by the lack of communication from the unit about Sam's self-harm and wellbeing and objected to a MHA as they felt there were insufficient grounds to pursue. The challenge for clinical staff who are seeking to build a trusted relationship with children, respect confidentiality as well as treat parents as equal partners is recognised, and it is equally appreciated that staff at the inpatient unit found the contentious nature of this relationship difficult. Related issues about working with parents as

[24] There is no evidence to suggest that Sam did not want her parents informed.

equal partners and the issues raised below (about BPD and the risks of triangulation) are discussed further in Sc5.

After a meeting with the treating psychiatrist, a decision was made that a MHA would not be started, and it was agreed that a second opinion would be commissioned. This collaboration was positive. The second opinion suggested an emerging hypothesis of Borderline Personality Disorder (BPD). The assessment and report provided a depth of observation and analysis not previously seen in Sam's care / formulations. The report identified important issues about her personality formation, commented on her traumatic history and significant attachment difficulties and provided an important opportunity to clarify the treatment pathway and approach that was needed**.**

This second opinion was welcomed by Sam and her parents who felt strongly that her symptoms fitted this diagnosis well and the treatment approach made sense. The report described how Sam appeared to feel safe by triangulating adults *which means people were working against each other* and noted that this was occurring between staff and parents. This was a helpful observation which served to improve the relationship between staff and parents. The assessment outlined the important components of a care plan, which were compliant with the relevant NICE guidance[25]. Relevant issues relating to the diagnosis and treatment of BPD are discussed in Sc5.

Concerns about Sam's eating and refusal to accept antibiotics for a significant self-harm wound led to her being detained under S3 of the MHA (1983). Thereafter, Sam was often restrained and nasogastric tube fed. Over this period, Sam and her sister went on home leave when they were cared for by their parents. Parents struggled with the different approaches adopted by the different T4 units in response to their daughters' eating difficulties and this presented specific challenges when caring for them at home.

Once a child is an inpatient in a T4 unit, lead clinical responsibility is held by the inpatient consultant psychiatrist. It is unusual to be in a situation where siblings are receiving inpatient care at the same time in different units and, whilst communication occurs between the community and inpatient treatment teams, there is not an established practice of formal collaboration in these circumstances. Relevant issues about formalising this collaboration and supporting parents in caring for traumatised children are discussed in Sc5.

4.6 Planning for discharge

Ongoing improvements in Sam's mental health and engagement at the unit led to removal of S3 (MHA 1983) and Sam spent increasing periods at home. Planning for discharge with community CAMHS continued, and Sam gradually re-integrated into her school in the community. Care Programme Approach (CPA) meetings had been occurring on a regular basis. It was accepted that Sam's discharge was planned not because she had recovered but primarily on the basis that continued inpatient stay was likely to be counterproductive. This is line with relevant research and national guidance on the treatment of BPD. It was accepted

[25] *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.

that Sam needed the support of multi-agency services in the community and plans for her care and treatment were made prior to discharge. Components of this plan included the need for on-going family therapy, Dialectical Behaviour Therapy (DBT)[26], ongoing psychiatric review, psychotherapy and community education support. Plans agreed for transition and discharge included a note that community therapy would need to include the therapist meeting with Sam on several occasions prior to discharge. These plans were consistent with the recommendations made in the assessment (previously discussed) although did not appear to include an important consideration raised in the assessment that meeting Sam's needs in the community would require a multi-agency approach. The local authority also had a duty to provide services under Sc117 (MHA 1983), but no referral was made at this time. It is unclear why this did not happen.

Education: Sam spent increasing amounts of time at her community school who were very supportive of Sam's education. Work had been sent to Sam at the inpatient unit and had been marked by teachers at the school. A group of key staff were integral to her successful integration, and they were well engaged throughout her admission in the CPA process. A senior member of staff attended most of the CPA meetings in person and played an active and constructive role in planning for Sam's return to school. Sam was consulted and engaged throughout - this was excellent practice.

However, an important issue arises about whether Sam's needs met a threshold for an Education, Health and Care Plan (EHCP). Sam had an Individual Alternative Education Plan (IAEP), which was reviewed regularly, but there are some important differences between an IAEP and EHCP, this became a critical issue over time. Related issues are discussed in Sc5.

Therapy: There was comprehensive liaison between the CAMHS care coordinator (CC) and the inpatient unit. However, the CC did not meet Sam and just before Sam's discharge the CC was replaced by a new CC. Sam engaged well with the new CC, who saw Sam immediately before and then after discharge, and there was a start of a positive relationship. Unfortunately, this CC unexpectedly left her post and Sam was without a CC for almost 3 months. This delay was in part due to the difficulties in finding a suitably trained and experienced CC who would be able to combine the CC and therapist role and so offer Sam the opportunity to engage in a therapeutic relationship. Whilst it is understood there is a local and national shortage of clinicians able to take on this kind of role it is important to appreciate that this was a critical juncture in Sam's care and meant that the opportunity to build a platform for future therapeutic work in the local community was lost[27].

During this period of transition, CAMHS confirmed with parents that the community psychoanalytic psychotherapist was unable to offer Sam any appointments. Assessments and discharge plans had clearly set this out as critical to Sam's treatment. Sam had agreed, and

[26] Dialectical Behaviour Therapy is an evidence-based psychotherapy that began with efforts to treat borderline personality disorder. There is evidence that DBT can be useful in treating mood disorders, suicidal ideation, and for change in behavioural patterns such as self-harm.

[27] The Cambridge and Peterborough Foundation Trust Serious Incident (SI) report notes that the 1st care coordinator's (CC) limited working hours, and limited experience of working with children who have complex mental health needs, were contributory factors. The CPFT Medical Director's (MD) Witness Statement to the coroner sets out the changes that have been made within the service to prevent re-occurrence of these events.

the trusted adult relationships she had formed at the inpatient unit and with her CC demonstrated an emerging willingness to trust and to engage in therapy. It is understood that the reason this therapy was not offered was partly based on the understanding that Sam would be in receipt of DBT and also that Sam would be unable to access long-term therapy due to transferring to adult services. In any event, there was no capacity within the community CAMHS to offer psychoanalytic psychotherapy at this time. Therapeutic provision is discussed in Sc5.

A farewell meeting took place between Sam and her key nurse at the inpatient unit. Sam was very distressed at saying goodbye and on her return home, fasting and self-harm followed. Sam was admitted to a local hospital and returned to the inpatient unit. The absence of post discharge support by out of area T4 units is discussed in Sc5. The local hospital made a referral to MASH[28], parents were contacted and a decision to take NFA was made. This was the 6th referral made to CS. Records state: *CS assured no safeguarding concerns and parents responding appropriately*. Reasons for the lack of involvement by CS have been discussed previously and are explored in Sc5.

After Sam had been given a diagnosis of BPD, parents researched the recommended treatment pathways and understood there was no discrete treatment pathway in CAMHS but there was an established pathway in adult services that they understood was a well-respected service. They requested an early transfer of Sam's care to adult services in order for the treatment to be provided and continued to make this request after Sam's discharge. The availability of a discrete service for children who have a diagnosis of BPD is a key issue and is discussed in Sc5.

Sam spent increasing time at home and integrating into school life, whilst Chris continued to be an inpatient. After eight months of inpatient care, a discharge meeting took place and Sam was discharged home. The plan remained as agreed at the CPA meeting (previously detailed) and was compliant with relevant guidance[29]. Whilst this was a clear plan, there was no local DBT or community psychoanalytic psychotherapy in place. The reasons for these gaps in service provision have already been discussed and are explored further in Sc5.

4.7 Responding to Sam's needs in the community

Sam, now sixteen, continued to attend school and over the following five months her integration went well. There was an excellent relationship between school staff, Sam, and parents, and a great deal of hard work went into achieving Sam's successful return. This was led by 3 senior members at the school, in partnership with Sam and her parents, who responded creatively and flexibly to Sam's needs, and ensured risk and safety planning routinely happened - this was good practice.

However, Sam's significant mental health needs meant she met the disability criteria and as a result had rights under The Equality Act (2010) and was entitled to an Education, Health and

[28] Multi-Agency Safeguarding Hub. At the time this was a new (national) initiative set up to enable a multi-agency decision making and response to referrals received by Children's Services.

[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.

Care Plan (EHCP). Whilst at the time it may have appeared that the school could meet her needs, and little more could have been done by the school to support her reintegration, there was a measure of optimism that may have been warranted at the time but over time proved to be misplaced. Sam had significant mental health needs that could not be safely predicted to stabilise and/or improve. A contingency plan was needed in the form of an EHCP, this issue becomes important later.

During this time, there was little communication and no joint work between community CAMHS and the school. The coming weeks and months were a critical time for Sam, a time when there should have been pro-active communication and partnership between CAMHS and the school. Undoubtedly, the absence of a care coordinator at this time was key to why this collaboration did not take place. The CPFT agency report highlights that there was an absence of a mental health link with the school at the time which would have been an added complication.

Sam continued to see her psychiatrist regularly when her medication was reviewed. She was offered the involvement of IST, and a clinical psychologist, which she declined. The CPFT Significant Incident (SI) report identifies that following her discharge Sam was not offered any other specific talking therapy, the key reason given for this was Sam's reluctance to engage in therapy. Therapeutic provision, and engagement, is discussed in Sc5.

Sam continued to receive a range of medication for depression, sleeping difficulties and anxiety. She continued to self-harm; some of these episodes were of such severity that she needed inpatient care at the local hospital. On these occasions, there was good communication between the acute trust and CAMHS, when safety plans were agreed prior to her return home. However, the continued absence of a CC meant there was a gap in how her care was informed and coordinated.

It is important to note that during this period of Sam's transition, Chris remained an inpatient. She was repeatedly self-harming and often expressed her intent, and making attempts, to end her life. The need for a think twins, think family approach, and for formal collaboration between the treating clinicians has been raised previously.

Sam was eager to have letter / telephone contact over the coming months with members of staff at the inpatient unit, in particular her key nurse. She called the unit on several occasions, and sent a letter asking for contact, but received no response. The inpatient unit later responded by saying that it was not within the terms of their contract to supply post discharge support. This position is not unique to this establishment, it is a systems issue relating to commissioning arrangements and is discussed further in Sc5.

Exceptional funding for DBT out of area was promptly agreed and Sam was offered an assessment appointment, there was good communication between the CAMHS teams. A decision was made that Sam should return for a further assessment appointment. The service later concluded they were unable to offer Sam treatment. It was a 4-hour round trip to access this treatment and Sam was clearly agitated during these appointments, she was regarded as resistant to accessing this therapy and was regarded as posing a risk to staff. This view was not shared by her psychiatrist who made contact with this service to advocate for Sam

although this did not result in a change of mind by the service. Therapeutic provision and the lack of local DBT services has been discussed previously and is explored in Sc5.

4.8 Sam's mental health deteriorates

After a short period of relative stability, Sam's mental health deteriorated.

A decision had been reached for Chris to transfer to an alternative inpatient unit and once a bed became available in a Low Secure Unit (LSU), some distance from home, arrangements were made for her admission. 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 or to be transferred to the unit where Sam had been an inpatient. Parents said that Sam was very keen on this, and they already had good collaborative relations with the staff there. Unfortunately, this option was refused. 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.

On the day Sam learnt that Chris was to be transferred to a new inpatient unit, she was stopped from jumping from a bridge. A detailed referral (7th referral to CS) was made to MASH by police. Parents were contacted, they confirmed Sam was receiving support from school and CAMHS and declined involvement from CS on the basis that they were unclear of their role. Multi-agency work and enabling parents to make informed decisions about the involvement of services, is discussed in Sc5.

Less than two weeks later, Sam had a serious dissociative crisis[30] at home. Parents called the police and ambulance service. Sam was restrained to stop her hurting herself and taken to the A&E department at a local hospital. The absence of a home treatment team / suitable crisis team was raised as an issue by parents at the time. Supporting parents to provide safe care is discussed in Sc5.

On the day of her sister's transfer to the secure inpatient unit, Sam had another serious dissociative crisis at home. Parents described Sam trying to take her life by extreme methods and struggling to prevent her, the police and an ambulance were called. Police attended and, during restraint, Sam kicked a police officer which left him temporarily unconscious. Full restraint was implemented; Sam was handcuffed and her legs restrained. She was arrested for assault and taken to the police station where she was strip searched and placed in a cell. Police recording at the time showed that the primary reason for this was to prevent harm to self and others; it is a requirement that this assessment be made. However, it was clear that Sam had visible self-harm scarring, records showed her mental health needs, and police had been called to prevent Sam inflicting serious self-harm. Police powers under Sc136 (MHA 1983) allow police to confine people with serious mental health difficulties in a place of safety. These powers cannot be used to remove a person from their home, although once Sam was in police custody greater consideration should have been given to Sam being taken to a place

[30] Dissociation is a break in how the mind handles information which can include disconnection from thoughts, feelings, memories and surroundings, it can affect a sense of identity and perception of time although each person's experience of dissociation is often different.

of safety in hospital. This was a significant episode that had far reaching implications on Sam, these implications are discussed later.

There are multiple systemic factors which would have contributed to this significant event. The limitations of post-discharge care, the lack of a MH crisis service, the lack of parental training in safe restraint / safe holding[31] the need to think siblings – think family and the need to provide a multi-agency response are all important issues. The systemic result can inadvertently lead to a situation where front-line police officers must deal with an emergency situation such as this. The unintentional consequences for Sam, and others like her, is re-traumatisation and a criminal record. The unintentional consequences for front line workers is that they have to deal with a situation where they feel ill-equipped and unsupported. Relevant issues are discussed in Sc5.

In response to a complaint made by parents, an internal enquiry was conducted by police. This was a single agency investigation focussing on the actions of individual officers which concluded with no concerns about conduct. It is beyond the scope of this review to comment on this enquiry, but it is important to highlight the Cambridge Constabulary agency report which identifies the need for officers to have appropriate mental health training, the importance of a multi-agency approach and the need to divert children with mental health difficulties from the criminal justice system. This is discussed in Sc5.

Following this incident, a 'child at risk' referral was made to MASH. The referral was good; it contained detailed information, was clear about the risks and was appropriate. CS had already accepted a referral from Chris's previous inpatient unit, who had been clear about CS's relevant statutory duties. A social worker (SW) was allocated to complete an assessment and the family engaged well with the SW. This highlights the importance of multi-agencies' understanding of relevant legal duties and is discussed further in Sc5.

After almost 3 months, a new CAMHS Care Coordinator (CC) was allocated. This CC was an experienced clinician who was qualified to take on the dual role of providing therapy and co-ordinating Sam's care. Although concerted efforts were made to engage Sam in a therapeutic relationship Sam was reluctant to meet. Sam's experiences of broken relationships with adults she trusted may provide an explanation for her reluctance. Parental views were that the CC consistently worked hard to advocate for Sam, but with few positive results in the areas parents felt were of most importance, such as: contact with the inpatient unit, responding to requests for safe restraint training for parents, and an early transfer to the Adult Personality Disorder Service. Achieving positive results in these areas was beyond the gift of the CC, it needed flexibility in service response and changes in commissioning arrangements. These issues are discussed in Sc5.

Sam attended an interview at a 6th form college. Ultimately, Sam was not given a place. The reason given was that they did not have the courses available that would meet Sam's needs. Parental copies of the email correspondence between the college and the school show that

[31] It is appreciated that provision of restraint training / safe holding techniques is a complicated area that requires careful consideration – it is not something that was provided at the time and because of the complicated legal and safeguarding considerations and there are no current plans to provide such training - this is discussed in Sc5.

this decision was influenced by concerns about Sam's mental health. Sam's parents described Sam's experience of this as a significantly upsetting rejection, she was keen to attend the courses offered at this college and knew that several friends who she trusted would be attending. The absence of an EHCP and the lack of compliance with relevant legislation are relevant issues and are discussed in Sc5.

Following her unsuccessful interview Sam fasted for several days, ending in an episode of significant self-harm; Sam was restrained by police and during restraint assaulted officers and a teacher. Police appropriately decided that Sam needed to be in a place of safety and took her to hospital. They recognised the extent of Sam's vulnerability / mental health needs and took no further action in respect of the assaults; this was good practice.

Sam was detained under Sc136 (MHA 1983)[32], the assessment concluded no grounds for detention and the Sc136 was discharged. Inpatient admission was not viewed as helpful by clinicians and they were mindful that some of Sam's behaviours had worsened during her previous admission. Sam was not in agreement to being admitted although parents were strongly in favour of admission, fearing they could not keep her safe at home. Parents were noted to be exhausted. The liaison psychiatrist promptly communicated with clinical colleagues expressing concerns about the complexity of Sam's case and the pressures on Sam's parents. The absence of a community home treatment team, suitable crisis team and the lack of support to parents has been previously discussed.

School responded to the alleged assault on the teacher by excluding Sam for five days. Sam was upset about this decision; she had been in a dissociative state at the time and had no memory of what had happened. Parents spoke to the school about how this appeared to be punishing Sam for an act over which she had no control. Relevant issues are discussed in Sc5.

4.9 Exclusion from school and impact

A meeting took place at the school that included education professionals, police and clinicians. There was a clear desire to work in the best interests of Sam but the lack of effective joint working across the multi-agency network contributed to a position where the school felt alone in managing Sam's needs. A few days later, parents were informed that Sam would not be able to return to school but instead would transfer early to a local 6th form college. Shortly after, parents were told that Sam had been excluded and that the early transfer to college was not possible. Instead, 1-2 hours a day of after-school tuition at a community venue was proposed and parents were advised to apply for an Education Health and Care Plan (EHCP)[33]. Whilst it is accepted that the risks posed within school and college were considerable, the approach taken to Sam and her needs showed little appetite to fully understand these needs and little understanding of the legal duties to make suitable adjustments under relevant

[32] Under Sc136 police can take someone to a place of safety if there are significant concerns about their mental health, an assessment by a mental health clinician is then completed to determine whether compulsory detention under the MHA is needed.

[33] An education, health and care plan (EHCP) is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHCPs identify educational, health and social needs and set out the additional support to meet those needs. An EHCP takes up to 20 weeks to be approved.

legislation[34]. The significant delay in recommending that parents apply for an EHCP was also an important factor.

It is also important to note that Sam had been excluded from the school premises, not from the school, and therefore remained on the school register. This meant that the school maintained legal responsibility for her education. A number of decisions made during this period of time were contrary to existing guidance and legislation[35] [36] which included the reduced timetable of education. In addition, as Sam had not been formally excluded, there were no options of appeal[37]. As a result, the normal processes that were in place to safeguard children who are the subject of an exclusion were not followed[38]. Relevant issues are discussed in Sc5.

Parents were extremely concerned that the decision to exclude Sam would increase her suicidality. Sam's psychiatrist made contact with the school and there was disagreement between the school and CAMHS on the risks within the school environment and the potential effect on Sam's mental health as a result of her exclusion. Thwarted belongingness and links to suicidality are highlighted by a renowned clinician and author[39]; the CAMHS psychiatrist and parents were right to raise these concerns.

The communication and joint working that took place between the school, CAMHS and the local authority inclusion service[40] appeared to be characterised by polarisation and as a result was ineffective. Multi-agency working with children who have complex mental health needs and who are at high risk can be extremely challenging for practitioners and the anxiety provoked can lead to splits in the network, this requires attention. Relevant issues are discussed in Sc5.

When Sam was told of her exclusion, she was extremely distressed and wrote two suicide notes (quoted on page 1). She sent messages to friends expressing her feelings about the exclusion. The content of these graphically illustrated Sam's level of distress, feelings of rejection, abandonment, hopelessness and helplessness.

Sam was unable to engage with the tuition offered until after her sister was discharged home. This left Sam with no education for two months immediately before her GCSEs.

4.10 Education provision and involvement of CAMHS & Children's Services

The impact of exclusion on children has been researched and documented. Sam was in Y11 and was about to take her GCSEs; this was a critical juncture in Sam's life. Over the following days and weeks Sam often self-harmed and spoke about ending her life. The record of events that followed details the prolonged and assertive attempts made by parents to advocate on

[34] The Equality Act 2010 & The Disabilities Discrimination Act 1995.

[35] *Supporting pupils at school with medical conditions*. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England December 2015.

[36] *Alternative Provision* Statutory guidance for local authorities. DfE January 2013.

[37] Cambridgeshire County Council Exclusion Guidance 2017.

[38] Since this time, the relevant education trust has made considerable changes to processes and practices to reflect the learning from Sam's experiences with the intention of ensuring that the mistakes that were made are not repeated.

[39] Why People Die by Suicide. T. Joiner (2007).

[40] Later in this period, the education inclusion officer was absent for prolonged periods and the lack of effective cover within the service was unhelpful.

Sam's behalf. The parents made numerous attempts to try and achieve a change of mind by the school to enable her to return, attend important events at the school and enable Sam to receive a suitable education. Parents made numerous suggestions for a more robust safety plan and proposed creative approaches to work closely with the school to facilitate Sam's return, but the exclusion remained in place and relationships became strained. This was a complicated and difficult situation for all, it was clear that the school struggled to balance meeting Sam's needs with their responsibility to the wider school community. Sam and her parents were engaging well with the SW, but it seemed that CS felt unable to influence the school's decisions. Relevant issues are discussed in Sc5.

Sam continued to attend regular appointments with the CAMHS psychiatrist when she was prescribed a range of medication and safety plans were reviewed. There was good communication between the psychiatrist and Sam's parents over this period. A referral was made to the Adult BPD Service but due to pressures on capacity, resulting in the prioritisation of children who had reached their 17th birthday, Sam was not offered a service. The issues raised previously about the absence of BPD pathways in CAMHS are relevant.

At this time, there was active involvement by the CC who made consistent attempts to meet Sam, but Sam never agreed to meet. Attempts were made by the CC and the community psychiatrist to engage Sam in therapy, but she remained reluctant to engage in any therapeutic work. At this point, the psychiatrist was the only clinician working directly with Sam. There was little support offered internally within CAMHS to support the psychiatrist and the CC, and there was limited involvement of other services. This meant that professional responsibility for Sam's care rested almost solely in the hands of the psychiatrist and the CC. Relevant issues have been raised about how a single agency response could not have safeguarded Sam or provided her with the support and care she needed. This seemed to be caused by a pervasive (mistaken) belief that CAMHS are solely responsible for meeting the needs of children with mental health difficulties. Whilst it is acknowledged that in these circumstances CAMHS are usually the lead agency, the involvement of multi-agency partners in meeting a child's holistic needs is vital.

Sam's sister was discharged from the inpatient unit and returned home, and the following week Sam was able to start attending tuition. A Child in Need[41] meeting was convened for both girls that week by CS. This was the first multi-agency meeting to take place during the period under review that involved CS and was considerably delayed. It is understood that the reason for this delay was in part due to the difficulties in securing a date for the meeting with involved parties. A number of areas were explored, and actions identified. As highlighted by the CS panel member, these were not SMART[42] and led to further delays. During the meeting, CS suggested that there was no specific role for CS, no date was set for a future meeting and there were no recorded decisions about how care/support was going to be coordinated in the future. Despite frequent requests, the minutes of this meeting were not received by CAMHS or parents. CS have identified that a lack of understanding about the role and remit of CS, in providing services to children who are at high risk as a result of their mental health needs,

[41] A Child in Need (CiN) meeting is held under the requirements of Sc17 of the CA 1989.

[42] Specific Measurable Achievable Realistic Timely (SMART).

contributed to the position that was reached. These issues have been discussed previously and are explored in Sc5.

4.11 Criminal justice

A decision had been made by the local police force that Sam should be prosecuted for the earlier assault[43] and this decision was discussed at the multi-agency Youth Offending Service Panel. There was a need to fully consider Sam's mental health, consult with multi-agency partners, consider the implications of this decision on Sam's wellbeing and challenge this decision. There was an over reliance on the police report as full multi-agency collaboration through the Out of Court Disposal Suite was not routine practice at the time[44]. On being told of this decision, Sam's anxiety heightened and stresses within the family increased. Sam's parents felt this decision unjustly criminalised Sam and said that this was particularly poignant for them when compared with the lack of action taken by the police against her (alleged) abuser. Relevant issues are discussed in Sc5.

The CC made contact with the police as soon as the decision was communicated and was clear about Sam's background, her propensity to dissociate and the adverse effect of the assault charge and the impact of the criminal process on Sam's mental health. This led to the police reviewing the decision to charge Sam with assault and a decision was made to dispense with this charge and instead issue a caution. The decision was based on information received from Sam's GP & CAMHS whose input was good practice. However, this delayed decision making was unhelpful.

At the time, parents were reported as positive about this decision – although concerned that it could have been made earlier. It seems Sam may have felt an initial sense of relief about this, although parents said that she went on to be concerned that a caution on her record would compromise her ambition to work with children in the future. The view of the Cambridge Constabulary agency report author is that the decision to dispense with the charge by issuing a caution was a mature and sensible decision that took into account extenuating circumstances. However, the author also emphasises the importance of diverting children from the criminal justice system[45]. Relevant issues are highlighted in Sc5.

4.12 Supporting Sam and her family at home

After Chris returned home, few events were recorded by services about intervention with Sam. Whilst parents continued to be vigilant about Sam's safety, and continued to work hard to meet her needs, it seems that this was a period of relative calm and stability for Sam. Sam attended tutoring and monthly appointments with her psychiatrist, where her medication was reviewed.

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[43] CSA victims and survivors have been found to be 1.4 times more likely to have contact with the police, and almost five times more likely to be charged with a criminal offence, than those who have not experienced CSA.

[44] Significant changes to this panel, and in working relationships, means that decisions are now taken by the full multi-agency group and alternative options for disposal are available.

[45] In hindsight parental views are that they should have challenged this caution on Sam's behalf while she was still alive and believe that it had a significant influence on Sam's negative views about her future. These events were later reviewed during the inquest and whilst it was accepted that the decision to issue a caution was well intentioned and primarily motivated by considerations about Sam's welfare, it was concluded that the mitigating circumstances meant that Sam should not have received a caution and the caution has been posthumously rescinded.

Following the CiN meeting the school stopped Sam's tuition and parents were asked to pay for a Health Care Assistant to enable tutoring to continue as Sam did not have an EHCP[46] in place and SEND funding was not pursued by the school. In the absence of an alternative option parents paid, and this worked well. Parents were keenly aware that Sam needed to feel some certainty about the future and attempted to find a provision that would enable her to re-sit her GCSE's. There was only one local option in the surrounding area, and this provision would not accept her.

It is clear from parental records that achieving consistent and suitable tutoring was a constant battle, as were their attempts to find a 6th form provision that would accept Sam. Sam's psychiatrist made several attempts to support education provisions to accommodate Sam's needs, but the lack of understanding about mental illness / trauma and its impact was apparent within the education system, and the lack of will / flexibility to make suitable adjustments was contrary to The Equality Act (2010). This period of rejection and uncertainty was detrimental to Sam's mental health and wellbeing**.** The issues raised previously about an EHCP, and the legal duty to make suitable adjustments under relevant legislation, are discussed further in Sc5.

Sam was not allowed to attend Leavers' Day before the end of the school term, but Sam attended the school Prom, and this went well. There were few self–harm incidents during the summer, however, Sam's parents said that she lost touch with most of her school friends following her exclusion and was very lonely.

A decision was made by CS to close their involvement and take NFA, this decision was based on a judgement that the service had no ongoing role. The relevant assessment had identified that Sam and Chris were at significant risk of harm due to their mental health difficulties and referenced some important social factors pertaining to the relationship between the twins, and the relationship between professionals and parents. However, the assessment did not sufficiently represent the views of Sam and the reference to social factors possibly impacting on how Sam's needs were being met was important as were parental requests for night-time support, neither of these issues had been adequately explored by the multi-agency network. This was an opportunity for CS to take up a crucial role of hearing Sam's voice, advocating for her needs within the wider system, making a significant contribution to safety planning and working with all those involved to support a productive relationship that placed Sam at the centre. The final assessment was not shared with parents or other agencies, it is unclear why this did not happen.

For the duration of CS involvement, their struggles to identify their role were apparent. This influenced the role they took up and directly contributed to parental ambivalence about the continued involvement of CS. The decision to close the case was based on a reasoning that no grounds were evidenced for involvement under the Children Act 1989 including Sc47[47] and

[46] An assessment for an EHCP takes 20 weeks

[47] 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.

Sc17[48]. The assessment and intervention showed that there was little understanding about the impact of trauma, of Sam's mental health difficulties and the ongoing risk of suicide. However, the decision that CS involvement under Sc47 was not needed was a correct judgment based on the available evidence. The lack of clarity about the role CS could take up under Sc17 directly contributed to their lack of involvement. It did not seem possible to frame Sam's high-risk behaviour and needs within the broader lens of safeguarding and there did not seem to be a way in which agencies could come together to think creatively about how parents could be supported in caring for their daughters at home. As previously mentioned, there was no multi-agency framework in place that set out the roles and responsibilities of services in these circumstances.

Despite the considerable challenges Sam faced, she successfully passed all four GCSEs that she sat and passed her BTEC level 2 Health and Social Care qualification – these were impressive achievements. In the absence of workable further education alternatives within state provision, parents secured a place for Sam in the private sector. It is important to note that for children in these circumstances, whose parents are unable to pay for private education, important educational achievements are unlikely to be within reach, with potentially negative implications for a child in terms of their sense of achievement and investment in the future. Relevant issues are discussed in Sc5.

Parents were aware that the anniversary of the twins disclosing CSA was approaching and made contact with Chris' psychiatrist concerned that this anniversary would lead to a decline in Sam and Chris' mental health. This was an important time for Sam and Chris, it took great courage to speak out about the abuse but for reasons already identified, this had not resulted in an outcome and remained an enduring feature of their lives. The need for victims of CSA to feel believed, and for justice, is a critical milestone in their recovery. The response to this important anniversary by CAMHS is unclear. Relevant issues about responding to CSA, the need to think twins and for formal collaboration within CAMHS has been raised.

4.13 The last days of Sam's life

One month later, Sam did not attend an appointment with her psychiatrist and parents were contacted. They informed the psychiatrist that Sam had not taken her medication for at least a month and had stored them in her room (which parents had removed). Parents expressed fears that this was preparation for an overdose[49] and that they would not be able to keep Sam safe. An appointment was made for Sam the following week.

Sam attended the appointment with her psychiatrist and said she had not taken her medication for the last 3 months. She said she was not feeling suicidal that day and although she was low in mood she was assessed as brighter than normal and did not report any recent acts of self-harm. The psychiatrist had sought advice from a local specialist service, who provided treatment to adults with emotionally unstable personality disorder (BPD), about a new medication that might be helpful. Sam was willing to try this medication and the risks

[48] 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.

[49] Sam's phone records confirmed she had been stockpiling tablets for three months with the intent to end her life.

and benefits of this medication were discussed. Sam was assessed as having the capacity to make this decision and a new prescription[50] was given. The existing safety plan was for parents to be in charge of her medication by keeping it safe at home. Sam did not give consent for her parents to be informed and on this occasion she was assessed as having capacity to make this decision. The psychiatrist considered a number of factors in making a decision not to inform parents; Sam had said she would inform her parents and wanted to be trusted to do so, enabling autonomy and building trust was an important consideration. In addition, to go against Sam's wishes risked compromising an already fragile alliance with the only professional who was seeing Sam. The end result was that parents were not informed of this prescription. Parental perspectives are that this decision was contrary to the existing safety plan, did not take into account Sam stockpiling medication in the recent past and that they should have been informed. Relevant issues about consent and risk are discussed in Sc5.

4.14 Sam's tragic death

A week before Sam was due to start at her new school, unbeknown to parents, Sam collected the prescription from the local pharmacy. Prescriptions had always been collected by parents in the past but this visit by Sam did not give rise to any concerns. Whilst there, she was told there was a months' worth of prescription held at the pharmacy (ordered by her parents before the discovery of the hoarded tablets) plus an additional prescription prescribed by the GP[51]. All this medication was given to Sam. The psychiatrist was unaware that this medication was being stored at the pharmacy and local pharmacies were not included in safety planning for children at risk; there was no communication between CAMHS and GPs with pharmacies at this time and no agreed protocol within CAMHS that would facilitate this communication[52].

That night, Sam took an overdose of medication. She tragically died during the early hours of the morning. The conclusion of the inquest was that Sam had died from taking a fatal mixture of medication which included the prescriptions that had been stored at the pharmacy[53].

In the witness statement to the Coroner, parents detail the events of this day. The constant vigilance, minute by minute assessment of risk, and the lengths taken to keep Sam safe, are apparent. They had no reason to think that Sam was at heightened risk that day and were unaware of the medication that was in her possession. They knew that the agreed safety plan stated that parents looked after medication and assumed that the plan would not be changed without them being informed. The importance of a multi-agency contextual approach in safety planning and risk management is discussed in Sc5.

[50] The new prescription given included a limited prescription of the new medication and a repeat prescription of an existing medication that equated to small doses that were not dangerous in overdose.

[51] The coroner concluded that this prescription had been prescribed in error.

[52] Action is being taken within CPFT to address this, in line with an existing approach adopted in adult services.

[53] This did not include the new medication but did include the medication prescribed in error by the GP and the existing medication recently prescribed although it was determined that this did not constitute a fatal dose.

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

It is important to start this section by highlighting good practice. As stated at the start of this SCR there was a clear commitment to, and care about, Sam demonstrated by many practitioners / school staff and clinicians. The following are examples:

- The work of the Approved Mental Health Practitioners and the positive relationship formed with parents.
- The flexibility of the inpatient unit psychiatrist in negotiating a second opinion about Sam's diagnosis.
- The assessment completed by the clinicians who provided the second opinion.
- The trusted relationships that were formed with her key nurse and another nurse at the inpatient unit that enabled Sam to speak about the abuse.
- The work that took place in the inpatient unit to improve the relationship between staff and parents after this second opinion was provided.
- The support and commitment of the community school staff before Sam was admitted, whilst Sam was an inpatient and shortly after her discharge.
- The standard of family therapy that was provided, the consistency and flexibility of provision and the efforts made to enable Sam to attend with Chris whilst they were both inpatients.

- The committed proactive work of the CAMHS Care Coordinator who was allocated during the last 6 months of Sam's life.
- The responsive approach provided by Sam's community psychiatrist.
- The responsiveness, advice and support offered by the Local Authority senior transitions adviser, the START[54] team and SENDIASS[55].

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 (CSA). In order to understand Sam's needs and appreciate the struggles of services to meet these needs, it is important to start with what has been learnt about how services responded to Sam'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 sixteen. 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. There is considerable evidence that children who are victims of sexual abuse are not identified by professionals, 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[56].

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[57].

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. The research evidence suggests that children will "*test out*" the response of professionals before making more serious allegations of harm. It is essential that professionals respond to children's help seeking behaviour.

54 START: Statutory Assessment and Resources Team.

55 SENDIASS: Special Educational Needs and Disabilities Information Advice and Support Services.

56 NSPCC Practice Briefing. Child Sexual Abuse 2013.

57 *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*[58].

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*[59]*.*

Sam was pulling out her hair and eyelashes at a young age. A diagnosis of trichotillomania[60] was given and a short course of treatment was provided aimed at stopping this behaviour. It was not known (although arguably knowable through a detailed exploration of psychosocial history) that Sam had shown *sexually inappropriate* behaviour in the past. This represented a second missed opportunity to consider what may have been going on in Sam's internal world, and to consider Sam's behaviour as a form of help-seeking behaviour which required more than the implementation of behavioural techniques. It is possible that this approach may have had the unintended outcome of compounding the response to Sam when she was 6 – internalising her feelings of shame and intensifying the silence. It appears she may have formed a trusted relationship with the therapist which ended quickly. This was Sam's first experience of therapy and whilst it seems a positive relationship was formed - it may have framed her early view of talking therapy – that it could not be relied upon / trusted and so was unhelpful. Recent evidence highlights the limitations of treatments available for victims / survivors of CSA and identifies that some services can inadvertently cause harm, compounding feelings of isolation guilt and shame[61] .

Key learning: Exploring wider formulation in a case, rather than applying a label or diagnosis in isolation, opens the possibility of seeing a child's behaviour through the lens of self-harm and trauma. Without this wider formulation, there is a risk that the shame and silence may be inadvertently compounded and the child's future engagement in therapeutic interventions compromised.

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[58] *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.

[59] *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.

[60] A review of research suggests several possible causes including a link between childhood abuse/trauma and trichotillomania. As suggested by the NHS – various causes should be considered including that it is a form of self-harm.

[61] Independent Inquiry Child Sexual Abuse 2020.

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[62].

Over the next few years, serious and regular self-harm followed, and Sam's mental health was of significant concern. An array of labels and diagnostic terms were used to describe her behaviour, she was prescribed medication and was seen by a variety of clinicians. Referrals were made to Children's Services, but the intention of these referrals were unclear. Equally, Children's Services could not see what role they would take up in circumstances where a child was suffering mental health difficulties and so the referrals were logged but no further action was taken.

The Children's Commissioner's report on CSA[63], associated research[64] and guidance[65] available at the time, detail the symptoms of sexual abuse. Sam'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 2009). Self-blame, self-harm, and suicide are commonly mentioned as consequences of sexual abuse[66].*

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. The role of Children's Services in the lives of children who are suffering from mental health difficulties is discussed later. Of critical importance is the role of this service in supporting professionals and parents to understand the symptoms of sexual abuse, to enable children's behaviour to be seen through a trauma-informed psycho-social lens.

> *A range of complex and interacting individual, relational, and social barriers may prevent children from disclosing abuse, to professionals or anyone else….the disclosure*

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

63 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.

64 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 Association 1986 Vol. 99, No. I, 66-77 0033-2909/86/

65 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.

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

process can be helped or hindered by the way in which any professional engages with a child about whom concerns exist[67].

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.

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*[68].

It takes great courage for children to speak out about sexual abuse, the response to the disclosure of sexual abuse by Sam mirrored findings in the joint area targeted inspection into sexual abuse[69]. There was a focus on achieving the evidence needed to pursue the investigation through a visually recorded interview, this focus is understandable as VRI's 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 the girls 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[70]. A number of principles contained within the Achieving Best Evidence[71] 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-agency partnership working, suggested that the importance of seeking justice over time was not recognised and

investigations take too long and therefore impact on children's well-being[72].

This disclosure was a critical juncture that offered an opportunity to place this trauma at the heart of a multi-agency response, and provide services informed by an understanding of child sexual abuse. 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

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67 *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.

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

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

70 This was particularly relevant for Chris who told the Family therapist that she wanted to make a full disclosure but was only able to write this down.

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

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

belief that they had no ongoing role. Responsibility to meet Sam's needs was left almost 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[73].

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 provided. For Sam, the police forces involved needed to be supported and challenged during the investigation that took place including the advice given to the family that therapy could not be provided[74]. Alternative ways of giving evidence should have been explored, Sam needed support to reconsider a VRI over time.

5.2.5 Seeking 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[75].

The deterioration in Sam's mental health and wellbeing after being told that the criminal investigation was closed has already been described. Thereafter, when she was asked by clinicians if she wanted to talk about the abuse, she declined. It was often recorded that Sam did not regard this trauma as linked to her significant mental health difficulties. Subsequently, when she spoke about the abuse with a trusted adult, no action was taken in response. Adult survivors have said that as children, they made implicit attempts to disclose and as adults, regretted that they had not been able to disclose. Relevant research points to a critical finding that trusted adults need to find ways to invite genuine disclosure[76].

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

[74] *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.

[75] *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.

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

Supporting children to speak out and achieve justice over time requires an approach that places the trauma at the heart of interventions over time. This includes the diagnoses that might be given to a child, the treatment/therapy that is provided and includes a clear understanding of the importance of justice in a child's healing journey. These components did not feature in the support that was offered.

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 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[77]. 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[78]

The Independent Inquiry into Child Sexual Abuse[79] 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[80]; 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.

> *Within CAMHS, safeguarding and social care play a key role in supporting children and families affected by ACEs[81]. Ensuring that there are robust frameworks for good communication between such services, and that treatment is available as close to the traumatic experience as possible is key when working with children and young people[82].*

5.2.7 Providing early therapeutic help and nurturing trusted relationships

Sam had previously been referred for CBT. After Sam's disclosure, there did not appear to be a consideration as to whether this treatment approach to address her symptoms was the right treatment, or whether her diagnosis needed to be revised.

Once CBT started in CAMHS, Sam formed a trusted relationship with the clinician, but the sessions stopped after a short while after Sam did not feel able to identify a goal she wanted to work towards. This was just one example of Sam experiencing the end of a trusted relationship. These relationships were important building blocks in a trauma-informed

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77 The Criminal Injuries Compensation Authority (CICA) is a government funded organisation that was created to provide compensation for blameless victims of violent crime, including child sexual abuse.

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

79 Independent Inquiry Child Sexual Abuse 2020.

80 Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018–2023 NHS England.

81 Adverse Childhood Experiences (ACEs).

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

approach that had the potential to strengthen Sam's belief in adults as a source of help. It seemed that a number of factors stood in the way of a trauma-informed approach being enacted.

One factor relates to treatment modality. CBT is an established treatment approach to a range of mental health difficulties and there is a strong evidence base supporting its use and success. Recent research suggests there is a mixed picture in terms of its helpfulness in cases of CSA. That said, a trusted relationship had been established and Sam was keen to continue seeing the therapist. The reasons for ending this therapy were likely to stem from the well-established CBT treatment model of short-term goal focussed work. Of utmost importance for Sam at this time was for this therapeutic relationship to be nurtured so that a trusted containing space was available for her over time. Therapeutic provision is discussed further in a later sections.

5.2.8 What has happened to you?

By relegating the full spectrum of trauma related problems to seemingly unrelated "comorbid" conditions, fundamental trauma related disturbances may be lost to scientific investigation, and clinicians may run the risk of applying treatment approaches that are not helpful[83].

As previously stated Sam's symptoms fell firmly within the range of symptoms suffered by children who have been sexually abused but this did not appear to be recognised at the time and her later disclosure did not change the diagnoses that were made for some time.

As described by a renowned trauma expert[84], *there is no other diagnostic entity that describes the pervasive effects of trauma on child development, these children are given a range of comorbid symptoms as if they occurred independently from the PTSD symptoms.[85]*

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. Sam often asked her parents "*what is wrong with me?*" It is accepted that Sam often said she did not accept that the CSA was linked to her mental health needs and that therapy focused on this abuse would be unhelpful, this was an important consideration and would have presented a conundrum to clinicians. However, this does not negate the need for a trauma-informed approach. Taking this approach has the potential to; provide opportunities for trusted relationships to be formed that enable the impact of trauma to be understood, provide opportunities for children to speak out in their own time, and empower children to envisage a future where they can 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?",*

[83] Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals 35:5 May 2005.

[84] Bessel A. van der Kolk, MD.

[85] Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals 35:5 May 2005

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 as understandable and courageous attempts to survive which were absolutely necessary at the time[86].

Key Learning: Research, literature, and guidance about child sexual abuse has been available for some time. The Independent Inquiry into Child Sexual Abuse began in 2015, since this time there has been some substantial 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[87] to provide lifelong care to survivors of sexual abuse and this year the government launched a national child sexual abuse strategy[88]. 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"*[89] and provide victims and their families with the services they need.

Whilst the national 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[90] in response to the Poppi Worthington case[91]. These issues are about 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 parents as the burden of proof needed to convict their daughters' 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.

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

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

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 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 meet Sam'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 Sam and her lived experiences. On occasions when there were opportunities to provide a multi-agency response, these opportunities were not utilised, and this had wide ranging implications on how Sam's needs were understood and met.

Several referrals were made to Children's Services, 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 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)[92]. Under 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 impasse; 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 Sam's mental health needs came under The Equality Act (2010) and therefore she was entitled to access 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, may have contributed to why consent was only forthcoming for a relatively short period.

It seems that the absence of a locally agreed multi-agency approach under the preventative agenda, coupled with misunderstandings about relevant legislation, guidance, and research provides a partial explanation as to why multi-agency working was not achieved. 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*

[92] 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.

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*[93].

Finally, an important area that has arisen is the issue of how authoritative practice[94] is facilitated and enacted across the multi-agency, multi-disciplinary workforce. In this case, this applies to challenging each other about service provision and/or the lack of provision. This is an issue that repeatedly emerges in SCRs as far back as the Lord Laming Inquiry[95].

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 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 that stand out 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)[96].
- 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.
- Awareness of the critical place of school in a child's life and finding creative and robust ways of advocating for a child's needs within schools (including academies) to prevent exclusion.
- Awareness raising and training in mental health for front line police officers and involvement of police forces and ambulance service in discussions about providing a trauma-informed response/approach to children in these circumstances.
- Proactive steps to divert young people with mental health needs away from the youth justice system, where deemed appropriate.
- 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[97] is therefore an important consideration.

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93 *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.

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

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

96 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 inpatient (psychiatric) service.

97 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.

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[98] has not included children who have significant mental health difficulties, despite the high risk of harm.

Several recommendations have been made in the 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 local service provision since the period under review, these include:

- 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 & 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 and support 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, and so the Strong Families Strong Communities: achieving best outcomes for children and young people strategy has recently been endorsed across the early help partnership. An Early Help, Older Children and Adolescent Strategy is currently being developed.

[98] Working Together to Safeguard Children 2018 HMG.

- Strengthened processes implemented at the relevant academy trust to improve the response to children with additional needs who are at risk of exclusion.

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: The 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: The 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 should be undertaken in collaboration with children, young people, and parents.

5.4 Meeting children's educational needs

Whilst it is important to acknowledge that five months passed after this exclusion before Sam took her own life it is equally important to recognise that Sam's exclusion[99] led to significant deterioration in her emotional wellbeing and mental health. The suicide notes she wrote at the time are a testament to the loss, hopelessness and isolation she felt.

The impact of exclusion on children has been well researched and documented. The sense of belonging children feel when they are part of a school is vital to their identity and personality development (particularly in adolescence) and school can be a place where children have opportunities to form trusted relationships with peers and adults. Parents raised their fears that Sam's 'thwarted sense of belonging' would increase her risk of suicide, this is supported by the work of Joiner[100] whose theory on suicide is well established[101]. However, this does not mean that schools are without their own challenges. Like their multi-agency partners, they operate under specific statute, policy, guidance, key performance indicators and resource constraints and there is a frequent tension between meeting the needs of an individual child balanced with the good of all pupils / the school community. When working in circumstances of relative isolation from other potential sources of support, this balance can be difficult to achieve.

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99 Ref: *Timpson Review on School Exclusions*: Fundamental drivers of practice: differences in leadership, which lead to too much variation in the culture and standards set within schools and how staff deliver them, differences in how LAs perceive and deliver leadership for schools and services to work together, that result in disparity in the support schools receive.

100 Dr Thomas Joiner is an American academic psychologist and leading expert on suicide. Professor of Psychology at Florida State University: Laboratory for the Study of the Psychology and Neurobiology of Mood Disorders, Suicide, and Related Conditions.

101 Why people die by suicide T. Joiner 2007.

Nevertheless, it is important to highlight a number of issues that arose at the time of Sam's 'informal exclusion' and thereafter that had a significant impact on Sam's education and on her mental health and wellbeing. These included; the illegality of informal exclusion and the resultant lack of opportunities to formally appeal, the lack of a demonstrable appreciation of the risks posed to children who are excluded, the unsuitable tuition arrangements, the view held that academies cannot be effectively challenged, the lack of support provided by the Council Education Inclusion Service[102], the lack of suitable provision in the state sector for children with complex mental health needs to receive further education, the limited options in the state sector for children to re-sit GCSEs and the lack of understanding of (and response to) Borderline Personality Disorder / complex trauma / suicidal risk.

The central issues that arise during this period relate directly to key learning already identified about developing a multi-agency response to children who are at high risk as a result of their mental health difficulties, which should include schools and council education services. However, this episode also raises some other important areas of learning.

Firstly, Sam's complex mental health needs fell under the terms of The Equality Act (2010)[103] which required suitable adaptions to be made and gave Sam certain rights to services, but this legislation did not appear to be considered. Secondly, the absence of an Education Health and Care Plan (EHCP). Sam had an Individual Alternative Education Plan (IAEP) for a short period but the distinction between an IAEP and an EHCP is that the latter is a legal document which gives pupils and parents certain legal rights in terms of a child's education, and access to resources where needed, which can be used to support a child's education. Sam met the criteria for an EHCP, certainly once an inpatient and arguably before this time yet her parents were only advised to start the 20-week application process for an EHCP after Sam had been excluded.

Since this time, a revised EHCNA (Education Health and Care Needs Assessment) strategy has been implemented in Cambridgeshire that recognises the rights of children with significant mental health difficulties and their entitlement to an EHCNA. Some considerable work has taken place to raise awareness within schools about this entitlement and the importance of EHCPs in meeting the needs of children such as Sam. Cambridgeshire are commended for this excellent development and are encouraged to continue to learn from the experiences of children like Sam and ensure that when children are inpatients in mental health units an application is made for an EHCNA at the point of admission. Where possible, the process of assessment should be expedited with the aim of completion as close as possible to the date of discharge. This should apply to all children who are inpatients regardless of where they are admitted. It is understood that Cambridgeshire has changed current processes to put this into practice – this now needs to be formalised.

[102] The Council has now appointed a named officer responsible for the education of children with additional health needs who will be able to support young people in Tier 4. It is important to note that once a senior transitions worker was involved with Sam and once the EHCNA process was commenced at a much later stage parents report that the advice they received, including from Special Educational Needs and Disabilities Information Advice and Support Services (SENDIASS) and the START teams, was excellent.

[103] This legislation says that if you are at a substantial disadvantage compared to other people who do not have a mental health problem, employers and service providers must think about making reasonable adjustments.

Key Learning: It is clear that the learning identified across all domains in this SCR had a systemic impact on Sam's education and the recommendations made elsewhere are relevant. The new strategy and associated work in place appears to address the concerns about EHCPs and the recommendations in this SCR, regarding the need for a joined up multi-agency response, supports the new approach. However, the issues identified earlier in this section have implications for how children with complex mental health needs are supported to receive the education they need, and these require attention.

Recommendation 5: Cambridgeshire County Council to formalise the new EHCNA approach to children who are inpatients in mental health units in guidance, policy and processes, raise awareness about this new approach and evaluate progress.

Recommendation 6: The CPSCPB to request a review by the Education Directorate to address the issues identified above and 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 7: The 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 CAMHS - Meeting children's mental health needs

5.5.1 Working together within CAMHS and across the tiers

Sam and Chris received a range of services across community CAMHS (Tier 3) and inpatient units (Tier 4). With the exception of the work by the family therapy teams, there appeared to be little formal collaboration across the treating clinicians.

5.5.2 Think 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 teams clearly held this in mind. However, this was not demonstrated across the system and led to parents feeling isolated in their attempts to coordinate their daughters' care and meet their needs.

An example of this was the different treatment approaches in place to address the girls' eating difficulties. Whilst it is understood that approaches were formulated to meet each girl's individual needs, parental views were that these eating difficulties were almost identical. These very 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 treatment teams to consider the needs of the siblings, or to hold the family in mind.

Achieving collaboration routinely and consistently amongst clinicians/professionals, especially when more than one sibling is receiving a service, is identified in agency reports and requires further work. When considering how this collaboration will be achieved, it is also important to acknowledge the isolation felt by the community psychiatrist and CC after Sam's discharge from the inpatient unit. These clinicians spoke to the independent reviewer of how difficult this was and how they did not feel supported within the service. This is an important consideration for CAMHS going forwards and service developments to improve collaboration should consider how clinicians can be better supported.

5.5.3 Think CSA & Think Twins

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 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 not apparently 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 be 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*[104].

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.

5.5.4 Gaps in service provision

Sam's experience of mental health services brings into focus gaps in service provision in a number of areas. These gaps included the limitation and/or absence of services that sit between community CAMHS and inpatient units, the availability of resources and services within community CAMHS that are in place to meet the needs of children diagnosable with borderline personality disorder, the resources and services available to meet the needs of children who are discharged from inpatient units and these issues had a profound impact on how Sam's needs were met, and how parents were supported in caring for Sam and keeping her safe.

Current crisis provision (IST): These gaps were partially complicated by Sam and her parents not finding existing services (such as IST) helpful. It is understood that the Intensive Support Team (IST) provide short term support to children and adults who are suffering from a mental health crisis. The CPFT agency report describes IST as offering support as an alternative to hospital admission when children are in crisis. However, this team is not an emergency service and so is unable to provide an immediate response at the time of an acute crisis and is not set up to respond during the night and weekends. It was at these times that parents felt Sam, and they, most needed the support. The role of IST in providing support to children such as Sam was discussed by the CPFT author with the community CAMHS team, there was a view held by the Senior Leadership Team (SLT) that alternative frameworks should inform crisis

[104] *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.

treatment such as AMBIT (Adaptive Mentalization-Based Integrative Treatment)[105]. Whilst a new approach may well be helpful, this will not remedy the gaps in crisis provision.

Home treatment / crisis support for children and carers: The CPFT agency report records the view of the community CAMHS SLT that it is often a lack of options which leads to a tier 4 admission. They felt this was highlighted by an absence of a home treatment and crisis team (which is locally commissioned for adults but not for children). The absence of these services meant that at times of acute crisis Sam's needs could not be met in the community and her parents could only rely on the involvement of emergency services to respond.

This SCR has highlighted the trauma that can result from such a response, and the burden placed on ill-equipped front line emergency services to deal with children experiencing mental health crises. It is important to observe that this situation prevailed for the entire time under review and included emergency call outs for Chris. As identified in the Cambridge Constabulary agency report, the events surrounding Sam's restraint and arrest directly, albeit inadvertently, led to parental reluctance to call the emergency services.

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

5.5.5 Support during transition from T4 and after-care

Care coordinators: The CPFT SI report identifies the important gap affecting care and service delivery relating to Sam's discharge from the inpatient unit and post discharge care. The role of care coordinators in achieving a therapeutic alliance with children is important and the importance of trusted adults in children's lives has been discussed. The CPFT MD Witness statement also covers relevant issues relating to the role of care coordinators, and how this role will be strengthened.

Psychoanalytic Psychotherapy: An important element of Sam's Sc117 care plan, during transition and post discharge, was for psychoanalytic psychotherapy to be provided. The CPFT SI Report lists the main contributory factors that contributed directly or indirectly to Sam's tragic suicide. Within this list includes difficulties in matching a therapist to Sam's needs which reflected, *in part, gaps in resources.* It is understood that the reasons for this lack of therapy arose as a result of considerations about the referral for DBT although the primary reason appeared to be a lack of capacity.

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[105] AMBIT is a framework to support developing practice, rather than a self-contained model of therapy. AMBIT uses evidence-based approaches developed for self-injurious, substance-using and often non-help-seeking, disaffected young people. It offers a robust framework within which to coordinate and integrate interventions from a range of agencies, which address complex problems that occur at the same time across a range of domains (see https://manuals.annafreud.org/ambit-static/ambit-in-a-nutshell

Transition and post discharge care: The final issue relates to the services provided to children post discharge from a T4 Unit. Sam was keen to have contact with some members of staff post discharge, with whom she had developed a trusted relationship. These relationships were important during this transition and were valuable building blocks that had the potential to strengthen Sam's perception of adults as a source of help. Parents were keen to have the advice of this unit in relation to Sam's care immediately after discharge. Sam had been in the inpatient unit for 8 months; these requests were reasonable and clinicians from CAMHS agreed. The requests were not responded to by the inpatient unit, and of particular note is the lack of response to the letter Sam wrote to her key nurse. Within this unit Sam had found adults she could trust; she spoke about the sexual abuse she had suffered for the first time and in her relationship with her key nurse Sam felt trust that she could be comforted and helped, and this inspired her to think about her future.

> *I kinda want to work in a mental health hospital - I just want to be someone's 'Maria' because 'Maria' helped me so much and I want to do that for someone else*[106]*.*

When a response was received by CAMHS from the unit some 6 months after discharge, it seems that it was not within the gift of the key nurse to provide a response as the unit replied that it was not within their contract to provide post discharge care. Whilst this is understood, on a human level - particularly in terms of responding to the letter - it seems overly bureaucratic and unkind for an organisation to take this stance so soon after discharge.

The lack of contractual obligation for post discharge support is noted in the CPFT SI report. The lack of provision for follow up care, from the out-of-area inpatient unit, is identified within a list of factors that contributed to Sam's suicide, but no recommendations are made. It is recognised that this is a complex area; there are resource constraints as T4 beds are in high demand and there are shortages, the role of outreach in conjunction with community CAMHS care and treatment requires careful planning. The independent reviewer is not suggesting that these knotty issues are easy to resolve, it is suggested that these issues require attention if child centred services are to be provided.

Key Learning: The gaps in service provision 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, as is the work in place to strengthen the role of care coordinators. However, no recommendations have been made about how gaps in psychoanalytic psychotherapeutic provision may be bridged or how the lack of post discharge care from out of area inpatient units may be tackled[107]. It is not known what would be reasonable in these circumstances although at minimum, it seems that flexibility is needed in the contracting arrangements with these units. The lack of a multi-agency approach undoubtedly served to compound these gaps and the recommendations made earlier will contribute to improving service provision. However, there remain a number of important

[106] Quote from Sam in social media supplied by parents – name of key nurse has been anonymised.

[107] It is important to note that Chris's experience of post discharge care from the CPFT inpatient unit was very different in that the support provided was excellent.

issues that require attention by CPFT, CCG & NHS England with support and oversight provided by CPSCPB.

5.5.6 Longing to be understood - therapeutic provision

Sam saw a minimum of fourteen counsellors/therapists/psychologists/psychiatrists during the period under review. There was a pervasive view held during Sam's treatment, and repeated during the course of this SCR, that Sam did not want to engage in therapy. It is clear that a number of attempts were made to provide Sam with therapy, and it is equally clear that as Sam got older her willingness to engage waned. In sessions with the CAMHS psychiatrist, the question of Sam accessing therapy was often posed but Sam was consistently clear she did not want any therapy. Sam was variably described as not engaging in therapy, not wanting therapy or reluctant to engage and these were key reasons why therapy was not provided. However, it is important to observe that when Sam engaged in therapy in the inpatient unit, whilst it was acknowledged that she made extreme efforts to hide her inner self, she had a 'longing' for people to understand how she was feeling and could see how therapy could help.

It is important to consider Sam's very early experiences of helping professionals in the form of counsellors and therapists. She engaged in these sessions, some of her experiences were unhelpful. When she formed a trusted relationship with counsellors, clinicians or with inpatient staff, for various reasons these relationships ended quickly. It is therefore possible that her experiences of counselling/therapy may have framed her view about therapeutic relationships and whether these could be trusted and relied upon as a source of healing and comfort. It is also important to consider that difficulties in interpersonal relationships[108] is a feature of BPD and can include a pattern of unstable and intense interpersonal relationships, alongside alternations between extreme idealization and devaluation & fears of abandonment. These issues were important to consider within a BPD approach, this is discussed in the next section.

It has been emphasised on a number of occasions during the course of this SCR that Sam was consistently clear that she believed her mental health needs were not connected to the CSA, this is accepted. However, it is equally clear that once a trusted relationship had been formed at the inpatient unit Sam spoke about the sexual abuse she had suffered.

There is little research or evidence about the suitability and effectiveness of therapeutic interventions for children who have been the victim of sexual abuse. Recent research, based on the experiences of adult survivors of CSA[109] and on children's experiences of approaches that work[110], confirms that this remains an area requiring further review/research. However, it is important to note that this research concludes with an overall finding that a trauma-informed approach is needed which allows children to engage in trusted relationships with

[108] *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).

[109] Systematic Review: Effectiveness of psychosocial interventions on wellbeing outcomes for adolescent or adult victim/survivors of recent rape or sexual assault. Jane Lomax and Jane Meyrick. SAGE 2020.

[110] *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.

caring and empathetic adults. This is in line with the current guidance on treatment approaches for people who have a diagnosis of Borderline Personality Disorder[111]. It is important to note that this guidance advises against provision of brief psychological therapy (less than 3 months duration). In addition, relevant BPD research[112] [113] [114] [115] [116] emphasises how BPD impacts on engagement in therapy citing an absence of resilience or lack of epistemic trust and advocates that extensive efforts should be made to maintain engagement which should include a focus on addressing the behaviours that interfere with therapy.

Some panel members have said that the limitation of professional working means that achieving trusted relationships can be difficult to realise in practice, this is accepted. However, the guidance available does not suggest that this approach is confined to CAMHS/clinicians. It urges that a more flexible and holistic approach is taken in enacting a trauma-informed approach that allows for individualised care planning across professional services.

Key learning: Taking a trauma-informed relational approach, informed by attachment histories (and, where a diagnosis of BPD has been made, by available guidance) has the potential to open the door to different therapeutic options by adopting an agile approach to children and therapeutic provision. This fits with the research about adolescent development and trauma[117] and with national guidance[118] and aligns with areas of learning previously identified. The section below addresses relevant issues about BPD. The wider issue about how a trauma-informed relational approach will be enacted when meeting the therapeutic needs of children has been discussed in previous sections. It is clear that this requires a whole system response where every effort is made to provide therapeutic support / a therapeutic relationship that stands the test of time and should be included in the work to build a multi-agency scaffold of care.

5.5.7 Borderline Personality Disorder

The narrative conclusion of the inquest that investigated Sam's death was that the predominant cause of her death was Borderline Personality Disorder (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 question, but the absence of a care pathway and relevant local resources (such as DBT) may suggest the local position is that it is not in a child's best interests to make this diagnosis.

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

112 *The relation between epistemic trust and borderline pathology in an adolescent inpatient sample*. W. Orme, L. Bowersox, S. Vanwoerden, P. Fonagy, C. Sharp. National Library of Medicine 2019.

113 A mentalization-based approach to common factors in the treatment of borderline personality disorder. A. Bateman, C. Campbell, P. Luyten, P. Fonagy National Library of Medicine 2017.

114 Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. P. Fonagy, P. Luyten, E. Allison. University College London.

115 Psychotherapy for Borderline Personality Disorder: Mentalization Based Treatment. P. Fonagy, A. Bateman. (2004b). Oxford University Press.

116 *What Works For Whom*? P. Fonagy, A. Roth (2004c). A Critical Review of Psychotherapy Research (2nd Ed.). Guilford.

117 *Trauma-informed approaches with young people*. Frontline Briefing Research in Practice 2018.

118 Such as: Strategic direction for sexual assault and abuse services: Lifelong care for victims and survivors NHS England 2018 – 2023.

UN Convention on the Rights of the Child Article 3: *When adults or organisations make decisions which affect children they must always think first what would be best for the child.*

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. However, bringing sense and meaning to a child's lived experiences is important - Sam was keen to have a diagnosis that could help her make sense of what she was experiencing. The diagnosis of BPD, made at the inpatient unit, made sense to Sam. A diagnosis can enable a shift from a place of helplessness, hopelessness and powerlessness to a position where agency is engendered. This is particularly important for children who have been the victim of CSA and, as research has shown, the sense of agency is of critical importance during adolescence.

From a parental perspective the diagnosis was helpful, not only because it fostered greater understanding and improved collaboration between them and inpatient staff but importantly served as a means of empowerment in meeting and advocating for their daughters' needs. From Sam's perspective, after a diagnosis of BPD had been made at the inpatient unit and the symptoms were discussed in therapy, her therapist recorded that Sam identified with the core difficulties associated with BPD and that Sam said the symptoms were: "*like a road map of me".*

Available guidance[119] sets out the evidence-based treatment pathways and approaches that should be in place and includes clear guidance about the limitations, and potentially negative consequences, of inpatient admission for any significant duration and the guidance contains cautionary notes about the use of medication in the long-term. 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 evidence-based treatment pathways and approaches are not in place, and it is understood there are no coherent plans[120] to address this; this reflects a national picture.

Entering an ethical debate about this issue 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 in order to safeguard them from harm. It is also the job of a SCR to consider what relevant research and guidance is available about a specific area of safeguarding practice.

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[119] *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.

[120] The CPFT Medical Directors witness statement to the coroner that there is no formal DBT service in community CAMHS and no plans to provide this locally due to cost and staff skills although some new initiatives to upskill existing staff in DBT techniques are referenced.

There is a wealth of such research and guidance on BPD. The recent position statement from the Royal College of Psychiatry[121] was informed by seventy-one pieces of guidance and research. This states that, where indicated, a diagnosis of BPD should be given as early as possible and that evidenced based treatment pathways, approaches and provisions should be available. This chimes with both the NICE Guidelines and a consensus statement written by adults who are diagnosed with a personality disorder[122].

Fonagy[123], a renowned clinician and author who specialises in the treatment of BPD states:

> *It is only through early active assessment and identification of youngsters with these problems that a lifetime of personal suffering and health system burden can be reduced or altogether avoided[124]*.

Key Learning: NICE guidance and relevant research reveals the sound evidential base for the diagnosis and treatment of BPD in adolescence. However, the national picture *shows considerable variation in whether services are available, what they offer and to whom[125]*. 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 *unwillingness* to diagnose BPD may have a significant bearing on the lack of treatment or plans to tackle this important issue. And, in the absence of diagnosis, there is no evidence to show that a bespoke approach and pathway is needed - this risks perpetuating a cycle which inadvertently results in this important issue being out of sight. As Sam's life and death have shown, it is a critical safeguarding issue that requires urgent action.

5.5.8 Consent & Risk

It was clear that decisions about whether Sam's lack of consent needed to be overridden was considered about an array of issues, and on numerous occasions, by clinicians in the community and by the inpatient unit. There were occasions when Sam did not want her parents informed of incidents, or about information she might have disclosed. On occasions, this was appropriately honoured and on occasions, it was concluded that the risks of not sharing eclipsed her lack of consent. There were occasions when parents challenged the judgement made by clinicians on the basis that not disclosing important information prevented them from providing safe care, inhibited their assessment of risk and compromised their ability to keep Sam safe.

Throughout the time under review what emerged was a picture of parents making an assessment of risk sometimes minute by minute, hour by hour, day by day. It was never

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

122 *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.

123 Peter Fonagy, OBE, FBA, FAcSS, FMedSci. Professor of Contemporary Psychoanalysis and Developmental Science, Head of the Division of Psychology and Language Sciences at University College London, Chief Executive of the Anna Freud Centre.

124 Practitioner Review: Borderline personality disorder in adolescence--recent conceptualization, intervention, and implications for clinical practice Sharp & Fonagy 2015.

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

assumed that Sam was not at risk; risk sensible decisions were at the heart of the care they provided. Parental views are that this was not always fully appreciated and some decisions that were taken compromised their ability to keep Sam safe. The decision not to override Sam's lack of consent to her parents knowing about the prescription she was given at the end of her life, was given as an example of this compromise.

Overriding consent is difficult, sensitive decisions need to be made and capacity to consent must be considered alongside risk. Mental health clinicians are required to comply with the Mental Capacity Act (2005) when making decisions about whether to override consent. These decisions must consider the specific issue in question, the capacity of the patient, and take into account a number of other factors in coming to a decision. It can be a difficult balance to achieve between sharing information and the rights of a young person to confidentiality. The clinician's decision not to override Sam's consent was based on a judgement that on this day Sam had the capacity to make this decision. The potential of alienating Sam from ongoing treatment, by overriding her consent, was also an important consideration in making this difficult judgement.

Sam's history of CSA[126], her long history of mental health difficulties including suicide attempts and acute self-harm[127], the nature of Borderline Personality Disorder[128] and the absence of a suitable care pathway[129] suggested that whilst the risk of suicide was fluctuating and unpredictable, it was a persistent risk. For reasons already discussed, at this point, a situation had been reached whereby this clinician was the only professional providing treatment; there were no other agencies involved in providing services or in safety planning.

Key Learning: It is clear that the psychiatrist was in an isolated position who had to strike a difficult balance when deciding whether or not to override Sam's consent. The psychiatrist was not aware of the medication stored at the pharmacy, there were no arrangements in place between CPFT and local pharmacies in relation to risk and safety planning and it is now understood that not all pharmacists are aware of, or required to follow, relevant guidance[130]. This was the subject of a national Preventing Future Deaths (PFD) report from the Coroner. It has been identified that local protocols will be developed to address this gap. In addition, it is understood that the Clinical Risk Assessment Policy is being rewritten, a new training package was introduced in February 2020 and a new recording system has been introduced to strengthen the recording and storing of risk assessments. It is recommended that as part of the service developments to improve assessment of risk that the paramount principle of

[126] A study by Calder (2010) found participants sexually abused in childhood were more than twice as likely to consider committing suicide in later life. *No one noticed, no one heard*. NSPCC 2013.

[127] When self-injury and other dangerous experiences become unthreatening and mundane – when people work up to the act of death by suicide by getting used to its threat and danger – that is when we might lose them. *Why People Die By Suicide* T. Joiner 2007.

[128] Among people who die by suicide, more than half are likely to have suffered from a diagnosed personality disorder (Cheng et al, 2000) quoted in *Services for people diagnosable with personality disorder*. Royal College of Psychiatrists Position Statement January 2020.

[129] Patients with personality disorder who died by suicide or committed homicide were not receiving care consistent with NICE guidance. *Safer Care for Patients with a Personality Disorder. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. Feb 2018 University of Manchester & Healthcare Quality Improvement Partnership.

[130] https://www.rpharms.com/resources/pharmacy-guides/children-collecting-medicines-from-a-pharmacy

safeguarding children, as set out in the Children Act 1989, is fully considered. This legislation requires no consent to share information to safeguard a child from harm.

5.6 Working together with parents/carers

During the course of this review, an overwhelming picture emerged illustrating the vast amount of time and energy invested by parents in trying to keep their daughters safe. Providing care to children with complex mental health needs and high-risk behaviours can often present immense physical, emotional and financial pressures within families and can be a considerable source of anxiety. Within this context, Sam's parents shared a steadfast commitment to achieving a standard of care, treatment and education they felt the girls needed and they shared a burning desire to defend and protect them.

The response to parents by education staff, social workers, practitioners, clinicians and police was variable. There were examples of staff entering into a respectful partnership with parents where the pivotal role parents played, not just in providing care but also in coordinating care, was understood and facilitated. There were other examples where the relationship with parents was fraught with unnecessary obstacles and disputes. The role they took up in advocating for their daughters, and the understandable frustration they felt when faced with the obstacles they encountered, led to some difficult relationships with professionals.

The learning identified in this SCR about multi-agency service provision had a bearing on how parents were supported to care for Sam and keep her safe. The changes that are needed have been identified, these changes will go a long way to support parents who are caring for children who have significant mental health needs. However, there are a number of other specific issues that need to be considered.

The first relates to how Borderline Personality Disorder can impact on relationships. The consultants who offered a second opinion about Sam's diagnosis at the inpatient unit commented on their observation about the potential for triangulation *where Sam seems to position people in the role of persecutor, herself as the victim and others as rescuers.* Sam was observed as placing her parents in the rescuer role, staff as persecutors and herself as the victim, this led to splitting the network around her. This was considered by the inpatient unit and by the family therapists in CAMHS. However, this important understanding did not appear to be appreciated across the multi-agency network.

There are two other areas that had a significant bearing on parental capacity to keep Sam safe. These relate to the requests made to CPFT by parents for training in safe restraint / safe holding and providing suitable medication at a time of crisis. These requests were supported by a senior clinician at the acute hospital and the CAMHS team leader. The CPFT SI notes that these requests were discussed within the clinical team at the time when it was decided they could not be agreed because of the 'risks involved'. The reasoning behind this decision is not known.

It is understood there is no such training available and no framework in place within which this training could be provided. It is accepted that this is a complex area that requires legal

and safeguarding considerations on a number of levels. However it is important to represent the views of parents that the risks of not providing this posed greater risks to Sam.

There were numerous occasions when Sam was in a dissociative state, was extensively self-harming, violent and/or attempting to end her life by extreme methods. The parents' description of some of these occasions is harrowing. In the absence of training, the only option available to parents was to call the police and the ambulance service. Ambulance crews could not administer tranquilisers unless Sam was restrained. On a number of occasions, Sam was restrained by police officers and the extremity of Sam's crisis required a number of officers needing to use considerable force. For Sam to be the subject of restraint by those unknown to her / in these circumstances was not in her best interests and posed a risk of re-traumatisation. Research conducted by MIND[131] about this type of restraint highlights how humiliating, distressing, and disempowering physical restraint can be. *This can only have a negative impact on recovery; some people told us of long-term psychological impact from an episode of physical restraint*. MIND urges better training on safe restraint so that this can be avoided.

The CPFT Medical Director's report to the coroner does not refer to these specific issues but makes the point that carers should be treated as equal partners when providing services to children. The changes that have been put in place to improve communication and collaboration across CAMHS, and with parents, and the changes proposed to strengthen crisis provision and home treatment will go a long way to demonstrate this. However, these specific issues about training in safe restraint / safe holding and provision of suitable medication at the time of crisis require additional thought. Other areas raised by parents with the author of the CPFT SI report was support in learning about Sam's mental health / her diagnosis of BPD.

Key Learning: The learning identified previously, in relation to the absence of a BPD approach in CAMHS, has a bearing on how the multi-agency network understood the role taken up by parents, and how this impacted on their work together. Referring to the parental requests for training in safe restraint / safe holding and access to suitable medication at times of crisis in this SCR has led to some controversy. These issues are not simple to resolve; it is not being suggested that there are easy answers, and it is not being advocated that adopting these practices is the right approach. It is suggested that a conversation needs to be had, and the question that is being asked of multi-agency services is: Can services be flexible enough to consider how these thorny issues might be holistically approached in a way that places a child's unique needs at heart of decision making? It is recommended that the helpful policy[132] developed by Cambridge University Hospitals NHS Foundation Trust is considered as part of this work.

[131] Physical restraint in mental health crisis care. A briefing for MPs. MIND 2013.

[132] Restrictive intervention and therapeutic holding for children and young people. Cambridge University Hospitals NHS Foundation Trust. February 2020.

Recommendation 8: **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 and support CPFT in raising issues that are of national importance. The learning in this SCR should play a key part in informing these service developments.**

Recommendation 9: **CPSCPB to make representations to relevant national bodies about the need for national compliance with the Royal Pharmaceutical Society guidance concerning children collecting medicines from pharmacies and to raise concerns about the lack of national guidance or standards relating to the appropriate sharing of safety plans with local pharmacies.**

Recommendation 10: **The East Region Mental Health Provider Collaborative, in partnership with Integrated Care Systems multi-agency partners and NHS England, to undertake a review of discharge provision and ongoing support following a period of admission into a Mental Health unit. The review focus is to ensure person centred wrap-around care remains paramount in discharge and post discharge decisions. This review should inform the national review of the service specification for Tier 4 CAMHS services.**

Recommendation 11: **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.**

5.7 Hearing the voice of parents – caring for traumatised children

There were views that parents worked hard to try and come to terms with the far-reaching ramifications for all family members of the CSA and their daughters mental health needs. It was also clear that the relationship between professionals and parents was not always easy.

SCRs frequently refer to the voice of a child and/or parent being absent from service provision. Hearing the voice of a child/parent requires hearing, recording and acting on the spoken word and being curious about what may lie beneath the words to better understand the day to day lived experiences of children, parents and families. Whilst it is clear that parental voices were heard, there was limited appreciation of their lived experiences.

It was 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 ameliorate the suffering of their loved ones. In this case, what was known 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. And in this case, another important component identified by police during the early investigation was that the disclosures made by Chris suggested that Sam was both the victim of sexual abuse and the witness of her sister's abuse. The impact of this abuse was all encompassing, pervading family life and impacting all aspects of inter-familial and intergenerational relationships. The following quote is taken from a note Sam wrote to extended family members and reflects the shroud of secrecy that is synonymous with sexual abuse, and the painful ramifications for children and families:

> *"I'm so sorry I never told you I was struggling. I thought I could fight this, I thought I would be okay, but I guess I was kidding myself. I know how much you care about me, and I didn't want you to worry. You always asked if I was actually happy, you always saw through my fake smile and laugh and I'm sorry for lying to you, just like I lied to the rest of the world. I love you: and that's why I had to lie to you. To keep you happy, I'm so, so sorry."*

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 supports this by identifying the way in which the neuro-biological impact of early abuse affects children resulting in traumatised children developing different neurological patterns to their non-traumatised counterparts[133]. 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. In addition, the intersubjective way in which children make sense of the world means that traumatised children develop 'mirror neuron patterning' that influences their understanding of the intentions of the adults who are caring for them; in effect they may

[133] *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, v9 September 2010, Pages 689-691.

interpret the positive intentions of safe and loving parenting figures as potentially abusive and threatening[134].

> *"Been doing really shit recently. Day after last entry Mum threatened to take me to hospital because I wouldn't eat. She makes it impossible to fast for over 20 hours. It's really horrible because she thinks she is helping me get better but the only thing she has done is stop me losing any weight. She is making everything else worse"[135].*

Research[136] [137] [138] 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, 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 part of family life, often for many years. Traumatised children are frequently described as hyper-vigilant; their parents may also become hyper-vigilant. They may have internalised a belief that, if they let their guard down, disaster is likely to 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[139].

Professionals must work to understand the profound and pervasive impact of abuse on children and the impact on families. Parents/carers therefore need consistent and empathetic support and understanding if they are to meet their children's needs in the short and long-term. Professionals need to help parents hold on to 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 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 the reduction in the sense of isolation that parents of traumatised children may feel.

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

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[134] *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

[135] Quote from Sam's diary shared by parents with permission to include in this SCR.

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

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

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

[139] It is felt important to Sam's parents that is was clear that they did not freeze or take flight – they fought hard.

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.

Recommendations: No specific recommendations are made in this 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.

5.8 Hearing Sam's Voice

On many occasions, it was clear that Sam's wishes about her care and treatment were sought by CS, CAMHS and the inpatient unit. However, questions have been raised about how well Sam's voice was heard during aspects of service provision.

It is important to consider the systemic picture in relation to how Sam's voice was not heard. The issues already detailed about the service response to her needs across a range of domains demonstrated to Sam that her voice was not being heard, and this may have influenced how far she felt able to trust professionals and clinicians to hear her voice and take action to meet her needs.

It is also important to appreciate that on several occasions Sam wanted to end her life and urgent action needed to be taken, against her will, to save her life. In addition, there were occasions when she did not want to accept treatment that would prolong her life and there were times when treatment had to be imposed or actions needed to be taken against her wishes to protect her. Parents felt they had to be mindful that what a suicidal child says she wants is not always what she needs.

There was a view held by some professionals and clinicians that at times the position taken up by parents to advocate for Sam's needs inadvertently resulted in professionals not seeking or hearing Sam's voice. The CS agency report comments on the need for the children's workforce to support children to articulate their perspectives and support them in the appropriate development of autonomy, particularly during adolescence, this is an important observation.

However, it is also important to consider the pervasive impact of CSA, the shroud of secrecy, silence and shame. It is also important to consider the observations made at the inpatient unit by the consultant psychiatrists who identified that a feature of BPD can be to split the network (as previously discussed) and the relevant research[140] that refers to the lack of epistemic trust. The lack of a BPD approach therefore has systemic implications across a range of domains and for all services, including how the relationship between professionals and a child, professionals and parents, and between professionals, are understood. Without this approach, it is not possible to understand how this may have influenced the way in which Sam's voice was heard.

[140] *The relation between epistemic trust and borderline pathology in an adolescent inpatient sample*. W. Orme, L. Bowersox, S. Vanwoerden, P. Fonagy, C. Sharp. National Library of Medicine 2019.

Key Learning: The learning that emerges supports the learning elsewhere in this report about the need to develop a shared practice model across the partnership for adolescents who have significant mental health difficulties which is informed by an understanding of adolescent development and needs. This approach should be underpinned by an understanding of mental health and the impact of a particular diagnosis on how the multi-agency network can support children and families and hear the voice of a child.

Recommendations: No specific recommendations are made in this section. It is expected that the work outlined in Recommendation 3 will include the learning in this section.

Concluding Note: During this SCR the author and panel have read some of Sam's posts on social media and extracts from suicide notes that she wrote during her life. It is clear that Sam was able to express herself in this virtual domain and in these suicide notes. It is a sad reality that the sexual abuse she suffered, and the relentless pain and suffering resulting from this abuse and from her illness, meant that there were few she could trust to hear her voice and therefore the virtual domain and her suicide notes seemed to offer an outlet. It is felt important to end this SCR with some quotes from Sam.

"Mum, Dad, I am so sorry for all the times we've argued. You've always been there for me, always done what you thought was best for me. I love you so much and I know I don't say it anywhere near enough, but I wish I had told you when I had the chance, I love you more than I can put into words." (February 2017)

"Why is something as simple as living, something everyone else does with ease, so fucking hard for me? What did I do to deserve this??? I just want to live, but I can't, and I don't know why." (February 2018)

Glossary

A&E	Accident & Emergency
ABE	Achieving Best Evidence
ACE	Adverse Childhood Experiences
ADCS	Association of Directors of Children's Services
AMBIT	Adaptive Mentalization-Based Integrative Treatment
AMHP	Approved Mental Health Practitioner
BASW	British Association of Social Workers
BPD	Borderline Personality Disorder (also called EUPD)
BTEC	Business & Technology Education Council (now called Edexcel). Vocational qualifications. Levels 1 & 2 are equivalent to GCSEs.
CA	Children Act 1989
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CC	Care Coordinator (CAMHS)
CCG	Clinical Commissioning Group
CETR	Care, Education and Treatment Review
CICA	Criminal Injuries Compensation Authority
CiN	Children in Need are defined in law under Section 17 of the Children Act 1989
CPA	Care Programme 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
DBT	Dialectical Behavioural Therapy
DfE	Department for Education (HMG)
EDS	Eating Disorder Service
EHCP	Education, Health and Care Plan
EHCNA	Education, Health and Care Needs Assessment
EUPD	Emotionally Unstable Personality Disorder (also called BPD)
FT	Family Therapy
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HMG	Her Majesty's Government
IAEP	Individual Alternative Education Plan
IST	Intensive Support Team

ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspections
LA	Local Authority
LSCB	Local Safeguarding Children Board
LSU	Low Secure Unit
MASH	Multi-Agency Safeguarding Hub
MD	Medical Director
MHA	Mental Health Act (1983) / Mental Health Assessment
MIND	Mental health charity in England and Wales
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
PFD	Preventing Future Deaths
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 (Chris)	Serious Case Review for Sam's sister Chris
SEND	(Children with) Special Educational Needs & Disabilities
SENDIASS	Special Educational Needs and Disabilities Information Advice and Support Services
SI	Serious Incident (*report*)
SLT	Senior Leadership Team
SMART	Specific, Measurable, Achievable, Realistic, Timely
START	Statutory Assessment and Resources Team
SW	Social Worker
T3	Tier 3. The term commonly applied to CAMHS community services
T4	Tier 4 NHS funded mental health treatment services (*usually inpatient settings*)
VRI	Video/Visually Recorded Interview