Child Safeguarding Practice Review

Maple

"No one is listening to me."

Surrey Safeguarding Children Partnership

Lead Reviewer: Bridget Griffin

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Executive Summary

Every child or young person who dies by suicide is a precious individual and their deaths represent a devastating loss, leaving a legacy for families that can have an impact on future generations and the wider community. As with all deaths of children and young people, there is a strong need to understand what happened, and why, in every case. We must also ensure that anything that can be learned to prevent future child suicide or young suicide is identified and acted upon.[1]

This Local Child Safeguarding Practice Review (LCSPR) has taken place after the tragic death of Maple, who sadly died from suspected suicide. This LCSPR respects that Maple's preferred gender identification was non-binary therefore, when referring to Maple the pronouns them, their, they, will be used.

Maple and their older brother have received multi-agency services at various points in their lives. Services were provided to Maple's brother and his parents for over ten years to meet his additional needs as a young person with disabilities. Subsequently, multi-agency services responded to concerns about neglect and Maple's emerging mental ill health. Overall, it is clear that multi-agency services attempted to respond to their needs as they arose, and practitioners were tenacious in their attempts to provide Maple with support. Several factors influenced Maple's experiences, and nature of service provision.

The key learning in this report explores the following:

- how Maple's identity was celebrated,
- how multi-agency services understood and responded to neglect - to Maple's emotional troubles, their developing mental ill health and suicidal intent, and
- how families are supported to provide the loving care they aspire to.

Since the time under review, services have adapted and evolved in response to children's needs. This LCSPR has identified a number of areas where multi-agency services need to be strengthened, although recognises that there are limits to the changes that can be made by local multi-agency services. As identified in recent national reports, there are national changes that are needed.

[1] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021.

Introduction

A decision was reached by Surrey Safeguarding Children Partnership (SSCP) that a Local Child Safeguarding Practice Review (LCSPR) should commence after being notified of Maple's sad death. It is understood that Maple died as a result of suicide, although this is still a matter for the coroner to decide. Given the issues raised in this review it was considered important to share the contents pending that decision.

Methodology

This LCSPR has complied with relevant guidance[2]; relevant information has been supplied by agencies involved in providing services to Maple and their family; a panel of agency representatives, who had no direct involvement in the services provided, has met on several occasions, the perspectives of practitioners has been gained and an independent lead reviewer has authored this report.[3] Family members, including mother, father and Maple's adult sister have been approached to share their perspectives. Regretfully, family members have not felt able to share their views - they continue to live with indescribable grief. The name Maple is a pseudonym, other pseudonyms are used when referring to family members.

At the start, SSCP agreed the terms of reference for this LCSPR. Specific questions about the services provided are addressed in the relevant findings. The following broad areas, identified by SSCP, have framed this LCSPR:

- **We are interested as a multi-agency system to learn what needs to be done to improve the way all agencies work together to safeguard children who are at risk of self-harm and suicide.**
- **What practice improvements need to be made to ensure effective intervention for children and young people with similar presenting needs and risks.**

Current guidance stresses the need for proportionality, discourages a detailed narrative of events and emphasises a focus on the learning. SSCP were mindful of this new guidance and were aware that there have been considerable changes in pertinent areas of multi-agency practice since Maple's sad death. The approach taken in this review aims to reflect relevant LCSPR guidance and focus on areas where multi-agency services still need to be strengthened. Therefore, there will not be a detailed analysis of all events, only those events directly relevant to the key findings will be presented.

Scope

The scope of this LCSPR covers a period of two years and eight months during which time Maple was aged between thirteen and fifteen. Agencies were asked to consider significant events prior to this timeline.

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

[3] Bridget Griffin CQSW, BA,MA. Bridget specialises in LCSPRs involving children who die from suicide.

The voice of the child

Maple's voice is reflected in this LCSPR, this has been made possible because, to the credit of multi-agency services in Surrey, trusted relationships were formed with Maple and their words were often recorded in agency records.

Maple

Maple was a gender non-conforming child of white British heritage. They adopted the name 'Maple' during adolescence, this was their preferred name, their preferred pronouns were - them, their, they. Maple lived at home with their birth parents and brother who has additional needs. Maple had a close relationship with their older sister ("Steph") who is an adult. Steph did not live in the family home. Maple attended a local secondary school where they had several friends. They said their favourite subject was Maths and that they really liked Geography and drama club. They liked playing Minecraft with friends and socialising with them. In their death note, Maple spoke about how much they loved their parents, sister, brother, friends and their cat 'Tiggy'. Towards the end of their life, Maple said they had plans to go to college and travel to Italy and California. Maple was an articulate and astute young person who engaged well with the various clinicians/practitioners and staff members at their school. Maple suffered with emotional troubles that escalated during adolescence, they were noted to have *feelings of shallowness inside.*[4] Maple self-harmed for a number of years, they expressed suicidal ideation and made three attempts to end their life during their teenage years. Maple sadly died from traumatic injuries as a result of suspected suicide.

Summary of Multi-Agency Involvement

There have been various multi-agency services involved in the life of Maple's family for several years. The focus of this early intervention was on providing services to Maple's older brother who had additional needs and multi-agency services were provided. Maple was twelve when their needs came into view after their GP referred to CAMHS as a result of Maple's low mood and self-harm. Over the following two years Maple spoke about their unhappiness to trusted members of staff at school and on occasions they were noted to self -harm. During these early years, referrals were made to emotional wellbeing services.

Maple was fourteen when they took a significant overdose, they were admitted to hospital and multi-agency services became involved at this time. An assessment by children's services resulted in Maple and their brother being made subject to a child protection plan for neglect. Various multi-agency community services were involved. Maple made two further attempts to take their life which resulted in additional services being provided. Maple and their brother continued to be the subject of child protection plans for neglect. Maple was fifteen when they died.

[4] Reported in records held within Surrey Child and Adolescent Mental Health Service (CAMHS)

Finding One: Celebrating difference and building belonging

Maple said they would love to live in the world after an apocalypse, meet someone, be nonbinary, be called Maple and wear tech-wear clothes.[5]

During the involvement of multi-agency services with Maple, Maple made occasional references to being non-binary. Non-binary people can feel that their gender identity and gender experience involves being both a man and a woman, or that it is fluid, in between, or completely outside of that binary.

Learning from lived experiences – Stonewall.

"In order to understand non-binary gender identities better, it's vital to understand the difference between gender identity and gender expression. Gender identity refers to a person's clear sense of their own gender. This is not something which is governed by a person's physical attributes. Gender expression is how you express yourself and just like everyone else, non-binary people have all sorts of ways to express themselves and their identity. They can present as masculine, feminine or in another way and this can change over time, but none of these expressions make their identity any less valid or worthy of respect".[6]

Analysis of service involvement

The first indication of Maple's preferred gender expression was recorded in school records when Maple was fourteen years old. Maple spoke to a member of school staff about their lived experiences at home and referred to the *unhappiness* they felt and that *their sexuality was not being taken seriously.* The opportunity to hold this in mind, explore what this meant for Maple and the implications on their day to day lived experiences was not taken up. It is unclear whether this was discussed with parents. Further opportunities to explore this with Maple arose in their school life and when multi-agency services were involved. On these occasions Maple referred to being non-binary but there was little seen to show how this was explored with Maple or how they were supported with their gender expression/identity. The exceptions to this were whilst Maple was an inpatient in the general hospital and when they were seen by a CAMHS clinician in the last month of their life.

In the general hospital environment, it was clear that Maple felt safe to talk about their identity and when they were admitted for a second time, staff had remembered Maple's preferred gender expression and preferred use of pronouns – it was evident how important this was to Maple. The CAMHS clinician promptly identified the importance of Maple's gender expression and gently explored this with them – it was at this time that Maple spoke about their wishes for the future (quoted above).

There was an array of practitioners and services involved in Maple's life but aside from the exceptions above, little was documented in agency records or assessments to show how the

[5] Practitioner reporting on a discussion with Maple.

[6] https://www.stonewall.org.uk/about-us/news/10-ways-step-ally-non-binary-people

importance of Maple's gender expression/ identity was explored or understood. It is important to note that CSC were not informed of Maple's preferred gender expression, there were no records seen to suggest that Maple did not give consent to this being shared.

Learning from research

As identified by organisations such as Young Minds[7] and Stonewall[8] some people who have chosen to identify with a gender identity that is not similar to the people around them, may experience bullying, hostility or discrimination and many can carry daily fears about; hiding their identity, feeling scared to share their preferred identity, frequently worry about their appearance, feel like they have to act a certain way and be someone they are not. Having these experiences, particularly if they are on a regular basis, can be extremely distressing and overwhelming. They might start avoiding places or making conscious decisions about everyday things that others don't need to think about.

"Constantly carrying these emotions and making these decisions can be exhausting, and they may find it makes everyday tasks like eating, concentrating at school/work, engaging in conversation, or getting good sleep very difficult. They may also find it leads to feelings of distress, anxiety, isolation, anger, depression, wanting to hurt themselves, or suicidal thoughts."[9]

This time in Maple's life was particularly important. Relevant research and literature about adolescent development describes the formation of personality during this time. Critical components of this include identity formation and a search to belong. Maple was a young teenager, whose sense of identity was forming. Like their peers, exploring who they were and where they belonged was a key part of their day-to-day life. As highlighted in the relevant research quoted above, when adolescents are exploring their gender identity and finding few places to safely explore this, the worst outcome is if this is met with silence at a critical time in their life. Relevant LCSPRs[10] and the thematic report from the National Child Mortality Data base[11] is a salutary reminder of the importance of this issue.

Learning from practitioners and panel members

During the learning event practitioners were open in saying that they found talking with young people about their gender identity challenging. They felt there is an assumption that practitioners working with children and young people have the appropriate knowledge and understanding and that organisations have not yet fully embedded an inclusive culture that nurtures discussions about gender expression/identity. The lead reviewer, several practitioners and panel members acknowledged that they too struggled with fully

[7] https://www.youngminds.org.uk/young-person/coping-with-life/gender-and-mental-health/
[8] https://www.stonewall.org.uk/about-us/news/being-non-binary-uk-today
[9] https://www.youngminds.org.uk/young-person/coping-with-life/gender-and-mental-health/
[10] . Such as: *Thematic child safeguarding practice review – child and adolescent mental health (Young Person H and others).* Ealing Safeguarding Children Partnership 2022
[11] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021

Learning from practitioners and panel members (continued)

appreciating the challenges that people from the LGBTQIA+[12] community face and that they worried about getting the terminology right and feared getting it wrong. As identified by organisations such as Young Minds and Stonewall, the worst result of these dilemmas is silence.

What has changed?

It is understood that inclusion is a priority in Surrey and there are some promising recent service developments:

- In July 2022 an inclusion conference took place entitled 'Meeting the Needs of LGBT Children & Young People' which was designed to *support schools in developing effective practice to promote equality and inclusion within safe, supportive and thriving school environments.*
- 'Ally and Supporter' sessions have been established predominantly aimed at parents and carers of LGBTQ+ young people and young adults aiming to provide a safe, welcoming and judgement free space for them to explore their journey whilst providing tools and knowledge to support a LGBTQ+ person.
- A local charity[13] offers support to LGBTQ+ young people and specialist practitioners have delivered workshops for local practitioners focussed on raising awareness and sharing information about the support services available through this charity. Further workshops are planned to be an open event that will include parents.

These are promising steps in nurturing inclusive organisational cultures. In order to build on these developments, the following recommendation is made.

Recommendation 1- Celebrating difference and building belonging.

Ensure gender identity is a key strand of equality action planning across all agencies. This should include reflecting the needs of LGBTQ+ in multi-agency strategies, policies, practice guidance, training and commissioning arrangements and service provision, and raising awareness in the children's workforce and in the community.

[12] LGBTQIA+ is an abbreviation for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more. These terms are used to describe a person's sexual orientation or gender identity.

[13] https://eikon.org.uk/our-services/lgbt/

Finding Two: Responding to neglect and cumulative harm

"I do not feel safe at home.
Nothing ever changes."
Maple

Chronology of events

Maple was twelve when they visited their GP on the first occasion and spoke about low mood and self-harm. On this occasion, and on a number of occasions thereafter, the GP referred to CAMHS. Maple was referred to a community emotional wellbeing service,[14] the service sent a letter to the family home inviting engagement. No response was received therefore the service closed their involvement.

Maple was thirteen when school staff noticed that Maple was self-harming and reported this to their father. Ten months later, when Maple was fourteen, they told a trusted adult at school that they felt unsafe at home. They spoke about a lack of food in the home, of being unhappy, that their parents were drinking alcohol and arguing, and said their sexuality was not being taken seriously at home. Parents were spoken to by the school. Subsequently, Maple was seen by their GP and spoke about their low mood and self-harm. The GP referred to CAMHS. Another community mental health resource was identified. There was some delay in this service making contact with the family due to a high number of referrals being processed at time although multiple attempts were subsequently made. After no response was received, the service closed their involvement.

In December 2020, self-harm marks were noted on Maple's arm by their school, this was discussed with parents. Two months later, Maple took a significant overdose of medication and was taken to hospital. They told clinicians they had taken an overdose of medication eighteen months previously but had not sought medical treatment.[15] They spoke about self-harming for the past two years. It was noted that Maple's mother had mental health difficulties and a previous suicide attempt. A referral was made to C-SPA/MAP[16] and an investigation under Sc47 (Children's Act 1989)[17] commenced. The assessment that was completed by Children's Social Care (CSC) resulted in Maple and their brother being the subject of child protection plans under the category of neglect. Child protection plans were put in place which took account of Maple's self-harm, the home conditions and parental alcohol misuse.

In June 2021, Maple took a significant overdose of their father's medication. Safety plans were reviewed and outreach mental health services were provided by a community

[14] CAMHS and the community emotional wellbeing service are part of Mindworks Surrey
[15] The timing of which fitted with their disclosures at school about their unhappiness at home.
[16] C-SPA/MAP is the Children's Single Point of Access and consists of two service areas – the multi-agency partnership (MAP) and the Early Help Hubs. The MAP is a multi-agency team responsible for safeguarding children in the Surrey area – they collectively perform a triage function in order to identify the most appropriate level of support required. Children whose needs require statutory assessment under the Children Act 1989 will be transferred to the Quadrant Assessment Teams for further intervention.
[17] A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

organisation. One month later, Maple called police from a bridge over a busy road and said they intended to jump. They spoke about feeling unsafe at home and their parents were equally concerned about keeping Maple safe. Services were provided by children's services, a CAMHS psychiatrist, school, and the outreach mental health services. Two months later, in September 2021, Maple sadly died.

Analysis of service involvement

Maple and their brother were made the subject of a child protection plan for neglect two years and seven months after Maple's initial presentation to the GP when they were twelve. When Maple presented to their GP, attempts were made to refer Maple to mental health services. There were prompt and appropriate responses to Maple's presenting needs, but this did not result in Maple accessing the services they needed.

Maple's lived experiences

Maple later spoke about a home environment that was chaotic, they said their parents consumed large quantities of alcohol, that piles of letters were left unopened and of being unable to find letters they needed for school. This was not known to the GP, to school or community mental health services at the time.

It was clear that Maple had found trusted adults at school with whom they could share their feelings/ their lived experiences – providing safe places and safe adults to children in schools is good practice. On these occasions, the designated safeguarding leads were informed, and parents were spoken to. However, there was no recording found about whether the full extent of the concerns was raised with parents or how the concerns were followed up with parents or with Maple and there appeared to be little consideration of a referral to Children's Social Care (CSC) or to mental health services.[18]

Maple's lived experiences

Maple spoke about their parents consuming alcohol every night and of frequent shouting and of arguments at home. They spoke about parents not remembering anything the next day – not recalling what was said or what arguments happened. They spoke about feeling unsafe at home and being unhappy.

When Maple was admitted to hospital after a significant overdose, a referral was made to Children's Services (CSs) and a prompt assessment was completed that resulted in Maple being made the subject of a child protection plan for neglect. This was a swift and appropriate response by CSs. The Graded Care Profile (GCP2)[19] was used to inform this work

[18] These issues have been followed up with the school and several actions have been taken with support of the Local Authority to strengthen practice and procedure.

[19] GCP2 is an assessment tool to help identify and measure risk of neglect https://learning.nspcc.org.uk/services-childrenfamilies/scale-up/graded-care-profile-2-gcp2 .

and resulted in a good assessment of the needs of both Maple and their brother – this was good practice.

The lived experiences of Maple's older sister (Steph)

Steph later spoke to professionals about her childhood experiences, she said that Maple's experiences of neglect mirrored her own, she spoke about the emotional consequences of these experiences on her as a child and as an adult. Steph receives support from adult mental health services.

The child protection case conferences and safety plans clearly articulated the concerns and set plans in motion to achieve the changes that were needed. The full multi-agency group were not engaged with these child protection meetings and plans – this is discussed in finding three. Maple and their parents were present at the case conferences and actively contributed to the plans, the engagement that was achieved was good practice. Over the following weeks and months, significant changes were made to the home environment to create a more ordered, pleasant home environment and Maple's parents accessed appropriate substance misuse services. Maple's Mother quickly reduced her alcohol intake and overtime achieved sobriety. Maple's Father was slower in his response, but he too engaged with substance misuse services and gradually reduced his alcohol intake.

Maple's lived world

Maple was clear that the changes their parents were making were positive, they felt *hopeful but hesitant* about the future. Prior to this point they had repeatedly said: *nothing ever changes.* After a short while of being at home, despite the evidence suggesting that things had changed, they said again – *nothing ever changes,* and - *I do not feel safe at home.*

By this point there were various multi-agency services involved in family life including the active involvement of: a community outreach mental health team, adult substance misuse services, a social worker, a CAMHS psychiatrist, and school staff which included a school counsellor. The social worker and community outreach team visited the family home and made attempts to understand and respond to the needs in the family. However, no specific services were provided to the family as a whole. Maple was waiting to see a CAMHS clinician and family therapy had not been offered. The impact of childhood adversity, including the impact of cumulative neglect, is complex and far reaching. On the surface things had changed but from Maple's perspective nothing had changed. Understanding the impact of trauma on children and care giver(s) is critical. Finding Five explores why this is so important.

The terms of reference for this review asked the following relevant question:

What sense does this multi-agency system make of adverse childhood experiences including cumulative harm and neglect in safeguarding children and young people who are at risk of self-harm and suicide?

Maple's experiences suggest that the multi-agency system struggled to make sense of their experiences at an early point. Once the neglect was identified, and active multi-agency services were provided, the system responded to this neglect but seemed to grapple with providing a response to Maple that changed their lived experiences/ their perceptions of life. A thematic report[20] exploring themes emerging from thirteen case reviews about suicide in Surrey (between 2016 and 2020) highlighted that recognising and providing a timely response to neglect was imperative to reduce significant harm. The report highlights how professionals can find it challenging to evidence significant harm as a result of neglect. More recently, Ofsted identified that a more consistent response to neglect was needed. [21]

However, as identified in relevant research and national reports, many of the issues are not confined to the local area. It is recognised that neglect is a complex safeguarding issue to identify, assess and respond to, in time for the child.

Learning from research and national reports

"We observed that professionals and parents can sometimes view the presenting issues older children face as the problem: this was often an unconscious assumption. When a child's presenting issues become the sole problem, professionals do not always consider their behaviour in the context of the impact of neglect on the child and they can fail to take action with parents regarding any ongoing neglect".[22]

Research suggests that physical and visible aspects of neglect are the ones most often identified by professionals. The appearance of home conditions, a failure to address a child's medical needs or delays in physical development are common ways of identifying neglect. These can be easier to identify than other forms of neglect a child may experience, such as emotional neglect".[23]

In addition, it is important to hold in mind that …it is not that… *neglect is impossible to define, but that it cannot be defined in absolute terms. Like other forms of child maltreatment, neglect needs to be interpreted in context.*[24] For Maple, this concept was important.

Learning from practitioners and panel members

Panel members and practitioners spoke about this being a 'middle-class family' who lived in what appeared to be relative affluence. They spoke about articulate parents who were able to engage well and negotiate with services. General concern was raised about how economic status, material wealth and access to resources, including knowledge and power

[20] https://www.surreyscp.org.uk/wp-content/uploads/2020/09/SSCP-Thematic-Review-Surrey-SCRs-and-Case-Reviews2020-Final.pdf
[21] *Inspection of Surrey local authority children's services.* Inspection dates: 17 to 28 January 2022. Ofsted HMG
[22] *Growing up neglected: a multi-agency response to older children.* Joint Targeted Area Inspection. Ofsted 2018
[23] *Missed opportunities: indicators of neglect – what is ignored, why, and what can be done?* Brandon M et al. Department for Education; 2014; www.gov.uk/government/publications/indicators-ofneglect-missed-opportunities. [24] *Child Protection and Introduction.* Beckett 2007.

Learning from practitioners and panel members (continued)

in society, can influence professional perceptions about family life and may lead to an unconscious bias that can mask safeguarding concerns. "There were indications of neglect over time - parents presented as caring and eloquent – did this skew attention away from Maple's lived experiences/from the neglect they were experiencing at home?"[24] .

This is recognised as a practice issue that requires attention. As identified by Professor Claudia Bernard in a webinar available on the Surrey Safeguarding Children Partnership website:[25] "Affluence can mask neglect……there may be an unspoken assumption that neglect per se does not happen in affluent families – material wealth can be a distraction/ a barrier to articulating concerns".

What would happen now?

"Where there is a coordinated strategic approach across agencies to support a shared understanding of the needs of neglected older children, we observed a significant difference to the quality of practice and experiences of older children suffering neglect."[26]

The Ofsted inspection in January 2022 has led to a renewed focus on neglect in Surrey. SSCP have produced a revised multi-agency neglect strategy[27] that articulates a three-year plan with an ambition to improve how neglect is understood, identified, and addressed. SSCP are well aware that in order to identify and respond to neglect in time for a child, practitioners must be supported in using an evidence-based assessment tool. The preferred tool in place nationally, and in Surrey, is the Graded Care Profile 2 (GCP2). When this was used to inform the practice in this case, it resulted in a good assessment and a timely response. Social media platforms have recently been used to raise awareness of neglect and training has been revamped and rolled out to the multiagency workforce, including the webinars (mentioned above) that are available on the SSCP website to support practitioners in understanding neglect and using GCP2.

These are all promising developments. However, in learning from the experiences of Maple and other children like them, the issue that appears to require more focus locally and nationally in strategies, policies, procedures, and practice guidance is a greater recognition of how childhood neglect may contribute to mental ill health. The JTAI[28] mentioned previously, is focussed on how neglect may lead to risks of sexual and/or criminal exploitation and there is relevant local and national procedure and guidance to support services in responding to these risks.[29] However, there does not appear to be an equal

[24] LCSPR Panel member.

[25] *Exploring how to engage with neglectful parents from affluent backgrounds in the CP system.* Professor Claudia Bernard SSCP Webinar June 2021.

[26] *Growing up neglected: a multi-agency response to older children.* Joint Area Targeted Inspection. Ofsted 2018

[27] *Neglect Strategy 2021-2023*. Surrey Safeguarding Children Partnership

[28] *Growing up neglected: a multi-agency response to older children.* Joint Area Targeted Inspection. Ofsted 2018

[29] Such as: *Surrey Child Protection Procedures.* Surrey Safeguarding Children Partnership. *Child Exploitation Assessment Tool – Guidance Notes* Surrey Safeguarding Children Partnership 2021. *Child sexual exploitation Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation.* HMG 2017. *Tackling child exploitation: resources pack.* Local Government Association 2017

emphasis on providing a multi-agency response to children at risk as a result of their mental ill health.

It was felt important to strengthen the understanding of how a child's behaviour is seen as form of communication about their internal world and to consider the part played by neglect in a child's developing emotional world and how this may manifest in adolescence.

Recommendation 2- Responding to neglect and cumulative harm.

Surrey Safeguarding Children Partnership Neglect Subgroup to review this LCSPR and consider what more may be needed to strengthen early identification and responses to neglect, and multi-agency responses to children with mental ill health who may have experienced neglect. SSCP Neglect Strategy to be reviewed in light of the findings of this LCSPR.

Finding Three: Multi-agency responses to children with mental ill health

"No one is listening to me – nothing ever changes."

Maple

Chronology of events

Multi-agency involvement commenced two years and seven months after Maple's initial presentation to their GP (when they were twelve) and continued for just over six months until Maple died.

Children's Services responded promptly and appropriately to the referral that was made by the general hospital when concerns were raised about Maple's first suicide attempt. Maple stayed in the general hospital for several days. During this time, they were assessed by the CAMHS Crisis Intervention Team. The RCADS[30] that was completed identified that Maple had social phobia, major depressive episode, generalised anxiety, and panic disorder. Maple, the nurses and clinicians, mental health services, children's services, Maple's parents, and their older sister were involved in safety planning. Maple was discharged to live with their sister. After considerable changes were made by parents, in line with the child protection plans, Maple returned home. Over the following period, there was active involvement by the CAMHS Crisis Team, the school, and children's services when safety plans were reviewed.

Approximately three months later (in late June) Maple was admitted to the children's ward at the general hospital after taking an overdose of their father's medication. The risk of a further suicide attempt was assessed as high. During Maple's eight day stay at the hospital, safety planning took place, clinical treatment was discussed, an intensive community outreach mental health service was involved, and school identified a counsellor to meet with Maple at school. Over the following period, children's services and the community mental health outreach team visited Maple at home to provide intensive support, core groups took place and safety plans were reviewed. Maple engaged with their school counsellor who noted that Maple had frequent plans to end their life and that Maple *doesn't feel safe and doesn't trust they will not do it again.*

Maple's parents were worried that they could not keep Maple safe and were concerned about the lack of therapeutic treatment provided by CAMHS. Representatives from school and children's services were vocal about the lack of clinical treatment and the lack of active involvement by community CAMHS with the multi-agency group.[30] At the end of July, approximately one month after Maple's previous suicide attempt, they called the police from a bridge over a busy road stating their intention to jump. Police promptly attended and secured their safety - Maple said they felt unsafe at home. Maple was admitted to an acute ward at the general hospital and a mental health assessment (MHA) was completed. During

[30] It has been clarified that as the community outreach service were part of Mindworks (which includes CAMHS) their active involvement represented community CAMHS involvement. This illustrates the lack of understanding about Mindworks by partner agencies during this time.

this time professionals discussed Maple's possible admission to an in-patient mental health unit. Some professionals, including Maple's social worker, felt Maple needed to be admitted and the social worker strongly advocated for this course of action to be taken. The MHA concluded that inpatient care was not warranted. Safety plans were reviewed by the multi-agency team and with Maple and their parents. Adjustments were made to the services provided in line with these plans and Maple returned home.

A period of relative stability followed when Maple was noted to be engaged in social and recreational activities and they spoke positively about their future plans. At the start of September, Maple attended their first appointment with a clinical psychologist in community CAMHS and thereafter regularly attended the appointments offered. At their last appointment, at the end of September, they spoke positively about their plans to attend college and travel abroad. A few days later, Maple took their life.

Maple's lived world

Maple left a death note and spoke about their love of their family, friends and pets. They thanked their friends for honouring their non-binary identity. They also spoke about feelings of failure.

"*….I was enthusiastic to answer your questions … I feigned a future for myself so everyone believed I was hopeful and thought I would live that far ……In reality I knew I would never live …..What is the point of prolonging a truly unhappy existence."*

Analysis of service involvement

As Maple's mental health needs emerged, Maple was supported by their GP and members of school staff. There was no multi-agency working to prevent Maple's emotional troubles becoming significant mental health difficulties. Sometime later, at a time of crisis after Maple's first suicide attempt, there were a range of clinicians, nurses, social workers, and members of school staff involved in providing services to Maple and their parents. Practitioners from across the services demonstrated care and commitment to Maple and their family. However, there were occasions when providing an integrated multi-agency approach was challenging.

Early intervention

The importance of identifying and responding to neglect has been discussed in the previous section and the work that is happening to strengthen this area of safeguarding work is critical in supporting children to access the emotional wellbeing services that are available in Surrey. In Surrey, emotional wellbeing/ mental health services are provided through Mindworks Surrey[31] which involves an alliance of organisations working together to deliver the new emotional wellbeing and mental health service for children and young people. When a referral is received, the referral is triaged and passed to the most appropriate

[31] Emotional wellbeing and mental health services for children and young people, including the CAMHS service. Https://www.mindworks-surrey.org

service. During the time under review, Mindworks was a relatively new service offer, and the alliance of services were at an early point of transition. The first community mental health service that were involved have reported that they were not the right service to meet Maple's needs, which were at a threshold higher than they could meet, they said they were not provided with enough information to conclude this when the referral was received. It is understood that the alliance of services under Mindworks has now been embedded and better sharing of contextual information within Mindworks has resolved this issue. Practitioners and panel members spoke about the need for better communication with the network by Mindworks and confusion about the service offer – this is discussed later.

Information sharing and communication.

When multi agency services became involved, information sharing and communication took place although there were gaps in a number of important areas including sharing safety plans with the GP, involving the full multi-agency network (such as police, the acute hospital, Maple's GP, school nurses and adult services) and sharing information with the school[32] about Maple's reports of being bullied at school. Of particular note was the absence of joint planning and decision making in child protection case conferences and core groups. CAMHS/mental health and adult substance misuse services were invited to attend these important meetings but did not attend, this was raised as a concern by children's social care at the time but resulted in little change.[33] CAMHS/mental health services reported that they did not receive copies of the case conference and core group minutes, or the child protection plans. The Rapid Review[34] identified that it was vitally important that this crucial area of joint working across children's services, adult services and CAMHS, is resolved.

Working together at times of crisis and resolving professional differences

There were a number of occasions when there were differences of opinion about the care and treatment Maple received. It is not unusual for there to be such differences especially when working with children who are at high risk in a multi-agency system that is facing considerable demands. These differences of opinion were focussed on some key areas. Firstly, there were concerns expressed by children's social care, school staff, parents, and Maple about the amount of time Maple had to wait for therapy to be provided by CAMHS. The view of CAMHS was that the risks to Maple had to be stabilised before this could be provided. This approach is often regarded as accepted practice to the provision of therapy as the therapeutic process may heighten risks if a child is living in an unsafe environment and/or is actively engaged in high-risk behaviours including self - harm. However, this is not a universal approach to the provision of treatment as pragmatic ways forward frequently have to be found in these circumstances. The other important national issue is the availability of specialist clinicians to provide therapy: *Some children have to wait too long for*

[32] Records show that Maple spoke about bullying to mental health practitioners - School have no records of this being reported to them.

[33] This was not appropriately escalated at the time. The effective escalation of concerns is a learning point for CSC which has been acknowledged and is being addressed.

[34] After notification of a significant safeguarding incident, local safeguarding children's partnerships may decide to convene a Rapid Review (RR). The core functions of a RR are to; gather the facts about the case, as far as they can be readily established at the time, discuss whether there is any immediate action needed to ensure children's safety, share any learning appropriately and decide whether the criteria for a LCSPR is met.

their mental health needs to be identified and to access a specialist service.[35] CAMHS services have been under considerable demand and these demands are growing.[36]

A further area of professional difference surrounded the question of whether Maple should receive treatment in an in-patient unit. Children's social care, school and parents questioned the conclusion of the mental health assessment, and the views of mental health practitioners, that inpatient care was not in Maple's best interests and was not warranted. On occasions, mental health practitioners questioned whether Maple should remain at home and whether an alternative 'placement' should be considered. The view of children's social care was this option was not in Maple's best interests and was not warranted. These different positions were reliably informed by research.

Learning from research

Increasing numbers of children are coming into care late and the outcomes are generally poor[37]. "Although use of S20/S31[38] 'can create some short-term physical safety, and give agencies a sense of false relief, this is often short lived and can be to the detriment of the child's relationships and psychological well-being".[39]

"The lived experience of mental ill-health and admission to hospital pose risks to young people's psychosocial development, their educational achievement, and family and peer relations."[40] ……. longitudinal datasets suggest that admission to hospital does not reduce the risk of suicide, and multiple admissions to manage suicide risk is associated with an increased risk."[42]

Many of these issues are national issues. The question that arises is how the multi-agency system can respond in these circumstances - there are no quick fixes or easy answers.

Learning from practitioners and panel members

Practitioners at the learning event said that an important aspect of providing services to all children with emerging mental ill health is the need to provide a prompt multi-agency

[35] '*Feeling heard': partner agencies working together to make a difference for children with mental ill health*. Joint Targeted Area Inspection December 2020

[36] *Growing problems, in depth: The impact of Covid-19 on health care for children and young people in England*. Nuffield Trust February 2022

[37] *The care files: Exploring the experiences of teenagers entering the care system*. The Nuffield Family Justice Observatory 2022.

[38] Section 20 (S20) of the Children's Act is a voluntary care arrangement based on agreement between, the person or people with Parental Responsibility, the child and the local authority. Section 31 (S31) of the Children's Act is a court order placing the child in the care of a designated local authority, with parental responsibility being shared between the parents and the local authority.

[39] Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding. Firmin C, Horan J, Holmes D and Hopper G. Research in Practice Dartington 2019

[40] *What do we know about the risks for young people moving into, through and out of inpatient mental health care?* Findings from an evidence synthesis. Deborah Edwards, Nicola Evans, Elizabeth Gillen, Mirella Longo, Steven Pryjmachuk, Gemma Trainor, and Ben Hannigan 2015 : https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689041/ [42] https://www.cambridge.org/core/journals/bjpsych-open/article/interventions-to-reduce-selfharm-on-inpatient-wardssystematic-review

Learning from practitioners and panel members (continued)

response. For Maple, this included the need to communicate with the referrer, in this case the GP, about whether community mental health services have been taken up, for schools to keep a watchful eye on children who are self-harming and take proactive steps to encourage and promote access to the services that are available and make prompt referrals where needed. Practitioners spoke about their confusion about the child and adolescent mental health services on offer in Surrey and were concerned that children and families are also confused. Of greatest importance to the practitioners was the need to provide a holistic response to children with mental ill health and for a reflective space to be available for multi-agency practitioners; to raise and resolve professional differences, *engage in a dialogue rather than just communication,* be curious about the services being provided and determine the best response. It was said that this is frequently raised by practitioners and in local LCSPRs.

Learning from research

Relevant research, inspections and LCSPRs, have identified the importance of multi-agency working with children who have mental ill health. However, it has been identified that this multi-agency working is not in place across the country for these children. "CDOPs[41] highlighted challenges with joint working and information sharing between agencies that have contact with children and young people with mental health issues. The lack of joined up working and poor information sharing limited meaningful multi-agency dialogue."[42]

Conclusion – multi-agency working.

These dilemmas have been identified in relevant LCSPRs[43] and remain a challenge to current multi-agency working. Supporting front line practitioners in working in situations where there are no easy answers requires organisations to find ways of creating a culture of mutual respect and respectful challenge in a fallible system. Supporting this culture through a shared multi -agency practice model is suggested to be a helpful way forward. "Children's mental ill health cannot be addressed by any one agency working in isolation. Partners need to come together at a strategic level, alongside those who use the service, and develop a joined-up and coherent approach and ensure that services are delivered in an integrated way at the frontline."[44]

While there is plenty of research and guidance about the need to provide a coherent multi-agency response to children and families in these circumstances, there is no established

[41] Child Death Overview Panels are established in local areas across the country and have a statutory responsibility for reviewing information on all child deaths, looking for possible patterns and potential improvements in services, with the aim of preventing future deaths.

[42] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021

[43] https://learning.nspcc.org.uk/case-reviews/national-case-review-repository

[44] *Feeling heard': partner agencies working together to make a difference for children with mental ill health*. Joint Targeted Area Inspection December 2020

national approach or framework that supports this multi-agency work. 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. Multi-agency service provision and associated guidance[45] has not focussed on children who have significant mental health needs, despite the high risk of harm. The recent JTAI inspection,[46] reviewing services provided to children with mental ill health, identified that multi-agency collaborative work *can be really effective when professionals work to a shared practice model* and that local partnerships have an important part to play in developing this work.

What would happen now?

Relevant service changes include the following:

- A joint meeting now takes place involving Children's Social Care and representatives from relevant health services to identify children with mental ill health who are at risk in order to plan interventions/identify appropriate services.
- Training has been made available for practitioners to enable a better understanding of Mindworks and an out of hours advice line for parents is established.[47]
- The importance of effective use of the escalation policy has been emphasised with child protection conference chairs and managers to resolve issues about multi-agency engagement.

Recommendation 3- Multi-agency responses to children with mental ill health

Surrey Safeguarding Children Partnership to lead on developing a shared multi-agency framework/practice model to guide multi-agency work with children with mental ill health. This model should include guidance on Mindworks, the inclusion of adult services, multi-agency forums to provide reflective supervision,[48] and the importance of engaging and supporting families.

[45] Working Together to Safeguard Children 2018 HMG.

[46] '*Feeling heard': partner agencies working together to make a difference for children with mental ill health*. Joint Targeted Area Inspection December 2020

[47] Mindowrks-surrey.org

[48] See: Joint Area Group Supervision (JAGS) model developed by Norfolk Safeguarding Children Partnership https://www.norfolklscb.org/?s=JAGS

Finding Four: Understanding the risk of suicide and responding

"When I am feeling down, people say 'smile, you will be ok'. I want a shelter I can go to if I need to."

Maple

The terms of reference for this LCSPR posed the following relevant questions: How were the risks identified in the National Child Mortality database report (published in October 2021, on suicide in children and young people) identified and understood in this case? How did multi-agency plans to safeguard Maple take these factors into consideration and what was done to mitigate their impact?

Learning from research- NCMD[49]

Of the 91 children who died from suicide between April 2019 – March 2020 common background factors were identified.[50] Maple's experiences suggests that the following factors were present in their life:

- Household functioning 63 (69%)
- Mental health needs of the child/ young person 50 (55%)
- Risk taking behaviours 45 (49%)
- Conflict within key relationships 41 (45%)
- Problems with service provision 32 (35%)
- Abuse and neglect 29 (32%)
- Bullying 21 (23%)
- Sexual orientation, sexual identity, and gender identity 8 (9%)

This report was not available at the time Maple was in receipt of services. Previous sections in this LCSPR have explored how these factors were taken into consideration and what was done to mitigate impact. This section will focus on Maple's lived experiences and how these experiences might yield important additional learning.

"When I am feeling down, people say 'smile, you will be OK'."

This suggests that Maple felt their feelings were not taken seriously enough and perhaps that practitioners were too quick to dismiss the depths of their despair. Relevant LCSPRs[51] have identified professional fears around having challenging conversations with young people on self-harm for fear of making situations worse, the NCMD concluded with a relevant learning point:

[49] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021

[50] NCMD stress that it is important to note this data represents a minimum number due to underreporting and limitation of information available to Child Death Overview Panels.

[51] Such as: *Thematic child safeguarding practice review – child and adolescent mental health (Young Person H and others).* Ealing Safeguarding Children Partnership 2022.

"Lack of confidence amongst professionals to talk about suicide with children and young people. CDOPs recognised a professional practice and development need related to a lack of confidence amongst professionals in talking about suicide with children and young people, including what to do if there is concern that someone might be considering suicide."[52]

"I want a shelter I can go to if I need to."

Maple made this request to mental health practitioners. It was understood that one of the community mental health services have a resource that may have provided this, but there were no spaces in this resource at the time. Aside from communicating this with Maple, it was difficult to see how this was explored with Maple or how viable options to provide this were investigated. Maple went on to refer to wanting a 'shelter to go to' on several occasions, it was clearly important to them.

"In the future I want to go to college and travel ……I had everyone fooled – what is the point of prolonging a truly unhappy existence."

In agency records it was clear that Maple experienced fluctuating emotions. It is well known that fluctuating emotions are part and parcel of adolescence, however, Maple's fluctuating mood was said to present challenges to mental health practitioners in terms of determining risk. It is understood that improved clinical guidance has been put in place in the relevant mental health trust to assist practitioners in how best to manage the risks in these situations.

Learning from practitioners and panel members

Practitioners at the learning event were keen to emphasise that as the NCMD research was not available, the risk factors were not widely understood but that these now need to be incorporated into relevant suicide prevention work. Practitioners felt that Maple's wish for a shelter at times when they felt unsafe at home appeared to be an understandable and reasonable request. It was recognised that nationally, there are such safe places although availability is limited. It was felt to be an important issue that should be considered in terms of what may be available to children in these circumstances (and should include consideration of how family and kinship might be better involved in providing shelter at times of crisis). Panel members spoke about the need to support children's service practitioners/social workers to better understand mental ill health and concerns were raised about the quality of mental health training provided during qualification.

What would happen now?

The relevant Surrey Thematic Report on suicide made a number of recommendations that have been progressed and the Surrey Suicide Prevention Group continues to adopt a zero-suicide approach by implementing relevant service developments. Excellent tool kits are available to practitioners to support their work with children who self- harm/are at risk of

[52] *Suicide in Children and Young People National Child Mortality Database Programme Thematic Report* Data from April 2019 to March 2020 Published October 2021

suicide and a suicide prevention officer in the police has been in place for 18 months. When considering how to respond to this learning, panel members felt it was important that SSCP were mindful of recently published NICE guidance[53] that warns against the use of risk assessment tools and scales to predict future suicide or repetition of self-harm. In learning from this LCSPR, relevant national reports and recent LCSPRs, the following recommendations are made.

Understanding the risk of suicide and responding:

Recommendation 4

Surrey Health and Wellbeing Board to be sighted on the findings in this LCSPR and through the Suicide Prevention Group to seek representation from local services, including early help services, to understand how the recommendations in the NCMD report are being implemented. Further consideration to be made of how confidence may be built in the children's workforce in talking to children at risk of self-harm/suicide and how the availability of safe places may be promoted/facilitated.

Recommendation 5

Surrey Safeguarding Children Partnership to make representation to the relevant national qualifying authorities raising the importance of the training and support provided to practitioners in understanding and responding to adolescent mental ill health and wellbeing.

[53] https://www.nice.org.uk/guidance/ng225

Finding Five: "Unblocking the potential of family networks"[54]

Changing the trajectory of children's lives, and making a significant difference to children's outcomes, cannot be achieved by professional intervention alone. There is a need to understand and embrace family, kinship, and communities.[55]

It was known that Maple had a good relationship with their older sister (Steph) and her partner, and a review of agency records has identified that Maple had maternal grandparents with whom they stayed. However, the full extent of this family and kinship was unknown during the period of service involvement and there was little to show how Maple's sister and their partner were supported in caring for Maple when they stayed with Steph at a time of crisis.[56] Apart from this period of crisis, Maple's extended family and kinship were not engaged in multi-agency plans and decision-making. As highlighted in the independent review of children's social care, it is just not possible to improve outcomes for children without the full involvement of family and kinship. Mapping family (including extended family members) and kinship is critical to children; it can nurture identity and a sense of belonging, establish sources of safety, and identify potential risks.

A further area that requires attention is how Maple's parents were supported in caring for Maple: "Older children who suffer neglect may have been neglected for many years and can carry the legacy and impact of neglect at a younger age with them into adolescence. This means they are often not well equipped to cope with the many challenges that older childhood brings and may not get the support from parents to manage this transition".[57]

Significant changes were made by the parents in response to the child protection plan. However, in Maple's view – *nothing ever changes.*

Learning from research

"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[58]. 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

[54] *The independent review of children's social care*. *Final Report*. Josh Mc Alister May 2022
[55] *Vulnerable Adolescents Thematic Review.* Croydon Safeguarding Children's Board 2019
[56] School reported supporting Steph and giving her food parcels whilst Maple was in her care.
[57] *Growing up neglected: a multi-agency response to older children.* Joint Area Targeted Inspection. Ofsted 2018
[58] *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.

Learning from research (continued)

intentions of the adults who are caring for them; in effect they may interpret the positive intentions of safe and loving parenting figures as potentially abusive and threatening".[59]

Research[60] [61] [62] 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 self-harm and making attempts to end their lives, is traumatic.

Learning from practitioners and panel members

During the learning event practitioners spoke about the challenges of engaging families in these circumstances; of possible feelings of intrusion by services and a sense of failure or wrongdoing that may unconsciously impact on engagement. They spoke about the lack of services available at a universal/preventative threshold to support the whole family system – *services are geared to respond to families only when a child is identified as having additional needs.* Panel members spoke about the need to *think about the individual and collective needs within families* and the relevant thematic report in Surrey recommended supporting parents with better knowledge and awareness of self-harm and suicide. Parenting programmes and mentoring were said to be available, but practitioners said they needed time to build trusted relationships so that family work can be undertaken. Police spoke about trauma-informed training in the police which has been invaluable in building trusted relationships with children and families.

Conclusion – Unblocking the potential of family networks.

Relevant LCSPRs[63], research and national reports[64] set out a clear case for trauma-informed support to be provided to parents/carers to help them develop skills to parent their older children. "Professionals must work to understand the profound and pervasive impact of abuse on children and the impact on families. 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". [65] In the vast majority of cases, it is family and kinship who are the critical repair agents - statutory services can support families but are rarely the solution. However, as practitioners have identified, the work that is

[59] *Grasping the Intentions of Others with One's Own Mirror Neuron Systems.* Iacoboni, Molnar-Szakas, Gallese, Buccino, Mazziotta, Rizzolatti (2005).
[60] *Reparenting the Child Who Hurts.* C. Archer & C. Gordon. Kingsley Publishers, London.
[61] *The Cost of Caring: Secondary Traumatic Stress.* Fostering Communications 2004.Vol. XVIII No.3.
[62] *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat The Traumatized*. C.Figley Routledge Psychosocial Stress Series.
[63] https://learning.nspcc.org.uk/case-reviews/national-case-review-repository
[64] *Growing up neglected: a multi-agency response to older children.* Joint Area Targeted Inspection. Ofsted 2018.
[65] *The Trauma of Parenting Traumatised Children.* Adapt Scotland, Scottish Attachment in Action. C. Gordan, K. Wallace 2015

needed requires time to build trusted relationships. As the review of children's social care has identified, social workers have limited capacity to complete this work.

What would happen now?

Panel members from across the multi-agency network spoke about how 'think family' is at the heart of service provision. The Family Safeguarding Model was implemented in Surrey in May 2019 and focusses on building strengths within families and supporting children to stay at home where it is safe to do so. Fully mapping the family and kinship, alongside supporting family and kinship, are important aspects of safeguarding a child with mental ill health.

Recommendation 6- Unblocking the potential of family networks.

When developing the multi-agency framework/model for working with children with mental ill health (identified in recommendation 3.) the importance of mapping the family and kinship, actively engaging and supporting them (in line with the relevant research outlined in this finding) should be key components of this framework/model.

Overall Conclusion

Maple experienced childhood adversity. In Maple's teenage years multi-agency practitioners understood this, and services were provided at various points in their life in an attempt to support them. There have been many practitioners involved, these practitioners were committed to providing the support Maple needed. This LCSPR has highlighted areas of service provision that need to be strengthened with particular emphasis on supporting children with their identity, understanding neglect (and responding as early as possible), and providing a multi-agency multi-familial response to children with mental ill health who are at risk of suicide. During this LCSPR it was clear that there is an existing culture in Surrey evidencing the commitment of multi-agency services to learn, adapt and evolve in response to children's needs. SSCP are committed to implementing the recommendations made in this report in order to support their journey of continuous adaption in response to changing demands, and in seeking excellence in the services provided.