Essex Safeguarding Children Board

&

Luton Safeguarding Children Board

Child Safeguarding Practice Review

Child V

Moira Murray

Lead Reviewer

March 2022 (Published June 2022)

Contents **Page**

1. Introduction:

1.1.1 The purpose of the report is to present the learning arising from this Child Safeguarding Practice Review. Whilst a brief background summary of the circumstances of Child V's tragic death is provided, the focus of the report will be on the following areas:

- Key themes and Analysis of Practice
- Findings and Lessons Learned
- Systemic Failings in the PICU: Evidence from the Inquest
- Good Practice
- Conclusions and Recommendations

Background to the Review

1.1.2 Child V died on 27 September 2019 at a Psychiatric Intensive Care Unit (PICU) in Essex. At the time of her death, Child V was subject to Section 3 of the Mental Health Act 1983. Child V had a history of self-harm and died from ligaturing, which resulted in her suffering a cardiac arrest. She was 14 years old.

1.1.3 Prior to her admission to the PICU Child V had been an inpatient at a specialist unit outside of Luton and in Hospital 2, a psychiatric hospital, which was also located in Essex. Child V was transferred from Hospital 2 to the PICU under Section 2 of the Mental Health Act, 1983, due to concerns about an escalation of risk to herself (an increase in the risk of suicide attempts by ligature).

1.1.4 Child V died in the Local Authority of Essex, although her home address was in Luton, where she lived with her parents and older half-sibling. Child V had a history of self-harming behaviours, possibly dating back to when she was 8 years old. On transition to secondary school, she was diagnosed with having ADHD, low self-esteem and lacked confidence. During the last year of her life, Child V's behaviour caused serious concerns to her family and teachers. The number of self-harming incidents grew in number and severity and included serious overdoses, cutting and ligaturing, as well as a significant eating disorder.

1.1.5 The circumstances of Child V's death required the Essex and Luton Child Safeguarding Boards to consider whether the case met the criteria for a Child Safeguarding Practice Review to be commissioned under Working Together to Safeguard Children, 2018. Working Together Guidance, 2018 states that: "*safeguarding partners should have regard to where the case may raise issues relating to safeguarding in institutional settings where detention of a child takes place under the Mental Health Act*."

1.1.6 The Statutory Safeguarding Partners of the Essex and Luton Safeguarding Children Boards having considered the circumstances surrounding Child V's death, decided in

November 2019 that the case required an independently chaired Local Child Safeguarding Practice Review. This decision was reached because Child V was a young person who had died whilst under Section 3 of the Mental Health Act, as an in-patient at a Psychiatric Adolescent Unit.

1.1.7 This was the second such incident to have occurred in an in-patient unit (1) in Essex within twenty months, (albeit a different unit). In both cases, there were significant issues concerning the use of ligaturing and observation of these young people, who had acute mental health issues. The intention of referring to the previous serious incident in this review is to determine whether there is any aggregated learning from these events.

1.1.8 In the context of this review there were additional questions concerning the involvement of partner agencies with Child V and her family, as well as the appropriateness of decisions made as to level of observation provided to Child V by the PICU staff immediately preceding her death.

Terms of Reference, Methodology and Scope

1.2.1 Full details of the terms of reference, including the issues for consideration and methodology for the review can be found in Appendix 1, as can details of the agencies involved, and the Lead Reviewer.

1.2.2 A multi-disciplinary Learning Event for practitioners was held on 19 October 2020. Due to the Covid 19 Pandemic, of necessity, the event took place using internet technology. The Lead Reviewer would like to thank all those who attended, especially during this difficult time, and also the two Safeguarding Children Board Managers for arranging and facilitating the event. Discussions arising from the event have informed the learning and recommendations arising from this review.

1.2.3 **The time period for the review is from 1 January 2013**, the year when it is understood that Child V started to self-harm **to 27 September 2019**, the date of Child V's death**.**

Involvement of family members in the review

1.2.4 The parents were informed on 11 August 2020 that a Child Safeguarding Practice Review had been commissioned. However, the family has not indicated that they wish to be involved with the review.

Parallel Proceedings

1.2.5 The circumstances surrounding Child V's death were investigated by the Major Investigation Team, Essex Police. No action resulted from this investigation.

1.2.6 A Root Cause Analysis Report into the circumstances of Child V's death was completed by the in-patient unit (1) in Essex in December 2019. That report has been shared with this review and has informed some of its findings.

1.2.7 An inquest into Child V's death took place in August 2021. The finding of the jury was that Child V killed herself in an act of deliberate suicide.

1.2.8 Evidence was given at the inquest, which was not previously known to the review. Because it is significant to the learning for improvement of professional practice, some additional information and resulting analysis has been incorporated into this report, arising from that evidence. (See Section 4)

2 Key themes and analysis of practice

Agency intervention with children and young people who self-harm

2.2.1 Little information is available to the review concerning Child V's early years. It would seem, however, that the first instance of her self-harming whilst the family was living in Luton, may have occurred in 2013 when she was 8 years old and found to have unexplained bruises on her arm. The school considered that the injuries may have been self-inflicted and said that they contacted Children's Social Care RIAT[1], (now known as the MASH) and was informed that the matter should be discussed with the parents. However, Children's Social Care could find no record of contact being made by the school. The school has informed the review that contact was made to seek advice from the RIAT.

2.2.2 The threshold for making a safeguarding referral at the time categorised an unexplained injury as Level 3-4, thus the criteria was met for a referral to be made. Because there was no medical assessment of the bruising or deeper exploration with Child V and her parents as to whether she inflicted the injuries herself, an opportunity to assess Child V's emotional wellbeing and mental health at that time was missed.

2.2.3 It is evident that staff did their utmost to integrate Child V into primary school when she arrived and there were no further concerns that Child V was self-harming whilst she attended primary school. At the request of her parents, Child V was assessed three years later, prior to her transferring to secondary school, by an Educational Psychologist. No evidence emerged that Child V was self-harming or at risk of self-harm at that time.

[1] Rapid Intervention and Assessment Team

2.2.4 It was not until Child V transferred to secondary school that serious concerns began to emerge about her mental health and wellbeing.

2.2.5 In 2017 when Child V was 13 years old, issues about her behaviour in school towards teachers and fellow students began to escalate. Questions were raised as to whether she was on the Autistic Spectrum and resulted in a referral to the Child Development Centre. Child V was not assessed as being autistic, but the assessment confirmed a diagnosis of ADHD and the assessment report noted that Child V was considered to be obese. This comment about Child V's weight was seemingly to have a profound effect on her confidence and self-image and may have directly influenced her to self-harm. There was little indication, however, that Child V was bullied because of her weight whilst at either primary or secondary school, something which was later confirmed by Child V. (However, see Section 4).

2.2.6 Whilst it cannot be categorically stated that the diagnosis of obesity and the comments made about her weight triggered Child V's eating disorder and self-harming behaviours, it is evident that it was from July 2017 onwards that her emotional wellbeing and physical health began to be at risk and from the summer of 2018 onwards, Child V began to rigorously control her food intake.

2.2.7 There is no indication in the information provided to the review that during the assessment by Child Development Centre in July 2017 that consideration was given to making a referral to Early Help, Children's Social Care, counselling services or CAMHS. There was a lack of exploration as to the reasons why Child V was obese, nor was the impact of her obesity on her self-image, confidence and ultimately the risk of her self-harming seemingly considered. The post assessment plan focused on medical intervention, including a referral to a dietician.

2.2.8 It was the secondary school which suggested that Child V be referred to CAMHS. When Child V was reviewed by a Consultant Paediatrician at the Child Development Centre in March 2018, a referral was made to CAMHS, at the request of her parents to address their concerns around autism. This was declined and a request was made for further information to be provided before a decision could be made on the referral.

2.2.9 Child V's behaviour deteriorated despite appropriate support being offered to her by her teachers and incidents appropriately documented in school records. However, there was seemingly no consideration given by the school that a safeguarding referral needed to be made to Children's Social Care. A clear picture emerges that towards the end of 2018 and in January and February 2019 Child V's behaviour was causing significant concern at school.

2.2.10 It was in early March 2019 that Child V took a serious overdose of painkillers. Immediately, prior to this incident, the school had been particularly concerned about Child V's loss of weight, self-harming and her general presentation, concerns which were shared with Father. Whilst the school is to be commended for the support offered to Child V and her family throughout this difficult period, contact should have been made earlier with other agencies to seek advice and intervention, prior to her admission to Hospital 1 following her overdose.

2.2.11 Within two days of Child V's admission to Hospital 1, the school appropriately contacted the MASH for advice, following Child V's threats to attempt suicide again as soon as the opportunity arose. At this time, Child V was receiving 1:1 nursing and was under the care of the CAMHS Team, in line with policy concerning the admission of all children presenting with self-harm. It was good practice on the part of the school to contact the MASH.

2.2.12 However, the advice provided was that it was for the Safeguarding Lead at Hospital 1 to make a referral into the MASH. The school was advised that if they still had concerns when Child V was discharged, a safeguarding referral could be made at that time. However, no referral was made either by the school or health professionals.

2.2.13 Child V had made a serious attempt to end her life and had continued to say that she would make further attempts in future. This needed to be viewed as a matter of child protection. Not making a safeguarding referral to the MASH was a missed opportunity for a multiagency strategy discussion and assessment to take place prior to her discharge from Hospital 1 and is a lesson learned from this review. Such an assessment could have holistically considered the family's history, Child V's school experience and history prior to her admission, as well as the risk her behaviour presented to herself.

Responsibility for coordination of the care of children and young people in NHS Psychiatric Units

2.3.1 It is important to note that the identification and management of bed availability for children and young people in psychiatric units (Tier 4 beds) at the time was the responsibility of NHS England, Specialist Commissioning. Whilst NHS East of England can provide support, the responsibility for coordinating multi-agency involvement concerning the care of children and young people, once they are admitted to hospital, remains with the organisation which placed the young person in the Tier 4 bed. It is necessary to clarify this issue as it demonstrates the crucial importance of the involvement of all partner agencies, including the local authority, to work together in the best interests of the child. This review has exemplified this issue.

2.3.2 After her transfer to a Specialist Adolescent Unit at the end of March 2019, the school and the CAMHS Team attended professionals' meetings convened at the Unit. As no safeguarding referral had been made, Luton Children's Social Care was not invited to and had no awareness of these meetings. When Child V took her own discharge in April 2019, which was supported by her parents, no consideration was given to informing the MASH. It is particularly concerning that within two days of her discharge from the Unit, Child V took a second significant overdose and was again admitted to the Paediatric Ward at Hospital 1, under the care of the medical team with CAMHS input. A care and safety plan was agreed with Father and Child V prior to her discharge from hospital, with CAMHS follow up. Despite CAMHS having responsibility for her care in the community and Child V being discussed at the school safeguarding meeting, there appears to have been no recognition on the part of professionals at the time that Child V was at risk of significant harm, which warranted a safeguarding referral to the MASH.

2.3.3 The reasons as to why a safeguarding referral was not made may have been related, for example, to the school's experience when previous contact was made with the MASH, together with a belief that a plan was in place to safeguard Child V, given she was under the care of CAMHS. The significance of the risk of harm Child V presented to herself because of her behaviour needed to be seen in the context of child protection, which necessitated the involvement of Children's Social Care.

2.3.4 Similarly, when Child V was admitted for the third time to Hospital 1 following further incidents of self-harm, no safeguarding referral was generated. When she was transferred to Hospital 2 in Essex, and then to the PICU, Luton Children's Social Care was not informed. The seeming lack of recognition on the part of health professionals of the urgency of informing the lead statutory agency for safeguarding children when a child is experiencing serious mental health crises is deeply concerning.

2.3.5 When Child V was admitted to the PICU, there was discussion with her parents about making a referral to Children's Social Care. After some delay, the parents agreed to the referral being made, however, this sadly did not happen before Child V's death. PICU staff have informed the review, that wherever possible it was important to involve parents in the process if a referral was to be made to Children's Social Care, so that relationships with staff could be maintained. However, it has been acknowledged by PICU staff that an earlier referral could have drawn resources together to support Child V.

2.3.6 The Essex Safeguarding Children Board *Practice Guidance and Care Pathway for Children and Young People who are admitted to Psychiatric In-patient Adolescent Units in Essex, 2015* states at paragraph 16.5:

"*All young people admitted to the Inpatient Units can be considered children in need - thus clinicians will routinely seek consent to refer all new admissions to Social Care. A referral will only go ahead if consent is provided (either by the competent young person or their parent/carer) unless there are reasons to believe a child is or may be at risk of significant harm as a consequence of the actions or inactions of another – in such circumstances a child protection referral will be made."*

2.3.7 The Practice Guidance had been in place for four years at the time Child V was admitted to the PICU. At the time the Practitioners Learning Event took place in October 2020, the protocol at the PICU was being changed so that all families would be made aware from the outset that children and young people admitted under Section 3 of the Mental Health Act would be referred to Children's Social Care for a Child in Need assessment.

2.3.8 An update of Statutory Guidance Working Together to Safeguard Children, 2018 was issued by the Department of Education on 9 December 2020, which includes the following additions concerning the mental health of children and young people:

"In the definition of safeguarding, impairment of children's health has been changed to ***children's mental and physical health." and***
Under the referral process ***Where a child or young person is admitted to a mental health facility, practitioners should consider whether a referral to local authority children's social care is necessary*** *has been added."* (emphasis from original update)[2]

2.3.9 Such additions to statutory guidance are welcomed and should clarify for professionals the importance of recognising the safeguarding needs of children and young people whose mental health is impaired. However, to share information in a referral without the consent of the parents or the child/young person is a question, which is frequently presented to practitioners.

2.3.10 In the case of Child V, she was a Child in Need, as set out in the Essex Practice Guidance, 2015 and Working Together, 2018. Given the serious deterioration in her behaviour whilst she was resident on the PICU, Child V could also be said to be a child

[2] https://www.trixonline.co .uk/articles/update-to-working-together-to-safeguard-children-2018/

at risk of significant harm. If viewed from this perspective, whilst it would have been good practice on behalf of the PICU to seek her consent and that of her parents to make a referral to Children's Social Care, it was not a requirement.

2.3.11 The involvement of Children's Social Care when a child or young person is an inpatient in a psychiatric unit, not least a PICU, is of crucial importance. It offers the opportunity for the child and parents to be supported, multiagency meetings to be convened which includes all agencies involved with the child and a discharge plan to be put in place to ensure that there are sufficient resources available to support the child and their parents in the community. Most importantly for Child V, such meetings would have enabled the sharing of crucial information concerning the background of the parents own mental health, as well as that of other family members; the effect of Mother's deteriorating health on Child V, whether she was a young carer and provide an opportunity to ascertain whether Mother met the criteria to receive appropriate support services from Adult Social Care.

2.3.12 This review has illustrated the many difficulties facing parents and children when a child is placed in an acute psychiatric hospital, not least when the placement is a considerable distance away from home. It is hoped that consideration will be given to ensuring that funds are made available for visits to be maintained between parents and their children, so that children resident in psychiatric units do not unduly suffer from a lack of contact with their family.

2.3.13 The necessity of effective coordination of care by a single agency to ensure information sharing and communication between agencies and families is a lesson arising from this review. Such coordination was not forthcoming from the in-patient unit (1) based in Essex, and it raises the question as to whether cases concerning children and young people on in-patient units are prone to a similar lack of information sharing. The absence of the involvement of Children's Social Care as the lead agency resulted in a missed opportunity for all agencies involved to holistically consider the needs of Child V and her family. **Recommendation 3.**

The significance of family history

2.4.1 Child V's family had a significant number of moves during her lifetime. There is no information as to whether the family was known to services prior to their return to Luton in 2013. It was disclosed to mental health professionals whilst Child V was in the PICU that both parents, and both sets of grandparents had a history of mental health problems. This information was not known to CAMHS. Mother had a chronic health condition, which seriously affected her quality of life and that of her children. It is known that Child V did not wish to return home to live with Mother when she was

discharged after her second overdose from Hospital 1, and Father rented a flat so that he and Child V could live together. The reasons for this have not been fully explored due to a lack of family history being available. However, little is known as to how any of these factors impacted on the family dynamics and whether support from Children and Adult Services could have improved Child V's lived experience.

2.4.2 The need to gather information and background family history, especially when a family arrives from another local authority, is a prerequisite to enable an appropriate assessment to be made of need and risk, to improve outcomes for children and ensure their health and wellbeing is protected. This is so often a finding of many Serious Case and Child Safeguarding Practice Reviews, and this review is not an exception.

Assessment of risk in relation to Child V's suicide ideation
Was the assessment comprehensive and accurate? What was the impact on staff of Child V's repetitive behaviours?

2.5.1 When Child V was admitted to Hospital 1 following her first overdose it is clear that her suicide attempt was taken seriously and the CAMHS Team was immediately contacted to undertake an assessment. This resulted in recognising the urgency for Child V to be admitted to a Tier 4 unit. Due to lack of capacity, a bed could not be identified for 15 days, during which time 1:1 nursing care was provided to Child V. This was standard practice on the part of the Paediatric Ward staff who identified that Child V was at serious risk of harming herself.

2.5.2 On her transfer to a Specialist Adolescent Unit in March 2019 it was anticipated that Child V would remain an inpatient for between 4 -6 weeks. During her stay Child V was reported to be making progress and although there was some self-harm, there were no reports of ligature use. It was anticipated that Child V would be able to reintegrate into mainstream school and the plan was for her to be discharged in early May 2019. This did not happen. Child V was a voluntary patient and with the agreement of her parents, took her own discharge. However, Child V was back in Hospital 1 within two days following another overdose.

2.5.3 Child V's admission to Hospital 2 in early June 2019 was with her agreement and that of her parents. However, when she began using ligaturing as a means of self-harming, the decision was taken that the risk was too high for her to remain as an informal patient at Hospital 2 and she was placed under Section 2 of the Mental Health Act. This was an appropriate decision, as was the increase in her level of observation (1:1, arms reach observations) when her use of ligature became more frequent and the ligatures tighter.

2.5.4 Child V was transferred to the PICU when it became clear that she could not be managed safely at Hospital 2. This was an appropriate decision. When the 28 days of her being under Section 2 were reached, the decision was made that Child V needed to be under Section 3 whilst on the PICU. Child V was initially on the same level of observation at the PICU as she had been at Hospital 2, with 1:1 nursing. This level of observation was stepped down to level 2 observations as part of a positive risk management plan.

2.5.5 At the Practitioners Learning Event, clinicians from the PICU explained that ligaturing was very common on the ward and the general approach of staff was not to overreact to the use of ligaturing.

2.5.6 It is important to note that from the time of her admission to Hospital 1 until she died, the local CAMHS Team was involved with Child V throughout. This provided continuity of care and enabled the CAMHS Team to express serious concerns when the extent of Child V's ligaturing became known after her admission to the PICU.

2.5.7 Child V had consistently stated that she wished to die whilst she was in the PICU. Given that the number of incidents of ligaturing escalated during her time on the Unit, which ultimately resulted in her death, it could be concluded that the risk of harm to Child V was not assessed accurately whilst she was an inpatient on the PICU.

Where appropriate safety plans put in place? Were the risks of Child V killing herself by ligature identified and assessed?

2.6.1 Whilst in the community Child V was at risk of significant harm, and it was recognised that such risk could not be managed by her parents and the CAMHS Team. From information provided to the review, it is evident that appropriate safety plans were in place whilst Child V was an inpatient in Hospitals 1 and 2. When it became apparent that the risks posed to Child V by her self-harming behaviour was increasing, appropriate steps were taken by Hospital 2 to monitor her. When such monitoring could not ensure her safety, Child V was moved to a more suitable inpatient facility, i.e. the PICU.

2.6.2 The Root Cause Analysis report found that the risk management plan put in place whilst Child V was on the PICU was not clear, and lacked clarity, resulting in an inconsistent approach by staff. The Child Safeguarding Practice Review agrees with these findings.

2.6.3 Whilst acknowledging the finding of the Root Cause Analysis Report that staff enabled Child V to be empowered, treating her with dignity, care and compassion, this review

has significant concerns as to whether the reduction in the level of observation of Child V was appropriate and risk assessed. The review can find little evidence to support the decision to lower her level of observation, apart from the view of some but not all staff on the PICU that Child V's risk behaviour escalated when under close scrutiny/supervision. This review considers that there was an inconsistency of approach by staff towards Child V and can find little if any evidence of what alternative support/arrangement was put in place to prevent Child V from engaging in risk behaviour once the level of observation was decreased. The sad truth is that at the very time Child V was not under close observation, immediately following an episode of ligaturing, she died.

What could have been managed differently, if anything, both in general and on the night she died?

2.7.1 The review has detailed how a referral to Children's Social Care could have resulted in a more coordinated approach to the management of Child V's care and support offered to her family.

2.7.2 What is known of events on the night she died is documented in the Root Cause Analysis Report and offers a clear breakdown of what happened. The report shows that on the night in question there was a high level of acuity on the ward. Four of the seven patients on the ward required 1:1 nursing and the three others, including Child V were on level 2 observations. There was concern about staffing levels and the nurse in charge of the ward requested additional staff from the main hospital. A decision had been taken, of which the nurse in charge had not been advised, that main hospital staff would no longer be able to support the PICU. It was by chance that a nurse who attended the ward that night agreed to remain on the ward for the remainder of the shift. This meant that the level of staffing, i.e. 9 staff to 7 patients was in accordance with the level of acuity of the ward.

2.7.3 When Child V self-ligatured, which resulted in her death, she was on level 2 observations. At 22:40 hours staff were alerted by two patients to noise coming from Child V's room, where Child V was found to have a ligatured. The ligature was removed as were other potential items which could be used to self-harm. The member of staff left the room at 22:45 to collect equipment to perform Child V's vital signs. The member of staff returned to Child V's room at 22:58 hours where she was found collapsed and unresponsive on the bathroom floor[3].

[3] This information provided to the review was inconsistent with the evidence given at the Inquest into Child V's death (see below, Section 4).

2.7.4 Emergency assistance was requested but despite all attempts at resuscitation Child V died. The learning from the Root Cause Analysis highlighted that the member of staff allocated to Child V had additional responsibilities as the security nurse, which meant there was a delay in in returning to Child V's room after the first ligature. Not all staff had been trained in enhanced emergency skills and there were significant issues in relation to emergency equipment during attempts to resuscitate Child V.

2.7.5 This report cannot conclude whether or not the poor state of the equipment and the lack of staff training to deal with the presenting situation contributed to the ultimate cause of Child V's death. This matter was considered by the Coroner's Court, together with the work practices imposed on the staff that night. It is hoped that lessons have been learned from Child V's tragic death and that action has been taken to redress the issues uncovered as a result of the Root Cause Analysis investigation, the findings of this review and the Inquest.

3 Findings and Lessons Learned

The importance of information known to professionals concerning families in order to assess the risk of significant harm to children:

3.1.1 The review has benefitted from a considerable amount of information being made available concerning Child V and her parents. However, there are gaps, and it is telling that some professionals were not aware of important information about the family history until it was shared in the context of the review process.

3.1.2 Whilst it is recognised that it is vital for agencies to share information if children are to be protected, professionals are also very much dependent on the willingness of parents to disclose key events and incidents from their past history. The CAMHS Team was substantially involved with the family from the time of Child V's first overdose and yet, information, which could have informed the reasons for their daughter's self-harming behaviour was seemingly not considered relevant to be disclosed to them by her parents. If an assessment had been undertaken of Child V's parent's parenting capacity, the past history of mental illness in the family may have come to light, which could have informed professional understanding of Child V's self-harming behaviour. However, this would have been dependent on Child V's parents' willingness to engage in the process and share painful and difficult information.

3.1.3 Whilst the parents did engage to some extent with agencies, it is evident that this appeared to be dependent on their willingness to accept the assistance and intervention which was being offered.

3.1.4 It is clear that Child V's presentation and demeanour underwent a drastic change whilst she was in her second and third year at secondary school. Having been described at primary school as a likeable child, with a bubbly personality and an accomplished singer who had friends, she became increasingly less confident, developed a disordered eating pattern, and began to self-harm. It cannot be definitively said whether such a change in her personality was triggered by learning that she was considered to be medically obese or if she was bullied because of her appearance. A number of factors may have played a part, including the family dynamics.

3.1.5 Professionals working with children and young people are reliant on the awareness and willingness of parents and carers to provide detailed information in order to assess the risk of significant harm, including self-harm, to children and young people. This case is no exception. As with many Serious Case Reviews and Child Safeguarding Practice reviews, this is a lesson arising from the review.

Referrals to MASH and MASH decision making:

3.2.1 Safeguarding concerns were noted whilst Child V was at primary school and given that concern was voiced that she may have been self-harming, a referral to MASH should have been progressed.

3.2.2 The threshold for making a safeguarding referral at the time categorised an unexplained injury as Level 3-4, thus the criteria was met for a referral to be made. Why this did not transpire, may have been due to the school's previous experience of meeting with a refusal on the part of the MASH to accept referrals on the grounds that they did not meet the threshold for investigation/intervention. This is a theme which frequently emerges in statutory reviews. As does the concern voiced by teachers that they have to engage with children and parents on a daily basis and if a referral is made and the decision is that it does not meet the threshold, the relationship with parents is often damaged, which in turn may adversely affect the child. This is a situation, which other agencies also commonly face, particularly health professionals.

3.2.3 During the course of this review, the issue of the provision of supervision for Designated Safeguarding Leads (DSLs) in schools has been raised. There appears to be a gap in the provision of supervision to enable DSLs to reflect on safeguarding concerns and decisions taken, an issue which was raised in a previous Serious Case Review undertaken by Luton (Child L).[4] The concern raised in the Child L Serious Case

[4] http://lutonlscb.org.uk/wp-content/uploads/2020/09/Child-L-final-report-final-sep-20.pdf

Review led to considerations being made to the Luton Safeguarding Children Board to review arrangements for the supervision of DSLs.

3.2.4 At secondary school, staff became increasingly aware of Child V's self-harming behaviour and support was offered to her and her parents. Although advice was sought, a referral was not made to MASH.

3.2.5 A significant finding of this review is the lack of any involvement with this family by Children's Social Care, and as far as is known Adult Social Care, given Mother's ill health and disabilities. Not making a safeguarding referral to the MASH was a missed opportunity for a multiagency discussion and assessment to take place prior to Child V's discharge from Hospital 1. If a referral had been made, it could be anticipated that Children's Social Care would have become the lead agency to gather information in order to produce a comprehensive and enhanced assessment, resulting in the allocation of a social worker to the case. Such action could have enabled a multi-agency coordinated approach and plan to be developed to ensure Child V's needs were paramount and is a lesson arising from this review. **Recommendation 2**

Assessment of suicide ideation in children placed in Psychiatric Intensive Care Units

3.3.1 It is evident from information provided to this review that staff on the PICU were facing significant pressure and demands on their time on the night that Child V died. The adequacy of equipment on the Unit and of staff training have also been raised. The Root Cause Analysis Report found that such issues may have significantly impacted on attempts to save Child V's life. However, it is acknowledged that the Inquest did not reach such a finding.

3.3.2 However, it is considered important for this review to raise the question of whether staff working on such demanding units, who care for children with the most serious of mental health conditions, may become institutionalised into accepting certain behaviours. The level of self-harm and the regularity of the use of ligatures by Child V was well known to staff on the unit. It could be said that the number of incidents of ligaturing became so many that not all were recorded. It has also emerged that whilst the general approach of staff was not to overreact to the use of ligaturing this was not the only view.

3.3.3 Whether the degree of self-harm and the regularity of incidents by patients on the PICU meant that staff lost sight of what was 'typical' behaviour is a concern raised by this report. That such incidents became the norm and staff were seemingly unable to appropriately judge the level of risk posed to Child V is a finding from the review. The necessity for those working with children who express suicide ideation to be aware of

the risk of significant harm, which can result if such behaviours are taken as the norm, is a lesson learned. **Recommendation 1**

4 Systemic Failings in the PICU: Evidence from the Inquest into the death of Child V

4.1.1 A transcript of the Inquest was requested by Essex LSCB, which has been made available to the review. The transcript has provided some important additional information.

4.1.2 The verdict of the Inquest Jury was that Child V died as a result of suicide. Whilst the Coroner did not make a finding of systemic failure on the part of the provider of Child V's care, there was significant information disclosed by witnesses attending the Inquest which was not known to the review, and which in the opinion of the Lead Reviewer raises serious issues about the systems in operation in the PICU at the time of Child V's death to ensure the safety and wellbeing of children.

4.1.3 These concerns can be summarised as follows:

- The review was not previously aware of the main means by which information was shared amongst staff working on the PICU. The use of a 'white board' was the way in which staff were made aware and updated about concerns/issues about patients. There was also a verbal handover at the beginning and end of each shift.
- Only Registered Mental Health Nurses and Managers working on the Unit were allowed access to the PICU recording system to enter information onto a patient's electronic record.
- Heath Care Assistants were dependent on reporting any concerns or changes about a child's presentation, mood and behaviours to a Mental Health Nurse, in order for such information to be updated on the system.
- Child V's care plan had not been updated since 31 July 2019 and was not readily accessible to those who possibly had the most interaction with her, i.e. Health Care Assistants.
- Child V had a basic Nokia phone from which she could make and receive calls, but which had no camera or internet access. This was a facility made available to all patients on the Unit. The phone was issued by staff in the morning and returned by the patient in the afternoon. The Review has been informed that PICU staff were not aware that Child V had an iphone/smart phone and did not know how she gained access to such a phone, which was discovered after her death. It was by using the iphone/smart phone that Child V learned that a young person who had previously bullied her had joined an activity, which Child V enjoyed attending. This caused Child V significant upset and distress.

- On 26 September 2019, Mother had telephone the PICU to pass on her concerns that Child V had told her that she knew that this young person was now attending this activity, that staff should be aware of this, and that Child V needed one to one observation. What Mother actually said to staff on the telephone about increasing the level of Child V's observation was not resolved at the Inquest, however, it is known that Mother's concerns were passed on to staff. Child V resorted to using a ligature on 26 September 2019.
- A number of notes were found by Police Officers in Child V's room after her death, indicating suicide ideation, which could have been discovered earlier and scanned onto the PICU case recording system.
- One professional was aware of the notes and letters which Child V had previously written, but these had not been scanned on to the case recording system.
- A Psychotherapist, who was also a qualified Social Worker (but believed to no longer be a Registered Social Worker) was part of the Assessment and Treatment Team. The Psychotherapist had eight individual therapy sessions with Child V. Neither the Psychotherapist nor any other member of the Assessment and Treatment Team, all of whom had equal decision-making responsibilities for making a Safeguarding/Child in Need referral, made contact with either Essex or Luton Children's Social Care to inform them of their involvement with Child V.
- Before the ligature which resulted in Child V's death, she had used two ligatures, one during the day, and one just prior to the fatal ligature resulting in her death.
- After Child V first used a ligature on the night of 27 September 2019, there were two members of staff in attendance, and she resisted the ligature being removed. Child V was described as being distressed and sobbing.
- Once the ligature was removed, both members of staff left the room. There appeared to be little communication between the two staff members as to whether it was safe to leave Child V alone after this incident
- There was no agreed process or training for staff as to whether a patient should be left alone after ligature use, and it was down to 'professional judgement.'
- There was a lack of awareness by staff as to how much time had elapsed between Child V being left alone and other young people on the PICU alerting them that something was seriously wrong.
- Because of infection control, staff on the unit were not allowed to wear watches. A member of staff who attended Child V when she first ligatured thought that the time lapse between leaving Child V and returning when she had ligatured a second time was 6 or 7 minutes, when it was in fact 16 minutes.
- Level 2 Observations required that Child V was to have 6 observations during a 60 minute timeframe, but there was no set timescale for such checks, so as to ensure that children and young people were not alert to the regularity of checks, which could enable them to self-harm.

- One of the members of staff on duty on 27 September 2019, and who attended Child V, was not aware that she had developed a technique that enabled her to tear a 'blue blanket', which was designed to be tear resistant, and had used this method of ligaturing the previous day. This was because the information was not on the white board. Child V managed to tear the blue blanket to use as a ligature a second time, which ultimately resulted in her death.
- The staff attending Child V the night she died did not have access to any risk assessments and were unaware of the number of times she had ligatured, including Child V tearing a blue blanket the previous day to use as a ligature. It was apparent that whilst Child V frequently used ligatures, not all ligaturing incidents were recorded. Neither were the staff aware of the reasons why Child V had transferred from Hospital 2 to the PICU. This was because, as Health Care Assistants, they did not have access to the case recording system.
- Staff were conflicted as to whether a child should be deprived of a blue blanket when they were at risk of ligaturing, given that they would be left to sleep on a bare plastic mattress.

4.1.4 From the information already provided to the review, together with the additional evidence which has been made available from the inquest, it is evident that there may have been individual failings in this case. However, it is apparent that there were also major systemic failures on the unit where Child V was being treated. This is manifest in:

- The lack of risk assessments and up to date care plans for young people who ligature frequently.
- The level of supervision/observation after a significant ligaturing incident.
- The need for a coherent and consistent approach towards young people ligaturing. Including the recording of all ligaturing incidents.
- The reliance of information being placed on the white board to make staff aware of patient risk.
- The lack of accessibility to case notes by all staff on the unit, irrespective of designation, resulting in information not being known, including Child V's risk assessment plan.
- A failure to recognise that the observation plan in place for Child V was not being adhered to.
- The lack of awareness by staff as to the time a patient was left unobserved, because of a policy of not allowing staff to wear watches.
- Important documents not being scanned into case notes.
- Information not being appropriately shared amongst staff, adding to patient risk.
- A lack of communication between social work professionals working in an NHS setting and their colleagues in Children's Social Care.
- A lack of fundamental training to ensure patient safety.

4.1.5 The inquest heard evidence of the need to recognise that young people on the unit needed to have a degree of autonomy and personal dignity, for example by not removing the blue blanket from Child V, which would have left her without a bed covering. However, from the perspective of this review, whilst acknowledging the dignity of patients is important, having in place systems that ensure patient safety is fundamental to the protection of vulnerable children and young people from significant harm.

4.1.6 The significant systemic failings detailed above, provided Child V with the opportunity to continue to self-harm, which sadly resulted in her death.

5 Good Practice

5.1.1 The support offered by staff from both primary and secondary school to Child V and her family is to be commended. The decision of secondary school staff to remain in contact and engaged with Child V during her admissions to hospital and a specialist unit was good practice.

5.1.2 The continued involvement of the CAMHS Team, once Child V was referred to the service and throughout her time in hospital and Tier 4 accommodation was good practice.

5.1.3 Hospitals 1 and 2 recognised the seriousness of Child V's mental health and risk to her wellbeing and acted immediately and appropriately to ensure that the care she received was appropriate to her needs and to ensure her safety.

6 Conclusion

6.1.1 This review has documented the serious deterioration in Child V's mental health culminating in her tragic death. It has also focused attention on the necessity for a referral to be made to the MASH not withstanding whether it will be accepted; the importance of taking into account the voice of the child in expressing their level of distress in the form of self-harm; the pressures and demands placed on those professionals working in PICUs and the necessity to involve Children's Social Care, as the lead agency when a child is at risk of significant harm because of their mental health.

6.1.2 Given the information that has been provided to this review, it is apparent that the focus of professionals was very much on Child V and her problems. There was little sense of a 'Think Family' approach. Whether Child V and her family would have

benefitted from a referral to Luton Early Help Services, when Child V's vulnerabilities first became apparent is a question raised by the review.

6.1.3 This report has demonstrated the difference in the approach adopted by PICU staff towards Child V's use of ligaturing. It would seem apparent that there was a lack of clarity and consistency in the Ligaturing Policy on the PICU. What has been learnt from this review is the necessity to continuously risk assess children and young people displaying behaviours indicative of suicide ideation, which seemingly did not happen in the case of Child V. This may have been because Child V's use of ligatures was so repetitive, there was a potential for the normalisation of such behaviour by PICU staff.

6.1.4 The information from the inquest into Child V's death has further enabled the review to highlight the systemic failings, which existed on the PICU at that time.

6.1.5 This case has highlighted the importance of children resident in psychiatric units needing to be seen as Children in Need. This is not to say that Child V's death would have been prevented. However, if Child V had been seen as a Child in Need from the outset, the involvement of Children's Social Care would have enabled multi-agency sharing of information, review of risk of harm on a multi-agency basis, the coordination of care planning and support to Child V and her parents. It is reassuring that the revised Working Together to Safeguard Children, 2018 recognises that children and young people in psychiatric placements are Children In Need.

7 Recommendations

The following recommendations are made for the consideration of Essex Safeguarding Children Board and Luton Safeguarding Children Board, NHS East of England and the National Panel

For Essex Safeguarding Children Board:

Recommendation 1:

The review has highlighted the shortcomings in relation to the care provided to Child V within the PICU. These primarily focused upon:

- **The risk assessments of young people who ligature frequently;**
- **The level of supervision/observation after ligaturing;**
- **The need for a coherent and consistent approach towards young people ligaturing, including recording of ligaturing incidents;**
- **Referral to the Local Authority of the young person as a Child in Need.**

The Provider Collaborative and the CQC are working together to ensure that these issues are being addressed. It is recommended that a progress report is submitted to the ESCB six months after the publication of the review.

For Luton Safeguarding Children Board

Recommendation 2:

The Luton Safeguarding Children Board will facilitate a pathway with partner agencies for the management of children and young people presenting with self-harm and suicide ideation, who are admitted to an acute hospital, so that their social care needs and those of the family can be assessed and met. (see Recommendation 5)

NB The Review has been informed that a pathway is now in place.

For Essex Safeguarding Children Board and Luton Safeguarding Children Board

Recommendation 3:

Partner agency practitioners, and those working in Adult Social Care, need to be reminded to adopt a 'Think Family' approach, to ensure that all aspects of safeguarding concerns are given sufficient consideration to enable children and adults to be protected.

For NHS East of England

Recommendation 4

The Provider Collaborative and the CQC need to review:

(a) Existing guidance on the management of children and young people placed in Tier 4 beds, in order to ensure that arrangements are in place for collaborative working between families, Children's Social Care and other relevant partners.

(b) Existing guidance on the management of ligaturing in Psychiatric Intensive Care Units.

For the National Panel

Recommendation 5

For the National Panel to consider informing Safeguarding Children Partnerships and Local Safeguarding Children Boards of the importance of establishing a pathway, for the care and management of children and young people presenting with self-harm and suicide ideation who are admitted to an acute hospital, so that their social care needs and those of the family can be assessed and met, as set out in Recommendation 2 above.

Appendix 1

1. Subject of Review

The subject of this Review will be referred to as Child V

2. Reason for the Review

Child V, aged 14, took her own life via hanging in September 2019 whilst at an NHS Adolescent Acute and Intensive Care Unit. Child V had previously had in-patient admissions to other in-patient units Northampton and in Essex. Her home address was in Luton.

Child V had a diagnosis of ADHD from Primary School and had a lengthy history of self-harming behaviour, seemingly going back to the first reference of her self-harming when she was 8/9. Child V was noted as having low self-esteem and confidence in herself. In the last few months of her life, there were a number of further self-harming incidents, overdoses, suicidal behaviours, including cutting and ligaturing, all combined with significant eating disorder issues.

3. Relevant time period for the review

1st of January 2013 (year that it is understood that Child V started self-harming) **to 27th September 2019** (the date of Child V's death)

4. Organisations who should contribute to the review

1) Children's services - Luton Borough Council.
2) Education - Luton Borough Council
3) Luton Clinical Commisioning Group
4) East London Foundation Trust (CAMHS) – Luton
5) Housing – Luton
6) In-patient Unit (1) in Essex
7) In-patient Unit (2) in Essex
8) Essex Police

5. Review Team Representatives

1) Children's Services - Luton Borough Council
2) Education - Luton Borough Council
3) Luton Clinical Commisioning Group
4) East London Foundation Trust (CAMHS) – Luton

5) Housing – Luton
6) In-patient Unit (1) in Essex
7) Essex Police
8) Designated Nurse – Essex

6. Questions to be considered within the Child Safeguarding Practice Review

1) Whether there could have been earlier interventions by partner agencies with Child V in respect of her mental health issues.

2) Whether the assessments of risk in relation to Child V killing herself were both comprehensive and accurate, and whether appropriate safety plans were put in place.

3) Child V regularly ligatured herself -were the risks of her killing herself in this way identified and assessed; what was the impact on staff of Child V's repetitive behaviours?

4) What could have been managed differently, if anything, in relation to Child V's ligaturing, both in general and on the night she died?

5) Whether Luton agencies could have responded differently to the presenting issues both from Child V and her family; and did agencies work collaboratively together (team around the family, for example)

6) There appears to be limited information as to the dynamics within Child V's family – how were these assessed, by whom, how much was known by professionals, were issues appropriately addressed?

7) When Child V was at thein-patient unit in Northampton, why was she discharged early, before the planned discharge date and the discharge CPA meeting, and what was the significance of this?

8) The School have stated that they sought advice from the MASH in March 2019, but Social Care have no evidence of this; if advice was sought, was the response given appropriate?

9) Was consideration given to a referral being made to Social Care, both before 2019, and once she was admitted to an in-patient adolescent unit for a child-in-need assessment?

10) What is the significance, if any, of the family having frequent moves, and having at least nine different addresses?

11) What was the impact of Mother's significant health issues both on the family, and upon Child V, and how were the family supported with these issues?

12) What was the impact of the parental relationship upon the children?

13) What was understood by professionals as to what daily life was like for Child V (what was her lived experience); was Child V's voice heard and understood? To include to what extent was Child V "a young carer", and to explore agencies' responses to the alleged bullying of Child V

14) How effectively was Child V supported in her transition from primary to secondary school?

15) The placement of children and young people in psychiatric units fall under NHS England; are NHS England effectively communicating who has responsibility for coordinating the care of those young people?

7. Methodology

The review process is designed to ensure an open and collaborative approach which includes the perspectives and views of family members and practitioners, that there is a focus on *what* happened and *why* practice decisions were made. The review seeks to move beyond a focus on individual practice to an understanding of lessons for the safeguarding system as a whole.

The process of the review will be:

1. Gathering and analysing written information via chronologies and other relevant reports.
2. Agreeing key practitioners who should be offered an opportunity to contribute.
3. Meeting with family members.
4. Meeting with practitioners led by the Lead Reviewer along with representatives from the Review Team
5. The key themes and learning to be agreed with the Review Team.
6. Production of a draft report to be agreed by the Review Team.

7. Sharing of the final draft with all those who have contributed.

8. Production of final report agreed with the Child Safeguarding Practice Review Sub-Committees in both Essex and Luton (this is likely to be a joint meeting) and then presented to the two LSCB Executive Groups

The Lead Reviewer

Moira Murray is a social worker by training and has undertaken numerous SCRs, Learning Reviews and Safeguarding Children Practice Reviews. She has been involved in safeguarding audits for the NHS, the voluntary sector and local authorities. She co-authored HM Government *Safeguarding Disabled Children Practice Guidance, 2009* whilst Head of Safeguarding at the Children's Society. She was a non-executive board member of the Independent Safeguarding Authority for 5 years, was Safeguarding Manager for Children and Vulnerable Adults, London 2012 Olympics and Paralympic Games; has undertaken a review for the Foreign & Commonwealth Office, reviewed the BBC post Jimmy Savile and undertaken safeguarding reviews of Premier League Football. Until recently she was the Senior Casework Manager in the National Safeguarding Team, Church of England.