Local Child Safeguarding Practice Review

W13

‘Sam’

April 2022

Jon Chapman

Contents

1. Executive summary – about this review	**page 3**
2. Focused chronology prior to incident and around incident	**page 4**
3. Application of relevant research, policy and other reviews	**page 7**
4. Single agency learning and conclusions	**page 10**
5. Partnership learning and conclusions	**page 16**
6. Learning already implemented	**page 17**
7. Action timeline for implementation of learning and development	**page 18**

'Workers from some agencies seem more interested in blaming Children's Services for what is not being offered rather than providing support and I do not need to hear that. I simply want professionals to work together'

Sam's father (2 weeks before Sam's death)

1. Executive summary - about this review

This review has been undertaken within the parameters set by the Walsall Safeguarding Partnership, which has included the format and length of the review by use of the partnership template. Although is a complex case with a significant background this review was commissioned to focus on the period from May 2020 to October 2020.

This review focuses on the lived experience of Sam, who at the time of his death was 15 years of age. Sam tragically took his *own life; this followed three recent hospital admissions as a result of Sam self-harming. Sam had been known to services* for a number years.

It is the role of a Safeguarding Practice Review to view the support that Sam and his family received to understand not only what happened but how things happened and whether different approaches or actions may have resulted in different outcomes.[1]

It is not the role of this review to examine the predictability of what happened to Sam or hold organisations to account, there are separate processes which should be undertaken to examine these features if appropriate. The role of a Safeguarding Practice Review is to reflect on how the safeguarding system worked together to safeguard Sam and provide support to his family and seek to prevent or reduce the risk of reoccurrence of similar incidents.

Sam, at the time of his death, lived with his father. His father and mother had separated when Sam was 2 years old, and their relationship remained difficult and acrimonious. Sam had lived with his mother and her partner, along with his sister up until 2017. This arrangement changed after a relationship breakdown between Sam and his mother and her partner, as a result Sam went to live with his father. The breakdown in their relationship was an enduring cause of anxiety and distress to Sam.

Both Sam's father and mother have engaged with this review and their involvement and frankness is very much appreciated, at what is a very painful time for them.

Sam was born a female but has identified as a male since 2016. Sam had been working with the National Gender Identity Development Service[2] (GIDS) since July 2019, who were undertaking an assessment and were due to complete a report towards the end of 2020, before which Sam unfortunately died.

Sam's behaviour had been seen as "challenging" for some time; he had attended three secondary schools and two other educational provisions and just prior to his death was undertaking a managed move under the Fair Access Protocol[3]. Sam had been the subject of

[1] Working Together 2018 HMG

[2] The Tavistock and Portman NHS Foundation Trust

[3] Walsall Council, Fair Access Protocol 2017 - a managed move is an admission which is arranged on a 12 week trial basis. This is a voluntary agreement between head teachers.

bullying and was also alleged to have been the perpetrator of aggressive behaviour. It is the strong view of Sam's father that there was a disparity of equality in how these incidents were dealt with by both the school and the police when they were reported. He would also state that there was no evidence which supported the allegations made against Sam.

Sam had been supported by a Child in Need Plan[4], which was instigated in September 2019, following an assessment.

Sam had been supported by the Children and Adolescent Mental Health Services (CAMHS) having first been referred in 2013 (aged 8). At this time a small piece of Family Therapy work was undertaken with Sam. Sam was referred to GIDS in June 2017 but had to wait 22 months for the first appointment. Sam was admitted to hospital on four occasions prior to the scope of this review, with what is described as "superficial self-harm and overdoses".

Through September and October 2020, Sam was admitted as an inpatient to hospital on three occasions, twice having taken an overdose of medication and once having self-harmed by cutting. On the first one of these occasions, he was detained under the Mental Health Act[5]. Before, during and after these admissions Sam's father made it clear to professionals that he felt unable to protect Sam from further self-harm and Sam stated that it was his intention to end his life. On each occasion Sam was assessed and was deemed not to be suffering any mental health disorder and was discharged back to the care of his father.

On each of these occasions there was no clear and coherent multi-agency risk assessment undertaken which was understood by all the agencies involved. Sam's father's perception is that each agency blamed the other but did not offer any solutions or real support.

2. Focused chronology prior to incident and around incident

Following two Child and Family assessments, in August and October 2019 (the first after a referral from GIDS and the second following Sam being admitted to hospital having taken an overdose) Sam and his family were supported by a Child in Need plan. During the period of the review (1st May 2020- 29th October 2020) there were five Child in Need meetings, which is in accordance with local procedures. This period steps across the first period of national lockdown due to Covid 19.

---

https://go.walsall.gov.uk/Portals/0/Uploads/Education/Admission%20documents/Secondary%20Fair%20Access%20Protocol%20Version%202%20December%202017

[4] Child in Need Plan - will follow where an assessment has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989

[5] Section 5(2) Mental Health Act - gives doctors the ability to detain someone in hospital for up to 72 hours, during which time you should receive an assessment that decides if further detention under the Mental Health Act is necessary

The Child in Need meetings did not always include relevant parties. There were a number of professionals working with the family, Children's Services (including Turning Point[6] from May 2020), CAMHS, GIDS and the schools Sam attended. The schools were not invited to all meetings. CAMHS attended the meetings they were invited to, but GIDS, who had a significant role during the course of the plan were not invited to any of the meetings.

From as early as May 2020 a Non-Violent Resistance (NVR) course was discussed and agreed with Sam's father. Sam was referred for Dialectical Behavioural Therapy (DBT)[7] in July 2020. Neither of these interventions had been delivered by the time of Sam's death. This was partly due to waiting times and the impact that Covid was having on delivering these interventions.

From August 2020, Sam started self-harming by cutting. This escalated in September and October 2020, with three hospital admissions.

Hospital admissions:

4th September 2020 to 7th September 2020 – Sam was admitted to hospital having cut his arms and taken Xanax[8] and previously MDMA. On the ward he was seen and assessed by a CAMHS psychiatrist. A history was taken and during the reflective discussion the psychiatrist described the mixture of drug use described by Sam as the worst they had experienced. Whilst on the ward drugs were found in Sam's bag. His father was concerned regarding possible drug debts and felt that he could not keep Sam safe from self-harm at home. Sam was detained under the Mental Health Act, after trying to leave the ward. Sam expressed no remorse for his actions and stated that if the opportunity were there, he would attempt to end his life again. No mental health illness was diagnosed, and it was assessed that medication was not appropriate. Sam was not deemed suitable for a Tier 4[9] admission.

28th September 2020 to 30th September 2020 – Sam was conveyed to hospital having taken Xanax tablets and MDMA and cut his hands. Sam was seen and assessed, and his father stated that he had found two bottles of bleach in his room. Sam stated that he would end his life by jumping off a bridge or putting himself in front of a train. There was discussion with the Local Authority regarding accommodating Sam. Sam stated that he took drugs to sleep and felt he needed medication. Hospital staff caring for Sam expressed concerns regarding his safety. The ICAMHS assessment was that there had been no change since the

[6] Turning Point - a specialist service which is part of Children's Social Care, designed to work with parents and children to strengthen inter-personal relationships and empower families to stay together where safe to do so.
[7] Dialectical behavioural therapy (DBT) is a type of cognitive behavioural therapy. Cognitive behavioural therapy tries to identify and change negative thinking patterns and pushes for positive behavioural changes. DBT may be used to treat suicidal and other self-destructive behaviours
[8] Xanax - Xanax is an antianxiety medication in the benzodiazepine family.
[9] Tier 4 – Specialist and inpatient services

previous admission and Sam was discharged into the care of his father. His father stated that he was receiving no additional support and requested a copy of the discharge plan.

12th October 2020 to 16th October 2020 – Sam was conveyed to hospital after stating an intention to kill himself and cutting his arms. Sam was assessed by ICAMHS on the day of admission and deemed mentally fit to be discharged. Concerns were raised by ward health staff regarding the response to Sam's escalating self-harm. The case was escalated within the hospital safeguarding team. Sam again requested medication and stated that he took drugs to help him sleep and cope. He stated he had never felt as bad as he did at this time and again stated an intention to kill himself. There was a multi-agency AMBIT meeting[10] on 13/10/20 and a multi-agency professionals meeting on 15/10/20 to discuss options. The second meeting recognised that whilst there was no diagnosed mental health condition, Sam was emotionally vulnerable. A plan was put in place for Sam to be supported daily for 2 hours by a worker who would visit his home. The plan also stated that if access could not be gained the police would be called. On 16th October 2020, Sam absconded from the hospital. He was located by his father and it was deemed he did not need to return as he was previously identified as being medically and mentally fit to be discharged. Sam's father expected that Sam would be returned to hospital and was surprised when this did not happen.

The additional care visits started on 19th October 2020, with an introductory visit. For the next two days there was no response when the address was visited but the police were not called as it was believed important to build a relationship with Sam, this was a conscious and considered decision made by the social worker. The carer was successful with two further daily visits (23 and 24 October). There were no visits over the weekend period as Sam's father was believed present. There were successful visits the following week except on one occasion due to a staff absence. On the Thursday of this week Sam died.

Sam was also seen by professionals post his discharge including ICAMHS on 22nd October 2020. During this appointment Sam again stated that he was low and that he required medication. He stated that he thinks about harming himself every day and different ways of doing this. He was discharged from ICAMHS back to the care of community CAMHS.

On 28th October 2020, Sam attended an appointment with CAMHS. The following day there was a Child in Need meeting planned, however Sam was discovered in his room having apparently taken his own life. Ambulance services attended but despite attempts to revive him Sam died.

---

[10] AMBIT - Adolescent Mentalization-Based Integrative Treatment is a developing team approach to working with hard-to-reach adolescents

3. Application of relevant research, policy and other reviews

There were three hospital admissions within a short period of time, these followed other instances of self-harm. There were a number of agencies involved with Sam and his family, but the activity lacked any overall coordination. A NSPCC review of themes from serious case reviews involving teenagers[11] finds that risk assessments for self-harm did not include a coordinated care plan or a lead professional. It also recognises that often behaviour is identified as “risk taking” or “challenging” but the root causes are not explored.

Self- harm is recognised in the Cross-Government Suicide Prevention Workplan[12] as a key indicator of suicide across community, hospital and custodial settings. The Government outcomes strategy to save lives[13] recognises that outside of the pandemic, rates of suicide and self-harm in 10 to 24-year olds in England have been steadily increasing over the last decade. The report also identifies that 60% of young people who died by suicide had been in contact with specialist children's services.

Sam undoubtedly suffered from anxiety and distress from the separation and perceived abandonment from his mother. It was understood to be a trigger for some of his self-harm. This factor is recognised by both his parents.

An added dimension for Sam was other people’s difficulty in recognising his gender identity. It is recorded that Sam felt his father did not really support his decision. His father would strongly refute this but states he did have concerns regarding his motivation and felt that Sam wanted to identify as a male to rekindle a relationship with his mother. Sam’s father would say that it was a cause of distress to Sam where agencies failed to correctly identify and refer to his gender identity. A notable exception to this was the CAMHS support worker who even though they knew Sam in his previous gender was always correct and sensitive in their interactions with Sam.

The Tavistock website states: "Adolescents who present with gender dysphoria and cross-gender identification well after the onset of puberty, are more likely to also have significant psychopathology and broader identity confusion than gender identity issues alone." [14]

There are recorded instances where Sam was subjected to abuse and bullying as a result of being transgender. These occurred both within and out of school and were recorded by Police or school. Most of these are out of the scope of this review but the view of the panel

[11] Teenagers: Learning from case reviews, NSPCC 2021

[12] Cross Government Suicide Prevention Workplan, 2019 HMG

[13] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives, 2021 HMG

[14] Tavistock GIDS Evidence Base http://gids.nhs.uk/evidence-base (accessed 10/05/21)

for this review was that support for schools involved with gender identity cases requires further development.

Research by Stonewall shows that 45% of LGBT young people have experienced homophobic, biphobic or transphobic (HBT) bullying at school, while 40% have been the target of HBT abuse online, placing LGBT young people at significant risk of poorer mental health outcomes, whilst 33% of LGBT young people did not feel safe at school.[15]

The NICE guidance on long term care of self-harm[16] states care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. A risk management plan should be clearly identifiable as part of the care plan. The care plan and risk assessment should be shared appropriately with all involved agencies and professionals including the GP. This did not happen in Sam's case.

One of the areas for consideration in this review is whether the case should have been escalated to Child Protection on the basis that Sam was likely to suffer significant harm[17].Sam was on a Child in Need Plan. Assuming the Child in Need Plan and the multi-agency group involved in it are strong and engaged then, in this case, it is difficult to see what a Child Protection Plan would have added. Although the legislative framework of Child Protection may have added more rigour, the focus was working with Sam and his family. As evidenced in relevant research[18], [19] , considerable stress is experienced by families when child protection is used and, especially when working with adolescents, this can result in alienating children and disempowering parents who are responsible for their care.

No one agency can identify or address the complex needs of Children in Need in isolation and it is crucial that children and families receive support in a co-ordinated way. Effective multi-agency working sees all services contributing to the processes of assessing, planning, and delivering support to improve outcomes – with the right information shared to achieve this[20].

The Child in Need plan in this case did not include all relevant partners and could not be described as robust. The meetings did not include the school on all occasions and did not include GIDS, who were unaware of the level of self-harm Sam was undertaking until they

---

[15] Stonewall Scholl Report 2017, https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf (accessed 02/06/21)

[16] Self-harm in over 8s: Long term management, National Institute of Clinical Excellence 2011

[17] Significant harm - The Children Act 1989 introduced the concept of significant harm as the threshold which justifies compulsory intervention in family life in the best interests of children. There are no absolute criteria for establishing significant harm. Whether the harm, or likely harm, suffered by the child is significant is determined by comparing the child's health or development with that which could reasonably be expected of a similar child.

[18] Rethinking child protection strategy: child protection and assessment. Devine L and Parker S ESRC evidence briefing 2015.

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

[20] Improving the Educational Outcomes of Children in Need of help and protection. Department of Education, 2018

were invited to an AMBIT meeting in October 2020 at the time of Sam's last admission to hospital. This is a large gap bearing in mind the impact that Sam's gender was having for him and his family. The plan lacked any real direction and did not appear to seek to understand and address the root causes of the Sam's issues. There is no mention on the use of controlled substances, the consideration of medication or the escalation of self-harm and his intent to take his own life and how these issues might be addressed. There is no cross reference to any other care or risk plans or other professionals' meetings.
There had been concerns raised by Sam's father that Sam was vulnerable to Child Sexual Exploitation (CSE) in September 2019, after he was found drinking with older people. This was appropriately assessed and at that time Sam was deemed to be at low risk.
When admitted to hospital in September 2020, concerns were again raised around potential exploitation. These related to Sam's use of drugs and potential debts that he had incurred, but his risk of exploitation was not assessed formally again. The rationale for this was because it was not considered to be necessary given the nature of the concerns raised. It was believed these did not indicate risk factors that would have changed the outcomes previously assessed. There is no record of CSE being considered or discussed in the Child in Need review meetings. The local Guidance on CSE states:-
'*Every professional who engages with victims of exploitation has a responsibility for keeping them safe. No single practitioner can have the full picture of a victim's needs and circumstances and, if victims and families are to receive the right help at the right time, every professional who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.'*[21]

At the same time as this review was being conducted the Black Country and West Birmingham CCG undertook a thematic review[22] into six cases of adolescent suicide or attempted suicide between October 2020 and April 2021 occurring the Black Country region.

The thematic review identified a number of factors that are present and relevant in this case.

- The presence and cumulative effect of Adverse Childhood Experiences[23] (ACEs) and how these '*would begin to provide evidence of the presence of safeguarding risks that could increase the potential likelihood of suicide antecedents and in-turn increase the risk of suicide.*'
- The impact of the pandemic and the isolation that this incurred for children and young people.
- The rising rates of mental health issues in children and young people, of the 6 cases considered 5 of the children were known to CAMHS.

[21] Exploitation Pathway Guidance - Walsall Safeguarding Partnership, 2020 - https://go.walsall.gov.uk/Portals/37/Pathway%20Guidance%20Ver%202_5%20FINAL.pdf (accessed 10/05/21)
[22] Safeguarding Review of suspected Child Suicides in the Black Country and West Birmingham, Black Country and West Birmingham CCG, May 2021
[23] Adverse Childhood Experiences (ACEs) - traumatic experiences that occur before the age of 18 and are remembered throughout adulthood – Public Health Wales.

The report makes ten recommendations, one of which is that the review is shared with the regional Safeguarding Partnerships who may wish to gain assurance that the recommendations are picked up by their safeguarding partners.

4. Single agency learning and conclusions

During the course of this review, agencies who have been involved have identified areas for internal development or the author has identified areas for single agency development.

Walsall Healthcare Trust

The Royal College of Nursing Guidance[24] that all children and young people who self-harm should normally be admitted into a children's ward under the overall care of a paediatrician and be assessed fully the following day. Those who are involved in the emergency treatment of self-harm by children and young people should be adequately trained to assess mental capacity in children of different ages, understanding how issues of capacity and consent apply to this group. They should have access at all times to specialist advice. In addition, they should understand confidentiality, consent, parental consent, child protection issues, and the use of the Mental Health and Children Acts.

The Trust has undertaken a Fact-Finding Enquiry on their involvement in this case. This enquiry has identified a number of developments to be implemented by the Trust. These developments have been made the subject of an action plan with Trust leads and target dates to monitor and ensure their progress.

Some of these actions are relative to the Trust and some that have been identified feed into the Partnership Recommendations of this review.

- To agree a service level agreement with mental health providers.
- Establish and communicate a clear process between the Trust and social care providers.

Walsall Children Services

- Need to ensure that Child in Need plans are robust and include: -
  - What support/services are needed to help the family achieve the changes.
  - Who will do what, by when, setting out clear timescales for action (that are realistic and achievable), change to be achieved and review of the plan.
  - That review meeting includes all relevant organisations that are involved with the child and that the GP is aware of the support.

[24] Mental Health in Children and Young People, an RCN toolkit for nurses who are not mental health specialists - Royal College of Nursing, 2014

General Practice

Sam is said to have avoided contact with his GP as on their records Sam was referred to as his natal gender and was referred to as his female name. He did access advice at the beginning of October 2020 when he was seeking support for medication. The GP was unable to prescribe medication as Sam was under the care of CAMHS. During the course of this interaction there was no direct conversation by the GP with Sam.

- GPs should ensure that where a person identifies as a gender that is different to their birth gender that this is reflected on their records and any correspondence also reflects this. This is also relevant other agencies and will be reflected in the partnership recommendations.
- GPs should ensure that they are able to capture the voice and wishes of children and young people.

Schools

It was established that when Sam moved schools, information regarding his vulnerability was not transferred and this impacted the ability of the new school to understand fully how Sam could be supported and necessitated Sam having to recount his story again.

- Walsall Education should ensure that the Fair Access Protocol allows for the exchange of information between schools which will assist in the transition process and enhance the safeguarding of vulnerable children.

Black Country Healthcare NHS Foundation Trust

Black County Healthcare NHS Foundation Trust has undertaken a separate Root Cause Analysis Investigation and produced a report and action plan. Some of the recommendations relate solely to the Trust but the below contribute to the Partnership recommendations.

- The wider multi-agency network must strengthen the shared responsibility and effective risk management between the young person, parents, extended family and professionals engaged.

- CAMHS/ICAMHS clinicians must ensure correspondence to the GP is also routinely copied to key services and professionals as appropriate to enhance information-sharing and multi-agency engagement.

- Where there is no clearly diagnosable acute mental disorder, reference to adverse childhood experiences or problems in the social environment be explored to support both communication and care delivery. Childhood experiences to adult outcomes indicator tools, for example The Adverse Childhood Experience and Resilience Scales, may strengthen the pathways across services related to young people.

This review finds that: -

- CAMHS should review the process for prioritising the referrals for Dialectical Behaviour Therapy and Non-Violent Restraint training, in particular where they are being relied on as part of a care and risk plan

GIDS

From the time of referral to the time that the GIDs service started to work with Sam 22 months had passed. There was an expected 6-8-month delay.

- GIDS should review the time that cases take to progress to contact with a prospective client.
- GIDS should review how they liaise and share information with other organisations when they are working with adolescents, including care and risk management plans.

5. Partnership learning and conclusions

Sam's case was complex for a number of interrelated factors. It is apparent that a deep-rooted cause of concern for him was his fractured relationship with his mother. This is recognised by both Sam's father and mother, as well as professionals who interacted with Sam over a period of time. Following an incident between Sam and his mother's partner, Sam had started to live with his father. The relationship between Sam's father and mother was acrimonious and this undoubtedly further impacted on Sam. Those who worked closely with Sam recognised emotional dysregulation triggered by feelings of abandonment and lack of attachment to his mother.

Sam was supported by CAMHS in the community, and of all the support afforded to Sam his father would comment more favourably on this support. There was consistency in the worker who supported Sam.

In June 2017, Sam was referred to the GIDS service by CAMHS but unfortunately his assessment did not commence for some 22 months. This waiting time is noted as unacceptable by an inspection of the service in October 2020[25]. During this time the CAMHS support worker did their best to support Sam and his father. Children's Services became involved with Sam again in September 2019 when they received a referral from GIDS over concerns regarding Sam's relationship with his father.

GIDS understandably attempted to explore the relationship between Sam and his mother as this seemed fundamental to Sam's wellbeing and potentially provided some motivation

[25] Gender Identity Services < Inspection Report 2021, Care Quality Commission - https://api.cqc.org.uk/public/v1/reports/7ecf93b7-2b14-45ea-a317-53b6f4804c24?20210301173155 (accessed 10/05/21)

regarding his gender identity. It is cited in records on more than one occasion that Sam felt his mother would have cared about him more had he been a boy. Sam's father felt that this dialogue with the mother excluded him and he felt that he was unfairly judged by GIDS.

The involvement of GIDS was a very important milestone for Sam on his journey, it is not clear that when this work commenced that GIDS had a full social care and CAMHS history and understood the difficult parental dynamic. During the period of 22 months, whilst the first appointment was awaited it was left for CAMHS to manage Sam's gender identity. Once the service started to work with Sam CAMHS made a number of requests to GIDS for care and risk management plans but these were never received. The CQC inspection report also found that care plans were not always in place for young people.

Sam seems to have been in a difficult circular conundrum, from which it was challenging for him, or others close to him to help him, particularly without a fully joined up and coordinated approach from agencies.

His relationship with his mother, his gender identity and uncertainty for the future caused Sam serious anxiety and emotional turbulence. These factors and issues emanating from them (isolation, loneliness, bullying, school breakdown, abandonment, drugs misuse, self-harm) impacted on Sam's stability in relationships and everyday life. A recent report by the national Mortality Database on suicide in children and young people found that of the cohort they looked at 69% had suffered a loss in the form of bereavement or living loss in the form of a losing a close relationship[26]. There are several references in agency records to Sam taking controlled drugs as a method of self-medication and he articulated that he felt he needed prescribed medication to help him cope, both with daily activities and to help him sleep at night. Consideration of medication was assessed by a psychiatrist on Sam's hospital admission in September 2020, but this was considered inappropriate due to the perceived lack of safeguarding in the family home and Sam's use of drugs. The GP felt unable to prescribe medication as Sam was under the care of CAMHS.

Due to the lack of stability, Sam's inability to maintain a school life and his use of drugs, compounded by the risk in his life and the perceived lack of parental support for interventions, Sam was due to hear shortly before his death that GIDS considered that he was not eligible for consideration of any physical interventions. This news would have been likely to have impacted significantly on Sam and increased his instability. There is no indication that Sam was aware of this decision prior to his death.

It is difficult to see how Sam was going to achieve the stability he needed to be considered for interventions without enhanced or a different type of support, which was not forthcoming.

[26] National Child Mortality Database, Suicide in children and young people,2021

As the self-harm and risk increased the professionals closest to Sam and his father expressed concerns that Sam would take his life. His father was absolutely clear with professionals that, despite best efforts, he could not keep Sam safe and he required more support. Sam was likewise clear that he would be unable to keep himself safe at home and he felt he could not live with his father any longer and wanted an alternative. The only considerations were a Tier 4 admission or a foster/residential care placement

Neither of these were deemed appropriate. The Tier 4 option was dismissed on the basis that Sam did not have a mental health diagnosis, despite recognition that his emotional wellbeing was very vulnerable, he had been referred for DBT since July 2020 and he had been admitted to hospital having self-harmed on three occasions within one month having repeatedly threatened suicide. The Children's Social Care Independent Management Report for this review makes the case that Sam being accommodated with foster carers was deemed not possible on the basis that it was not agreed by his parents and Sam did not meet the threshold for care under the Children Act[27], although it is clear that the decision on accommodation was not based on a threshold basis. Sam's father's concern with Sam going to foster carers was their ability to keep Sam safe. It was apparent that accommodation was being considered as the minutes of the professionals meeting on 15th October 2020, during Sam's last admission into hospital, reflect this consideration and there being no appropriate placement available.

This review has established that there was consideration of a placement but there were a number of factors to consider. It was viewed that although Sam's relationship with his father was strained, his father was a protective factor, and his absence could have been detrimental. There was also difficulty in sourcing a suitable placement, which potentially would have entailed Sam moving a considerable distance and the potential for this having a negative impact on Sam. Whilst these considerations may have been made, they were not adequately reflected on records or conveyed to Sam and his father. On his last hospital admission Sam was still expecting that alternative accommodation was being located for him. Sam's father was not aware of this at the time or that this had been proposed to Sam as a possibility.

Although it is impossible to say whether there would have been any impact on the eventual outcome, consideration could have been given to accommodating Sam under a section 20 Children Act[28] to allow Sam's father and an opportunity to get some respite and to allow for a hiatus to allow for assessment, risk planning and DBT to commence. There is a view that this would have been counterproductive and allowed Sam to push boundaries further than he had done already. What would be good practice is to evidence that all options were

---

[27] Section 31 Children Act 1989, Care and Supervision - https://www.legislation.gov.uk/ukpga/1989/41/section/31 (accessed 09/05/21)
Sam was still of the

[28] Section 20 Children Act 1989 - https://www.legislation.gov.uk/ukpga/1989/41/section/20 (accessed 09/05/21)

considered. There is evidence that Sam's issues were seen as a mental health or social care issue as opposed to a multi-agency problem requiring a coordinated approach.

Very late in the proceedings Sam started to discuss the possibility of living with a grandparent in another part of the country, as he felt they understood him. This arrangement may not have been achievable or appropriate but there is no evidence that it was fully explored as an alternative.

On the last admission to hospital Sam absconded and there was an apparent acceptance of this by all agencies on the basis that Sam was medically and mentally fit to be discharged. Whilst it was the case that Sam had been deemed fit for discharge, he was being allowed to remain in hospital while consideration was given to further support and accommodation. Sam's father found it surprising that more consideration was not given to the reasons why Sam had left hospital.

On each of the occasions that Sam was discharged from hospital, although there was an increase in support, there was a lack of a coherent care and risk plan which was jointly agreed, clear on responsibility and lead and understood by all. Guidance on suicide and self-harm in adults published by the Royal College of Psychiatrists[29] recognises that there is emerging evidence of the effectiveness of safety plans (Zonana et al.2018).

The multi-agency professionals meeting held at the time of the last hospital admission had agreed a support worker/carer would visit each day to support Sam (as his father was working) and if access could not be gained the police would be called. This was a practical measure but did not seek to address any of the root causes or continuing risk of self-harm. At the professional's reflective workshop for this review there was a difference of opinion as to whether Sam's discharge and the plan was agreed by all agencies. This is not apparent in the minutes, which were only in draft and not circulated to those attending the meeting. Had there not been agreement and if professionals still had concerns an escalation should have been considered[30].

Sam was on a Child in Need plan, GIDS had a care plan, CAMHS had a risk plan. After the final admission there was a multi-agency AMBIT meeting on 13th October and a multi-agency professionals meeting on 15th October 2020. Not all those involved with Sam were invited to meetings and there was insufficient link up or cross reference to the meetings or plans. The minutes were not circulated and in the final two meetings there were no clear actions and deliverables. There was no coherent lead or coordination. Certainly, Sam's father felt that nothing changed as a result of the hospital admissions and there was no tangible support for Sam or him. It must be recognised that there was considerable focus

29 Self-harm and suicide in adults, Royal College of Psychiatrists, 2020 - https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10 (accessed 11/05/21)

30 Escalation and Resolution Policy - https://westmidlands.procedures.org.uk/local-content/4gjN/escalation-policy-resolution-of-professional-disagreements/?b=Walsall (accessed 11/05/21)

from agencies, but this lacked multiagency thinking and coordination. There seemed to be a sense of helplessness from agencies, which mirrored Sam's own feelings.

The Royal College of Physiatrists guidance on managing self-harm in young people[31] recognises that it is essential that all providers of healthcare, including NHS trusts, Primary Care Trusts and local health groups ensure that a protocol for the management of self-harm is agreed between the professional staff and managers. It recommends that a consultant paediatrician (local lead) and a consultant child and adolescent psychiatrist be nominated as the joint service leaders. It goes on to recommend that they should work together to ensure that protocols for assessing, caring for and treating young people who harm themselves are negotiated with and agreed between their employing Trusts or directorates, where they are different.

This initiative is also recognised in the Walsall Multi-Agency Suicide Prevention Strategy[32] which states that a self-harm and suicide information sharing protocol between key partners will be developed.

Partnership recommendations

1. The Walsall Safeguarding Children Partnership should ensure that relevant partners including Walsall Healthcare Trust, Black Country Healthcare Trust and Walsall Children Services develop a protocol and pathway for assessing, caring for and treating young people who harm themselves which is understood and agreed between their agencies. This work should include: -

> (a) Ensuring that where there are care and risk plans, they are jointly developed and owned. That there is a clear understanding on which agency is responsible for designated actions and there is an identified lead professional.
>
> (b) To ensure a Think Family approach is adopted and requires safeguarding and risk to be considered and documented.
>
> (c) In the context that Mental Health Services remain the experts in mental health, that all staff receive appropriate training on self-harm and suicide according to their role and this includes and understanding of the roles and expectations of other agencies.

[31] Managing self-harm in young people, Royal College of Psychiatrists 2014 - https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr192.pdf?sfvrsn=abcf1f71_2 (accessed 11/05/21)

[32] Walsall Multi-Agency Suicide Prevention Strategy, 2018-2023 - https://www.walsallintelligence.org.uk/wp-content/uploads/sites/6/2019/03/Walsall-Multiagency-Suicide-Prevention-Strategy-2019.pdf (accessed 11/05/21)

2. The Walsall Safeguarding Children Partnership should review the Walsall Resolution and Escalation Policy to ensure that it is effective and that this policy is used to appropriately challenge safeguarding decisions.

3. Gender Identity Service should develop a protocol on working in parallel with young persons who are receiving their services where there are other agencies involved such as CAMHS or the Children Social Care.

4. The Walsall Safeguarding Children Partnership should be assured that all partner agencies are appropriately involved in Child in Need plans and that Children's Services ensure that relevant agencies are invited.

5. The Walsall Safeguarding Children Partnership should share the findings of this review with the leads for the Walsall Suicide Prevention Strategy and Walsall Adolescent Strategy.

6. Walsall Education should use the findings of the recent schools safeguarding audit to further develop the support offered to schools in relation to LGBT children.

7. All agencies involved in this case should review their transgender policy, procedures and training to ensure that they are fit for purpose and understood by all staff. That they should ensure that where a person identifies as a gender that is different to their birth gender that this is reflected on their records and any correspondence.

8. All agencies should ensure that staff are aware of, and consider the use of, the Exploitation Pathway, where it is deemed not necessary the rationale should be clearly recorded.

6. Learning already implemented

Walsall Children Services identified that during the course of Sam's case the police and CSC undertook a strategy meeting in relation to a disclosure by Sam's father that he purchased Sam and his sister alcohol. It is recognised that this strategy meeting was not compliant with guidance[33] in that such a meeting should include health and other relevant bodies who are working with the child. This gap was identified by the CSCS IMR and addressed by an action plan, which includes both single and multi-agency audit and scrutiny.

The Black Country and West Birmingham Safeguarding Review of suspected child suicides has been appropriately shared at all levels within the Partnership and there is continued activity to take forward the learning from it.

[33] Working Together 2018, HMG

7. Action timeline for implementation of learning and development.

The most important recommendation in this review is the joint understanding of care and risk planning. This is an important piece of work and already is referenced in part in other plans. Some work will need to be done to understand what progress and has been made and then to build on that.

It is recommended that all the accepted recommendations of this review are formulated in a joint delivery plan, driven by SMART actions which are time limited and overseen by the Safeguarding Partnership.