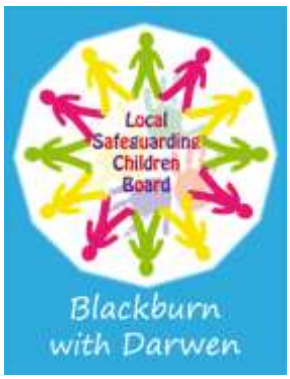

Serious Case Review following the suicide of Child Y

Independent Author: David Mellor BA QPM

Foreword by Local Safeguarding Board Chair

This serious case review (SCR) was commissioned in April 2017 following information presented to me that Child Y had died and had been known to a number of services relating to abuse.

Before I outline the response from Blackburn with Darwen Local Safeguarding Children Board (LSCB) to this SCR, I would like to offer my heartfelt condolences, on behalf of all the agencies involved in this SCR, to the family of Child Y for their tragic loss. I would also like to thank the family members that contributed very bravely to this SCR and for their insights into how services can be improved in the future.

All SCRs identify findings that individual agencies and multi-agency systems need to learn from so that the future recurrence of similar circumstances can be reduced. This case is no different and as an LSCB, covering all services that undertake work to safeguard and promote the welfare of children, we have fully accepted the recommendations made by David Mellor. With these recommendations, the agencies directly involved with Child Y and her family have also identified a number of learning points so their practitioners improve their practice and the agencies improve their safeguarding processes. All of these actions are being monitored by the LSCB and it is anticipated that they will be fully implemented over the coming months. In particular the learning from this SCR is being implemented into the Lancashire and South Cumbria Suicide Prevention Plan.

In addition to the recommendations from this SCR and the priorities in the regional Suicide Prevention Plan, the LSCB has prioritised improvement actions in its 2017-18 Business Plan aimed at continuing to develop the skills and competencies of practitioners that work with our children and families so that indicators of abuse or neglect are responded to and children and families receive the services that are available locally.

Earlier this month I chaired the Quality Assurance Committee of the LSCB and I was provided with an update on all the progress made with implementing the recommendations from this SCR, both multi-agency and single-agency. A number of agencies had already implemented their action plans in full and others were on their way to fully implementing their learning in the coming months. The LSCB has been recommended by David Mellor to monitor changes to some safeguarding processes that were implemented very soon after this SCR was commissioned and I will make every effort to ensure the learning is embedded in practice and leads to processes and systems that consistently safeguard and promote the welfare of children in the borough as expected by statutory guidance and local procedures. Our collective aim remains to maintain a local safeguarding system that helps in preventing abuse and neglect, and where abuse and neglect does take place that children are effectively safeguarded.

Nancy Palmer
Independent Chair, Blackburn with Darwen LSCB
January 2018

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1.0 Introduction

1.1 Child Y died in late February 2017 having taken an overdose of prescribed and over the counter drugs at her home address four days previously. At the time of her death she was fourteen years old.

1.2 In April 2017 Blackburn with Darwen LSCB decided to commission a serious case review (SCR) on the grounds that Child Y was known to have suffered abuse and had died.

1.3 The LSCB appointed David Mellor as the independent SCR report author. David is a retired police chief officer who has over five years experience as an independent author of SCRs and other statutory reviews. He has no connection to services in Blackburn with Darwen. It was decided to adopt a "systems" approach to conducting the review. A more detailed description of the process by which the SCR was conducted is set out in Appendix A.

1.4 An inquest took place in June 2017 which determined that Child Y had died by suicide.

1.5 Blackburn with Darwen LSCB wishes to express sincere condolences to the family and many friends of Child Y.

2.0 Terms of Reference

2.1 The timeframe for the SCR was from October 2014 until February 2017 (the date of Child Y's death).

2.2 The following generic terms of reference were set:

- Understand precisely who did what for Child Y and the underlying reasons that led individuals and agencies/services to act as they did;

- Establish if there are lessons to be learnt about the way local agencies and services within these agencies worked together;

- Review of individual/agency adherence to agreed agency and multi-agency policies and procedures; and

- Inform and improve local inter-agency practice on safeguarding children so that it leads to reducing the risk of future harm to children.

2.3 The following specific terms of reference were set:

- Were indicators of unmet need, risk and/or compromised parenting appropriately identified by practitioners through assessments and any disclosures?

- Were service responses to indicators/disclosures of unmet need, risk and/or compromised parenting in line with single and multi-agency policy?

- Were service responses provided in a timely manner to promote the child's welfare?

- What role did management oversight play to enhance the quality of practice?

3.0 Glossary

A **Child in Need (CiN)** is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

Child and Family Assessment (C&F Assessment) The purpose of the assessment is to determine if there is identifiable evidence of risk or identifiable significant harm to the child or whether they are unlikely to achieve or maintain a reasonable standard of health or development or they have a disability.

Continuum of Need is the framework to assist all those whose work brings them into contact with children, young people and their families to identify the level of help and protection required to assist children to grow up in circumstances that achieve their best outcomes.

Fraser Competent - the Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Lord Fraser stated that a doctor could proceed to give advice and treatment:
"provided (s)he is satisfied in the following criteria:

1. that the girl (although under the age of 16 years of age) will understand his/her advice;
2. that (s)he cannot persuade her to inform her parents or to allow him/her to inform the parents that she is seeking contraceptive advice;
3. that she is very likely to continue having sexual intercourse with or without contraceptive treatment;
4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
5. that her best interests require him/her to give her contraceptive advice, treatment or both without the parental consent." (Gillick v West Norfolk, 1985)

Independent Sexual Violence Advisor (ISVA) is trained to provide emotional and practical support to survivors of rape, sexual abuse and sexual assault who have reported to the police or are considering reporting to the police.

Section 47 Children Act enquiry – Children's Social Care must carry out an investigation when they have "reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm". The enquiry

will involve an assessment of a child's needs and those caring for the child to meet them.

A **Strategy Discussion** must be held whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm.
The purpose of the Strategy Discussion is to decide whether a Section 47 Enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry.

4.0 Synopsis

Significant Practice Episode 1 – October 2014 until August 2015 during which sexual abuse of Child Y took place, partner agencies responded and the support offered and/or provided to Child Y appeared insufficient.

(A significant practice episode is an episode from which is is possible to gain an understanding the way the case developed and was handled.)

4.1 During a late evening in mid October 2014 Lancashire Police received a report from the paternal grandmother of Child Y to the effect that Child Y (then aged 12 years) had been sexually assaulted by Child Q (then aged 15 years) whilst Child Y was staying at the home of her paternal grandparents. Child Q lived with Child Y's paternal grandparents. Child Y lived elsewhere with her mother.

4.2 The sexual assault caused Child Y to become distressed. Child Q asked Child Y not to tell anyone about the assault but she informed her father, who was also present at Child Y's parental grandparent's address at the time.

4.3 The police attended, safeguarded Child Y and preserved evidence of the offence. Child Q had left the scene. Child Y was taken to the SARC (Sexual Assault Referral Centre) where she arrived in the early hours of the following morning. She was accompanied by her mother and police officers. The SARC provides forensic examinations, advice and comprehensive support services for women, men and children of all ages who make a complaint of rape or sexual assault.

4.4 Child Y was examined by a forensic medical examiner who noted some injuries which were consistent with the account Child Y had provided to the police. Forensic samples were obtained and handed to the police. There were said to be "no concerns" in relation to Child Y's general health and wellbeing. No requirement for a Genito Urinary Medicine (GUM) referral was considered necessary. Neither the police nor the SARC appear to have considered a referral to an Independent Sexual Violence Advisor (ISVA) at this time.

4.5 Child Y and her mother were later returned home by the police. A letter was sent to Child Y's GP to notify them of her attendance at the SARC. The SARC also notified their local paediatric liaison team who passed the information to hospital paediatric liaison team and then on to the school nurse service. (See paragraph 4.15)

4.6 The police submitted a crime report in respect of this sexual assault. The crime report provides an opportunity for the need for victim support to be identified by tick

box. In this case the relevant box was not ticked. However, the investigating officer has advised this review that victim support was verbally offered during a subsequent joint visit by police and children's social care. The officer recalls that mother made it clear that support was not required at that time. The police suggest that the verbal offer of victim support and the declining of that offer may be the reason why the relevant box on the crime report was not ticked. (The offer and refusal of support does not appear in either the police or children's social care chronologies. Apparently not all contact including offers of service were recorded on the police victim management system. (Vicman))

4.7 In mid October 2014 Child Q was arrested and interviewed. He was later bailed pending further enquiries. On the same date Child Y provided an achieving best evidence (ABE) interview in relation to the incident.

4.8 The same day the police informed children's social care emergency duty team of the sexual assault on Child Y by Child Q. The police notification included reference to the Special Guardianship arrangement under which Child Q resided with Child Y's paternal grandparents. The contact from the police was picked up by the multi-agency safeguarding hub (MASH) manager the following morning who decided that the case should be referred to children's social care as the level 4 threshold on the continuum of need appeared to have been met. The case was allocated to a social worker and a strategy discussion took place involving a children's social care team manager and police and the health representatives (specialist safeguarding nurse) from within the MASH. Neither the school nursing service, Child Y's school or her GP were invited to participate in the strategy discussion. The health practitioner within the MASH would have been the conduit for obtaining information from the school nursing service and GP.

4.9 The outcome of the strategy discussion was that Section 47 enquiries were initiated. The social worker carried out a home visit at which an officer from the police public protection unit (PPU) was also present. Child Y and her mother were spoken to and the former was described as being "in good spirits". Her parents were said to have acted appropriately and presented as being able to safeguard their daughter. It is unclear how confident children's social care could be about these judgements about parenting capacity given that they did not contact father at this time. There appears to have been no exploration of why victim support services had been declined. The parents were also noted to be co-operating fully with the police investigation. The outcome of the Section 47 enquiries was to continue with the children and families assessment (C&F Assessment) which had also been triggered that day.

4.10 The same day Child Y's elder sibling came into the latter's school to collect Child Y. As the elder sibling was not recorded on the school's list of contacts for Child Y, the school was initially unwilling to allow her to take Child Y home in the absence of consent from Child Y's mother. The elder sibling then told Child Y's school pastoral manager that Child Y had been sexually assaulted and needed to come home. This information was then shared with the school's senior leadership team who gave permission for Child Y to leave school with her elder sibling as these were considered to be "exceptional circumstances".

4.11 No further action was taken at that time by the school in respect of the information that Child Y had been sexually assaulted.

4.12 Two days later the police created a vicman record within their crime recording system which detailed contact with victim and family. Child Y was described as "vulnerable / intimidated".

4.13 The next day the school nursing service was advised via the paediatric liaison information sharing form that Child Y had attended the SARC for examination following an assault. School nurse 2 reviewed this information and recorded that the referral was "for information only at this time" and took no further action. The school nurse was aware that the police were involved and that the case had been referred to children's social care.

4.14 Subsequently (early November 2014) the police notified the school nursing service of the October sexual assault on Child Y by sending them a Protecting Vulnerable People (PVP) report. The consequent plan drawn up by the school nurse was to "await further contact from children's social care" and the PVP was scanned onto the school nursing Electronic Care Records (ECR) for Child Y. No contact was made by children's social care, nor was there any attempt by the school nursing service to initiate contact with children's social care.

4.15 In late October 2014 children's social care completed the C&F Assessment in respect of Child Y. Appropriate checks were said to have been undertaken with school and health. However, school and school nursing records do not indicate that further information was sought by or provided to children's social care for the assessment. The assessment identified no further safeguarding concerns and the outcome was "no further action" on the grounds that Child Y had an "excellent support network and all the adults involved with Child Y are acting appropriately and with her best interests as their focus". However, it was noted that Child Y was "upset and scared about what is going to happen next".

4.16 The letter from the SARC was subsequently received by Child Y's GP and placed in her patient records. It is assumed that receipt of the letter prompted the GP's late October 2014 contact with the hospital to inform the paediatric department of the sexual assault and contact the following day with children's social care, who subsequently advised the GP that they were aware of the assault on Child Y and her case had now been closed. The GP did not contact Child Y or her parent to ask if she required support and did not raise the issue at the next appointment with Child Y.

4.17 In late October 2014 the SARC manager telephoned Child Y's mother to check on her daughter's welfare. Mother was recorded as saying that Child Y "was doing OK", "had no problems" and was said to believe that Child Y had "lots of support". The SARC manager noted that Child Y and her mother had the contact numbers for the centre, should either of them feel the need to make contact.

4.18 In early November 2014 Child Y told her school pastoral manager that a peer had made a comment about the sexual assault. Although this conversation was recorded in the pastoral manager's log book there is no record of any action being taken and the pastoral manager is unable to recall any further details. This represented a second opportunity for the school to intervene in respect of the sexual assault on Child Y.

4.19 The police kept Child Y updated on the progress of the investigation of the sexual assault by advising either her mother or paternal grandmother of progress. The police have advised the review that they were aware of the potential conflict of interest in providing updates to the paternal grandmother, given that she had had a special guardianship order in respect of Child Q (and his birth sister). However, the paternal grandmother was seen by the police as a strong character who appeared to act as the family spokesperson. (In her contribution to this review, Child Y's mother disagreed that Child Y's paternal grandmother was the family spokesperson at that time.)

4.20 In mid January 2015 Child Y became involved in an altercation with a peer at school which was resolved by holding a restorative justice session between Child Y and two peers a few days later.

4.21 In February 2015 the police further interviewed Child Q in respect of Child Y's allegations following receipt of forensic evidence and telephone search history results. Following this interview, the police prepared a file for consideration of charges by the Crown Prosecution Service (CPS).

4.22 In early March 2015 Child Y was treated for an asthma attack at the urgent care centre (UCC).

4.23 Following consideration of third party material (relevant information retained in respect of Child Y and Q by other agencies), the CPS authorised the charging of Child Q with a sexual assault on a child under the age of 13 years. He was duly charged at the beginning of July 2015 and bailed to the Youth Court where he entered a guilty plea in mid August 2015. The case was adjourned for six weeks to enable the youth justice service to assess Child Q in order to prepare a pre-sentence report. Child Q was granted Court bail subject to conditions which included no direct or indirect contact with Child Y.

4.24 In addition to working with young people who have offended, the youth justice service also has a duty towards victims of crime, including having processes in place to ensure that victims of youth crime are involved, as appropriate, in a range of restorative processes which seek to put right the harm they have experienced.

4.25 Accordingly, in late August 2015 a standard letter was sent to Child Y's mother to notify her of youth justice involvement and advising that this was a voluntary process from which victims of crime could opt out if they wished. Youth justice simultaneously made contact with the victim support service to find out if their service was working with Child Y so that options for contact such as a joint visit could be considered. The victim support service advised that their service had not had involvement with Child Y.

Significant Practice Episode 2 – August until November 2015 including agency responses to concern about Child Y's relationship with Young Person R, provision of support for Child Y and impact upon her of sentencing of Child Q and his partially successful appeal.

4.26 In late August 2015 a youth justice worker made a safeguarding referral to children's social care in order to advise that Young Person R, who was known to the youth justice service because of his sexually harmful behaviour (having been convicted of the sexual assault of a child under 13 by touching in July 2015 and sentenced to a 12 month referral order), had disclosed that he was in a relationship with Child Y. The disclosure had been made whilst he was being interviewed for a pre-sentence report. It was suspected that the relationship may be a sexual one. This information was also shared with Young Person R's social worker.

4.27 The referral appeared to be received by the MASH at the beginning of September 2015 and an advice and consultation social worker telephoned Child Y's mother who said that the relationship between Child Y and Young Person R was now over. Mother added that she had not seen any evidence of texts, phone calls or social media contact since Child Y told her the relationship had ended. She also said

that she did not think that Child Y was sexually active. Mother accepted advice that she should safeguard her daughter to ensure that there was no further contact.

4.28 During the conversation, mother said that whilst Child Y had "a lot of support around her", her mother felt Child Y needed someone independent to open up to regarding her experiences. Mother confirmed that support had recently been offered by the youth justice service as a result of the court proceedings in respect of Child Q. A telephone discussion subsequently took place between the social worker and the youth justice service worker in which the latter agency advised that whilst they could not offer counselling to Child Y they would be able to support her through the court process.

4.29 With Child Y's mother's permission, MASH subsequently contacted Child Y's school in order to discuss appropriate emotional support for her. The school was advised that Child Y had recently been in a relationship with a "known sex offender" (Young Person R) which had now ended. The MASH was concerned that Young Person R may show up at Child Y's school. (At that time Young Person R was dual registered at Child Y's school and an alternative provision) The school was also advised that the young person who had sexually abused Child Y in October 2014 was due to be sentenced soon and that this had caused Child Y "significant distress". As a result, the school's child welfare officer said she would arrange to meet with Child Y and her mother the following week to discuss any ongoing support the school could offer. The child welfare officer advised that if counselling was needed, this would need to be accessed by mother via their GP.

4.30 Seven days after MASH received the referral in respect of Child Y, her case was closed to children's social care. Two days later Child Y's mother telephoned the MASH to report concerns of harassment towards Child Y from Young Person R and his family. Child Y's mother was advised to contact the police. Mother was said to be acting appropriately by blocking Child Y's phone and escorting her in the community.

4.31 The advice and consultation social worker later re-contacted mother who said that the situation was now calm, adding that she had been in contact with Young Person R's mother who had "begged" her not to contact the police as the family did not want any further trouble. Child Y was also said to be unwilling to report the matter to the police. Child Y's mother was said to have agreed not to report the matter, unless there were any further issues. Updates were subsequently provided to the youth justice worker and Young Person R's social worker. (In her contribution to this review mother could not recall any contact with Young Person R's mother)

4.32 Child Y's mother's view appeared to be decisive in not reporting this matter to the police. Child Y was said to be in agreement with this course of action but she does not appear to have been spoken to directly by the social worker. The suggestion that Child Y had been harassed by Young Person R and his family does not appear to have been treated sufficiently seriously and there appears to have been no consideration of whether the alleged harassment had played any part in Child Y or her mother's reluctance to report the matter to the police.

4.33 Mother was advised to contact children's social care or the police if she had any further concerns and Child Y's case was confirmed as closed to children's social care.

4.34 In mid September 2015 Child Y was seen by her GP and disclosed that she was experiencing flashbacks and panic attacks following the October 2014 sexual assault. She said she was struggling at home and in school. Her sleep had been adversely affected. School was said to be supporting her. She said she had experienced some bullying in school from other pupils who knew about the attack. She said she had received no victim support from the police and no counselling as yet. Child Y's GP faxed a referral to Child and Adolescent Mental Health Services (CAMHS).

4.35 Also in mid September 2015 Child Y's school contacted her mother who expressed concerned that Child Y was struggling emotionally and was not sleeping properly. Mother had taken Child Y to the GP to access counselling for her. Mother advised that Child Y has not heard from her "ex-boyfriend' (Young Person R) for approximately two weeks. Mother said that she would contact school if Child Y needed support. Mother also advised the school that the offender in the sexual assault case (Child Q) was due in court at the end of that month.

4.36 Later the same day Child Y was spoken to by the school child welfare officer. She said she was feeling upset and struggling with what was going on with her court case. She said that she still had to complete an impact statement. Child Y said that she didn't think that she would have any issues with her "ex- boyfriend" (Young Person R) and was said to be able to identify it as a negative relationship. Child Y was told that she could see the school child welfare officer about this incident at any time. Additionally, Child Y's head of college was made aware. There was no contact between the school and the school nursing service at this, or any other time, in respect of Child Y.

4.37 Two days later a restorative justice worker from the youth justice service made a home visit to Child Y and her mother to explain the restorative justice process and describe the sentencing options available to the youth court. Both Child Y and her

mother said that they were struggling emotionally and mother confirmed that Child Y had been referred by her GP to CAMHS.

4.38 In late September 2015 Child Y was supported by the police to complete a victim impact statement at school. Her mother was also present and was advised by the school to seek information about counselling from her GP and a local sexual health service, which is a provider of sexual health and wellbeing support to people under the age of 25. (It is unclear what prompted this advice as the family GP had already referred Child Y to CAMHS.)

4.39 The following day Child Y's mother contacted the school to say that Child Y would not be attending that day as she was upset about the impending court hearing in respect of the sexual assault.

4.40 Near the end of September 2015 Child Q was sentenced by the youth court to a Detention and Training Order for 18 months, was made subject to an indefinite restraining order and a Sex Offenders Notice for 5 years. Child Y was at school that day and was sent home early because of distress arising from the court hearing. The restorative justice worker offered to make a home visit to Child Y to provide support but her mother declined this saying that Child Y was "fed up of talking about it". Youth justice contact details were left for Child Y should she change her mind about accessing support from the service. Support was also offered to her mother should she require it in her own right.

4.41 The following day the restorative justice worker referred Child Y to the National Probation Service (NPS) Victim Contact Scheme as this was a case in which a young person under the age of 18 (Child Q) had received a custodial sentence of 12 months or more for a violent or sexual offence. NPS victim services involve liaising with the victim about outcomes and protection that may be required when their offender is ready for release.

4.42 At the beginning of October 2015 Child Y disclosed to the school child welfare officer that she was struggling with the outcome of the court case. She added that her first appointment with CAMHS was imminent, but she wanted information about other places she could get help from. She was signposted to unspecified agencies which did not include the school nursing service.

4.43 In early October 2015 Child Y told the school child welfare officer that she was worried about her CAMHS appointment which was scheduled for the following day. During the conversation Child Y stated that she wanted to "end her own pain" but the welfare officer established that Child Y was not suicidal by asking her directly whether she planned to take her own life and receiving a reply that she was not.

It was agreed that Child Y's mother would be contacted and this later took place.

4.44 The next day Child Y was seen by CAMHS. Trauma based individual therapy was offered and arrangements were made for a clinical psychologist to see Child Y. Child Y disclosed previous self harm behaviour and some suicidal ideation but she was said to have no plans to act upon these thoughts. (Child Y's mother and elder sister have contributed to this review and said that Child Y began cutting her legs for a period. It is not known if this is the "previous self harm behaviour" referred to above.)

4.45 There does not appear to have been any consideration by CAMHS of whether a referral to children's social care or use of that agency's "advice and consult" offer may have been justified at this point given the disclosure of previous self harm, suicidal ideation and vulnerability to, and arising from, sexual abuse.

4.46 The following day Child Y informed the school child welfare officer that her CAMHS appointment had been "OK" and that they were going to offer her treatment.

4.47 In early October 2015 Child Y became distressed in a school lesson in which abortion was being discussed and left the lesson. She received support from the school child welfare officer.

4.48 In mid October 2015 Child Y missed one or more lessons because of distress arising from the first anniversary of the sexual assault. However, the individual paper log books kept by staff at that time do not provide any detail of how many lessons Child Y missed and what support was offered or provided.

4.49 For two consecutive days in late October 2015 Child Y was absent from school with mouth ulcers and cystitis for which she visited her GP. Whilst a full history of her physical symptoms was taken, Child Y's sexual history was not taken as the outcome of physical examination supported the diagnosis of cystitis.

4.50 On her return to school the next day Child Y and three of her peers were involved in an unspecified disagreement. Pastoral staff were made aware of this.

4.51 The next day the NPS victim liaison officer closed Child Y's case to the service after her mother did not respond to offers of support made by letter and telephone.

4.52 In late October 2015 Child Y's GP received a letter from CAMHS advising that she had been assessed and that further psychology therapy sessions were planned.

The letter advised that Child Y had expressed thoughts of self-harm but had no plans to act upon them.

4.53 Towards the end of October 2015 the restorative justice worker contacted Child Y and her mother to advise them that Child Q had been allowed to appeal against his sentence. Mother advised that she had received the earlier letter from the NPS and was happy to be re-contacted. (See Paragraph 4.52) However, when a further letter was sent by the NPS, they again received no response from mother.

4.54 At the end of October 2015 Child Q's appeal against sentence was successful in that the Detention and Training Order was reduced to a 12 month (non-custodial) Intensive Referral Order. The Sex Offender notification period was reduced from 5 years to 30 Months. The indefinite restraining order remained in place. The restorative justice worker telephoned Child Y's mother to advise her of the outcome of the appeal. Mother was upset but declined a home visit, saying that she would rather speak to Child Y first. It was agreed that the restorative justice worker would make contact again the following week.

4.55 At the beginning of November 2015 mother advised the school child welfare officer of the outcome of the appeal and said Child Y was very upset about it. Mother was advised to contact youth justice and CAMHS and was informed that relevant school staff would be made aware and an email was subsequently sent to relevant staff. (not including the school nurse) The same day the school child welfare officer spoke to Child Y to see how she was feeling following the release of Child Q. Child Y felt she was doing better than she had been when she first found out and that she had support from both home and school. However, she did say that she was feeling overwhelmed in some lessons and finding it hard to concentrate. As a result, it was agreed that staff would be told she would be allowed to leave a lesson for 10 minutes if she was feeling overwhelmed.

4.56 On the same day the restorative justice worker followed up on her contact made in late October 2015. She was informed by mother that Child Y had been "in bits" but that she was receiving support from school and had had her first appointment with CAMHS. The restorative justice worker reiterated her offer of support.

4.57 From November 2015 until July 2016, multi-agency risk management meetings took place at three monthly intervals throughout the term of the Order in respect of Child Q. Safeguarding considerations in respect of Child Y were represented at these meetings by her restorative justice worker. No safeguarding concerns arising from the risks that the perpetrator could present to Child Y were said to have been noted

in any of the meetings. Restorative justice processes were not considered to be in the best interests of Child Y, given the sensitivities of the case.

4.58 In mid November 2015 a peer at school made a comment to Child Y and another peer that they would end up pregnant at a young age. Pastoral staff responded by bringing all three girls together to resolve the issue. On the same date Child Y spoke to the school child welfare officer about her mother who she had found crying in the early hours of the morning because of the "current situation". Child Y was very upset about this. Child Y rang her mother and the child welfare officer spoke with mother and offered her support from the school. Mother was said to have had contact with victim support. (The reference to "victim support" may have related to the support offered by NPS.)

4.59 Also in mid November 2015 Child Y was seen by CAMHS and said that her mood swings were getting worse. She had also been experiencing disrupted sleep. She mentioned memories of her grandfather dying and the sexual assault. Two further sessions were arranged.

4.60 When Child Y attended her next CAMHS appointment in late November 2015 she saw Young Person R in the waiting room. During the session with CAMHS she disclosed that Young Person R used to be her best friend but he had told her that he was going to court for an alleged sexual assault on someone. She said that Young Person R had been found not guilty but then started to use drugs and a decision had been made to keep Child Y away from him. Child Y said that their relationship was never sexual. After discussing the matter with children's social care, and obtaining a more accurate account of the risks Young Person R was considered to have presented to Child Y, CAMHS took steps to ensure that Child Y's appointments would not coincide with those of Young Person R in future.

4.61 At the same appointment Child Y also disclosed to CAMHS that she had recently had consensual sex with a 13 year old boy. She added that she wasn't in a relationship with him but felt that because all her friends were "doing it", she wanted to fit in. Additionally, Child Y disclosed that whilst with her friends she had seen the perpetrator of the earlier sexual assault (Child Q) but he had walked away.

4.62 CAMHS considered the possibility of discussing the case with the Child Sexual Exploitation (CSE) team which works to identify and support children and young people at risk of sexual exploitation and their families, raise awareness of child sexual exploitation and bring offenders to justice. No referral was made after discussing this option with mother who said she wished to talk to Child Y before making a decision. CAMHS decided to revisit the question of a CSE team referral at

their next meeting with Child Y but there is no documented evidence that any such discussion subsequently took place with Child Y or her mother.

4.63 The following day Child Y informed the school child welfare officer that she had seen "another student" at CAMHS. Child Y said that it had been agreed that CAMHS would make sure that their appointments do not clash in future. From the information shared by the school with this review it does not appear that the identity of Young Person R was obtained from Child Y.

4.64 In early December 2015 Child Y was seen by CAMHS. An imagined "safe place" was discussed with her as were techniques for relaxing.

4.65 In early January 2016 Child Y told the school child welfare officer that she had been diagnosed with post traumatic stress disorder (PTSD) and that she was receiving treatment from CAMHS for this. This information was accepted at face value and with the permission of Child Y, was shared with her pastoral team. Steps could have been taken to confirm the diagnosis and consider whether there were any implications for the support Child Y should receive at school. (CAMHS has confirmed that the symptoms of PTSD seen in Child Y were within the clinical range of a PTSD diagnosis. The diagnosis did not change the treatment offered to Child Y which was consistent with the trauma pathway.)

4.66 In mid January 2016 Child Y was seen by CAMHS and disclosed that a friend had texted Child Y that week to say she had been raped by her 16 year old boyfriend. Her friend had later said that she had been raped by a stranger and not her boyfriend. Child Y said that her telephone had been seized as evidence by the police. Relaxation techniques were again discussed with Child Y.

4.67 A police investigation took place following the rape investigation referred to above. Child Y provided a statement. Her phone was taken by the police and returned to her later in January 2016. The school's child welfare co-ordinator continued to provide support for Child Y as before.

4.68 In late January 2016 Child Y was treated by her GP for perineal irritation caused by thrush. She was asked whether she was sexually active whilst her mother waited outside. Child Y said that her last sexual intercourse had been several months ago and a condom used. CSE risk factors were not explored by the GP because it was assumed that the sexual intercourse disclosed had been consensual. Sexual health advice was provided.

4.69 When Child Y was seen by CAMHS later in January 2016, she disclosed that her friend had lied about being raped which had made her angry. Relaxation techniques were again discussed.

4.70 In February 2016 Child Y was seen at home by CAMHS when relaxation techniques were discussed. However, two subsequent CAMHS appointments were cancelled by mother and rebooked.

4.71 In early March 2016 Child Y was seen by CAMHS but struggled to focus on the therapy session. CAMHS has advised the review that their records indicate that Child Y found it difficult to access a safe place in her mind or to practice skills between appointments and in part this was due to Child Y reporting a decrease in the level of heightened emotion and arousal that caused symptoms to be present to a distressing or intrusive level.

4.72 In mid March 2016 Child Y asked the teacher if she had ever had chlamydia in a sex and relationships lesson during which sexually transmitted infections were under discussion. This was reported to Child Y's head of college and Child Y was later spoken to and appeared to understand why the question was inappropriate.

4.73 After her early April 2016 CAMHS appointment was cancelled by her mother because of family illness, a week later Child Y was seen by CAMHS. Following a discussion with Child Y and her mother, discharge from the service was discussed and agreed. Child Y was considered to be much calmer and said she did not wish to talk about the sexual assault anymore, added that self-harm was no longer an issue when asked directly about this. Alternative therapeutic approaches were discussed before discharge from the service was agreed whilst retaining the option of re-referral. (Although Child Y told CAMHS that self-harm was no longer an issue, this appeared to be contradicted by her response to the health questionnaire in early May 2016 (Paragraph 4.76) where she said that she had self harmed seven weeks earlier.)

4.74 In their mid April 2016 letter to Child Y's GP, CAMHS stated that there were no current difficulties to work with in therapy and Child Y was reporting to be much calmer at home and at school. She had received eye movement desensitization and reprocessing (EMDR) therapy over several sessions and an improvement in her symptoms had been noted by the child and the psychologist. The letter added that advice had given for self-help specifically relaxation, visualisation and safe space for the future together with re-referral if needed.

4.75 Also in mid April 2016 Child Y was said to have had issues with a peer at school. Lack of recording means that it is unclear what the "issues" were, or what the school response consisted of.

4.76 In early May 2016 Child Y completed a health questionnaire in school which is given to all school attenders of Child Y's age by the school nurse service. The aim of the questionnaire is to identify individual and school population health needs in order to target services accordingly. Some of Child Y's answers raised concerns about her emotional health and wellbeing. When asked "Do you often feel angry or lonely", she answered yes to both questions. She also responded that she had worries about her "past" and her "family". Child Y also wrote on the questionnaire that there had been sexual abuse in the past. When the questionnaire asked "Have you ever harmed yourself deliberately", she answered yes and stated that this had taken place 7 weeks prior to completion of the questionnaire. The questionnaire asks if the young person would like an appointment with the school nurse which Child Y declined. Child Y's responses also indicated that she had had a previous poor experience with health care provision.

4.77 It appears that Child Y's response was reviewed by school nurse 3 and a decision made to follow up on the content of Child Y's responses. It also appears that Child Y failed to attend the follow up appointment with school nurse 3 scheduled for late June 2016. However, it is not clear how details of the appointment were communicated with Child Y, or whether she received any such communication. There is no indication that Child Y's non-attendance generated any further action.

4.78 Child Y had disclosed self-harm and also declined the offer of an appointment in the questionnaire. In these circumstances it is considered to be good practice to offer an appointment. However, no contact was made between the school nurse service and an adult with parental responsibility for Child Y regarding her disclosure of self-harm. It is important to document any rationale which informs decisions not to share significant health information with parents and there is no evidence of any such rationale within Child Y's school health record.

4.79 In mid May 2016 Child Y attended at a sexual health clinic, which is a longstanding provider of sexual health and wellbeing support to people under the age of 25. She was accompanied by a female friend and was seen by a nurse who completed an under 16 years assessment which disclosed that Child Y was assessed as Fraser Competent; that she had had consensual sexual intercourse as a 13 year old on one occasion with a 14 year old boyfriend of three months with whom she was no longer in a relationship; that she said she was not currently sexually active and intended to wait until she was older before having sex again; that she was

concerned about pregnancy; was provided with contraceptives and that she disclosed details of the October 2014 sexual assault.

4.80 Child Y's disclosure of previous sexual abuse should have prompted contact with local safeguarding children's services, but not a referral. This did not happen. Nor was the sexual health provider's safeguarding decision making proforma completed. And the rationale for the eventual decision to take no further action was not documented fully in the client notes. A safeguarding alert was not added to the service's Caution Register which was significant as, had this been added, subsequent consultations would have been prompted to identify the missed disclosure of historic abuse and lack of referral to social care.

4.81 It is not clear why these omissions took place. The nurse concerned was a new member of staff and had yet to fully complete the service's training but had a wealth of previous safeguarding experience. However, the nurse did discuss the case with a nurse manager but the details of this discussion are unclear and neither party has any recollection of the conversation.

4.82 Also in mid May 2016 Child Y was said to have fallen out with her (female) peers at school and presented as "very upset". It is not known what was the reason for the dispute. The pupils "were sat down to resolve the issues".

4.83 In late June 2016 school nurse 3 made an entry in Child Y's school health records, to the effect that Child Y failed to attend the follow up appointment relating to the health questionnaire referred to earlier. At this time the school nurse also recorded that "records checked – concerns regarding sexual abuse dealt with previously by MASH team".

4.84 In early July 2016 Child Y's case was closed on the youth justice service system. Child Q was still subject to the restraining order and sex offender registration.

4.85 In late July 2016 Child Y's mother attended the emergency department (ED) having fallen the previous night whilst under the influence of alcohol, hit her chin on the pavement and lost consciousness. Examination revealed a damaged tooth and lacerations to her chin. After treatment she was discharged and advised to visit her dentist. There is no evidence that mother was asked about any dependants she was caring for. There are no prompts in ED documentation to ask about responsibilities for children until the point at which an adult is admitted into hospital, which Child Y's mother was not.

4.86 In early September 2016 Child Y attended the sexual health clinic with a female friend. A nurse completed an under 16 years review assessment which disclosed that Child Y was in an on/off relationship with Young Person S who was also 14 years old. Child Y said that her mother was aware of her previous sexual activity and she was advised to discuss the contraception provided with her mother. (When medication is dispensed by sexual health clinics, there is no requirement to notify the patient's GP) No safeguarding concerns were documented. There is no evidence that the notes of Child Y's previous visit to clinic were reviewed which would have disclosed the sexual assault.

4.87 In mid September 2016 Child Y attended the sexual health clinic and was seen by a nurse with whom she discussed some concerning symptoms experienced since commencing the oral contraceptive pill and was provided with advice including the need to see her GP for treatment. She was also advised to return for a pregnancy test later in the month. No under 16 review assessment was completed in accordance with policy and although there is evidence of reference to the previous assessment, there is no evidence that the initial consultation was considered which would have disclosed the earlier sexual assault.

4.88 There is no reference to Child Y visiting her GP following the sexual health clinic attendance in mid September 2015.

4.89 In early October 2016 Child Y was said to be spreading rumours about another pupil and was spoken to about this. The next day Child Y was said to have fallen out with one of her close friends and the school encouraged them to reconcile but Child Y was said not to be ready to do this. (It is noted that this was just before the second anniversary of the sexual assault on Child Y.)

4.90 In late October 2016 the school's child welfare officer was alerted by a member of staff that Child Y had been talking to her peers about being pregnant. She met with Child Y who told her that she thought she could be pregnant. Child Y said she had had unprotected sex earlier in the month with a boy she was no longer in a relationship with. Child Y was advised how she could check whether she was pregnant. The welfare officer told her that she would need to speak to Child Y's mother. When the welfare officer rang Child Y's mother, she said she was shocked as she did not know Child Y had had a boyfriend. She said she would arrange for Child Y to have a pregnancy test. (There is no reference to Child Y returning to the sexual health clinic at this time.) Given that the school was aware of the October 2014 sexual assault, the Young Person R referral, the CAMHS referral and incident in school where a pupil had taunted Child Y about being pregnant at an early age, this could have prompted further professional curiosity and possibly a discussion with a school nurse.

4.91 During the latter months of 2016 Child Y began a "relationship" with Adult P, a 20 year old man. Her mother became aware of the relationship and has advised this review that she told her daughter to end the relationship because she was under age and he was much older. Child Y's relationship with Adult P continued.

4.92 At the beginning of January 2017 Child Y attended the sexual health clinic and was seen by a nurse who completed an under 16 review assessment. Child Y said she was still in a sexual relationship with Young Person S and that this relationship began nine months earlier. She said that she spoke openly with her mother about sex and relationships. Once again, there is no evidence that the notes of the original consultation were reviewed.

4.93 In early January 2017 it is alleged that Child Q contacted Child Y in contravention of his restraining order by attempting to add her as a friend to his Facebook account. This alleged contact was unknown to any agency until after Child Y's overdose. According to her family, the contact caused Child Y anxiety and upset and after a discussion with her parents, Child Y decided not to report the matter to the police. At the time of writing the alleged breach of Child Q's restraining order has been investigated by the police and the Crown Prosecution Service has decided to prosecute.

Significant Practice Episode 3 – from January 2017 until Child Y's death, during which agencies responded to concerns about Child Y's relationship with Adult P.

4.94 Also in early January 2017 the police received a report from a "concerned member of the public" that Child Y was in a sexual relationship with Adult P. Initial enquiries were made to confirm the identity of Adult P and the age and identity of Child Y. This involved contact with Child Y's school who acknowledge that they should have told the police about the October 2015 pregnancy test and that Child Y was sexually active. The school could also have considered referring Child Y to the CSE team at this point.

4.95 The police then saw Child Y and her mother at a police station. Child Y acknowledged her friendship with Adult P but denied any sexual relationship. Mother expressed unhappiness with Child Y attending Adult P's flat unaccompanied. Child Y was said to appear quite mature for her age and to understand that if Adult P had a sexual relationship with her, he would be breaking the law. Child Y was perceived to have a good relationship with her mother with "open lines of communication". Child Y added that she felt comfortable speaking to her mother about any issues or pressures that may arise. (By this stage, agencies had information which challenged

the impression that lines of communication were open.) No immediate safeguarding concerns were noted and a PVP was completed by the officer and submitted to the MASH. The officer who had interviewed Child Y and her mother assessed the risk as standard but this was later increased to medium by police officers based in the MASH. The PVP was shared with children's social care, school nursing service and the CSE team. As no disclosure had been made by Child Y no further police investigation was conducted and Adult P was not interviewed.

4.96 Three days later the PVP in respect of Child Y was received by the MASH. Consent had been given by Child Y's mother for welfare checks to be carried out. Child Y's school was informed and they stated that, on the whole, they had no concerns although they mentioned the October 2016 "pregnancy scare" which had been shared with her mother by school staff. The school advised that mother had been shocked by the news that her daughter might be pregnant but had been supportive. The school states that they have no record of this MASH contact and the social worker appears to have only become aware of the pregnancy issue in February 2107 when completing the C&F Assessment. No checks with health were requested by the MASH team manager at this stage as it was anticipated that these checks would be carried out as part of the forthcoming C&F Assessment. However, these checks had still not been carried out prior to the home visit to complete the C&F Assessment. (Paragraph 4.119) Had they been requested, the usual checks would be A&E attendances, GP and school nurse. Sexual health checks would not be undertaken as standard unless specifically requested by the MASH team manager.

4.97 Advice was sought from the CSE team Social Worker and her manager who agreed that it was appropriate to conduct a CSE assessment alongside children's social care C&F Assessment. (The case was also discussed in the CSE Team as police shared the PVP with the team to discuss allocation.)

4.98 The same day Child Y truanted from a lesson but was located and later spoken to by her pastoral manager.

4.99 The next day the PVP completed by the police was received by the school nursing service where it was scanned onto Child Y's record. The action plan recorded by a community staff nurse was to await the outcome from the MASH assessment. School nurse 5 was electronically tasked "for information only" at that time. Having reviewed the tasked information, the school nurse decided that no further action was necessary. There is no evidence that the information was considered in the light of earlier information about Child Y, including the sexual assault, nor is there evidence that case weighting school nurses allocate to prioritise health and social care unmet needs was reassessed.

4.100 At the end of January 2017 the MASH team manager decided that the threshold for children's social care intervention had been met and that further assessment was required in order to address concerns about the relationship between Child Y and Adult P, in particular to determine if Child Y had been a victim of grooming/CSE and to consider if any preventative and awareness raising work needed to be completed. This case should have progressed from MASH within two working days as opposed to the actual time taken which was 13 working days. It is understood that factors in this delay included a high number of referrals at that time, reduced capacity in MASH and the requirements to attend a number of meetings which detracted the manager from the screening process. The MASH team manager's decision appears to have been a further opportunity to prompt a CSE assessment.

4.101 At the beginning of February 2017 the case was allocated to a social worker. A joint visit with the CSE team was considered but after no response was received from the CSE team manager it was decided to go ahead with a single agency home visit and subsequently refer to the CSE team if appropriate providing Child Y and her mother consented. The co-working protocol between children's social care and the CSE team envisages telephone or face to face discussion between the respective agency's team managers to agree a plan for joint working, specifically the arrangements for joint visits. It is understood that the CSE team was affected by sickness absence just prior to this time. The child and family assessment was initiated by the social worker the next day.

4.102 In early February 2017 Child Y attended the sexual health clinic with a female friend and was seen by a nurse who completed an under 16 review assessment which disclosed that her relationship with Young Person S continued; she underwent a (negative) pregnancy test; she was advised to return in three weeks for a repeat pregnancy test and was said to openly confide in her mother. No safeguarding concerns were noted and once again, the initial consultation notes were not reviewed.

4.103 The next day the social worker made a home visit to Child Y and her mother in order to discuss the recent referral and begin to gather information for the C&F Assessment. Contact with Child Y's father, who did not reside at the family home, was considered but apparently not acted upon. There is an expectation that prior to such home visits all welfare checks would be completed with agencies involved currently or in the past with the child. These checks had not taken place. Additionally, it appears that information from the MASH record that Child Y had had a recent pregnancy scare was not reviewed until after the overdose. And the home visit was significantly delayed, taking place a month after the allegation was first reported to the police.

4.104 On the same date the school contacted Child Y's mother to raise concerns about Child Y's attainment in maths. When contributing to this review, mother indicated that being placed on report had not caused Child Y undue worry. She then added that "Child Y was a very clever girl" which implied that being placed on report (for the first time) might have been an issue of more substantial concern to Child Y.

4.105 During a late evening in mid February 2017 Child Y visited Adult P at his flat. In the statement he provided for the inquest into Child Y's death, Adult P said he had known Child Y about a year. He said he knew she was 14 but described her as "quite an adult teenager". He described their relationship as close but not sexual although he said many people seemed to think it was and spread rumours to that effect. During January 2017 Adult P's manager moved him from the shop where he normally worked to another shop because of concerns about Adult P's relationship with Child Y who would call into the shop to see him.

4.106 In his statement, Adult P said that he and Child Y talked for several hours on the stairs leading to his flat. When she decided to go home he said he called a taxi for her. At this point he said her mood changed and she said she had been diagnosed with schizophrenia and had been hearing voices. She said she was not doing well at school and was concerned that she would be taken back into care after children's social care had recently become involved in her life again. He said that Child Y then began intimating that she may take her own life by making comments such as "making all the problems go away". He said he made her promise not to harm herself and called a taxi to take her home shortly after 3am the next morning. As agreed, Child Y texted him when she arrived home at around 3.20am.

4.107 Child Y's mother was not at home as she had been working an evening shift at a local public house and then went to stay at the home of her partner. She had been unaware of Child Y's whereabouts. Child Y's elder sibling was at the family home. Child Y's mother arrived home later that morning. She saw Child Y who told her she felt unwell following which her mother contacted school to advise them that Child Y would not be attending that day. Child Y's mother later left for work.

4.108 Adult P said he awoke around 12.30pm the same day. He said he then received a telephone call from Child Y in which she was crying and he said he could hear what sounded like pills being pushed through foil. He said that Child Y then put the phone down on him before sending him two lengthy text messages which have been deemed to represent a "suicide note". These were sent shortly after 1pm.

4.109 In these texts Child Y described herself as "the family fuck up" who had been strong once and internally beautiful but that that girl died at the age of 12 when "he ruined my body. And my mind, my soul, destroyed by one person." (It is assumed

she was referring to Child Q) She mentioned her love for her mother but added that she (her mother) had been unable to cope and had resorted to alcohol. She said that she had longed for a relationship with her father but he wasn't always there. She said she had fallen in love with Adult P in early December 2016.

4.110 Adult P said that after receiving these texts he tried to ring Child Y but was unable to obtain any reply. He then contacted the ambulance service anonymously via the 999 system and advised them that Child Y had taken "a load of pills" and provided her home address. He had no contact details for Child Y's parents but managed to locate them via social media and sent them messages which Child Y's father was able to pick up. Adult P's relationship with Child Y was subsequently re-investigated by the police and they ultimately decided to take no further action.

4.111 Child Y's father received the message from Adult P and contacted Child Y's mother who returned home by taxi to find Child Y unconscious. Child Y's elder sibling had been present in the house but unaware of Child Y's actions. The family called an ambulance which arrived at 2.28pm to find Child Y in cardiac arrest having apparently taken an unknown quantity of mother's prescribed drugs and over the counter drugs. The ambulance service contacted the police.

4.112 Child Y was initially taken to hospital but later transferred to a children's hospital paediatric intensive care unit - as there were no local ICU beds available - where she died on four days later.

4.113 On the day on which Child Y took the overdose, the school decided that Child Y would be placed on report for two weeks due to concerns over her academic performance. During that period the pupil's attitude and attainment in lessons would be monitored.

4.114 The police searched Child Y's bedroom and removed a number of personal items to assist with their investigations. The police also examined the phones of Child Y and Adult P which confirmed they had been in a relationship and also indicated that there had been a disagreement between them which had been resolved prior to Child Y's overdose.

4.115 During the period between Child Y taking an overdose and her death, the C&F Assessment was said to have been "completed" by the social worker and submitted to her manager who returned it for further information to be gathered. The C& F Assessment identified that Child Y's mother was acting appropriately to ensure the safety and well-being of Child Y. Child Y had presented as happy and content and engaged in discussion about her home, school and personal life. Child Y presented as having a good understanding of appropriate relationships and denied

any sexual activity between herself and Adult P. Child Y had not displayed any concerning worries or behaviours and had said that through her involvement with CAMHS she had learned to deal with her feelings and emotions. Child Y appeared to have demonstrated resilience and strength in managing her traumatic experience of sexual assault.

4.116 The author of the assessment concluded that a further home visit was required with the CSE team in order for them to complete an assessment. Before this could be completed Child Y attempted to take her own life and remained in a critical condition with a poor prognosis. It was recommended that further exploration of Child Y's relationship with Adult P and her parents' capacity to safeguard Child Y from future harm would need to be undertaken. The C&F Assessment recommended that to ensure that Child Y was safeguarded from future harm, the family should be supported via a child in need (CIN) plan until fuller information had been gathered and that an assessment with CSE team should be completed.

5.0 Contribution of the family to the review

5.1 Child Y's mother contributed to this review. Also present were an elder sibling of Child Y and her maternal grandparents. Child Y's father was offered the opportunity to contribute but did not respond.

5.2 Mother was asked about the October 2014 sexual assault on Child Y but after describing how she received a phone call from Child Y's paternal grandparents to say that Child Y was "in a state" she became too upset to talk about it.

5.3 When asked to comment on the support offered to Child Y after the sexual assault, mother said that she had tried to "block out" a lot of what happened during this period and so she found it difficult to remember specifics. She recalled that after the sexual assault, Child Y began trying to carry on with life, but the police investigation seemed long and drawn out, and she doesn't feel that her daughter had sufficient support during this period. She referred to a long wait to access CAMHS and when Child Y did attend, this was for only a half an hour session every two weeks which she did not think was sufficient. She said that some of these appointments were cancelled. She commented that Child Y thought the sessions with CAMHS to be "pointless" adding that her daughter did not find the mode of therapy used to be helpful and did not relate to what CAMHS was trying to achieve. Mother said that she didn't see any difference in Child Y as a result of the sessions and Child Y's elder sibling felt that Child Y should have been offered a different form of therapy, to which she was able to relate.

5.4 Mother commented that prior to the referral to CAMHS Child Y was able to confide in the child welfare officer at school. Although she was not aware of what they spoke about, mother was aware that this relationship was positive and that Child Y felt she could approach the child welfare officer. During the period prior to Child Q's trial, mother felt that Child Y seemed to be coping "OK", but the family have since become aware that she may have been confiding concerns to others including her best friend.

5.5 Turning to the trial of Child Q, Child Y did not attend court but received a phone call to tell her what sentence he received. Within a short time, she received another phone call to say that an appeal had been lodged. Mother said that Child Y had had mixed feelings about the original sentence because prior to the sexual assault she had loved Child Q as an uncle and couldn't understand why he would do that to her. Mother said Child Y wasn't happy about the reduction in Child Q's sentence following his appeal.

5.6 Mother commented on the impact of the sexual assault on family dynamics. She said Child Y began to spend less time with her father who became distant in mother's opinion. Mother wondered if he may have felt guilty as the sexual assault took place in his parent's house whilst he was staying there. Mother also felt that Child Y's paternal grandmother appeared to be more upset about losing Child Q than about what had happened to Child Y. Child Y had been upset that Child Q's sister continued to see him and generally felt that her father's side of the family were not fully supportive of her.

5.7 Turning to Child Y's contact with Young Person R, mother recalled receiving a phone call from children's social care to say that Young Person R could pose a danger to Child Y, but she couldn't recall them saying anything else. Mother said that they weren't friends for long and that their relationship just "fizzled out". Mother said that she had no personal contact with Young Person R's family but recalled his uncle threatening Child Y via facebook because she had told a friend that Young Person R was a danger. When mother became aware of the threat from Young Person R's uncle she wanted to report the matter to the police but she said that Child Y begged her not to because she was worried that this would only make matters worse. Mother commented that Chid Y's faith in the police had been affected by the outcome of Child Q's appeal for which she blamed them.

5.8 Mother said that she knew nothing about the health questionnaire Child Y completed in 2016 and had not heard about it until she was asked about it during her contribution to the serious case review. Family members present asked why mother was not told about the questionnaire if the answers Child Y gave raised concerns?

5.9 As time passed by Child Y talked about the impact of the sexual assault less. Family members said she sometimes appeared to be moody but they felt that this was "a teenage thing".

5.10 Mother said she was aware that Child Y had been to the sexual health clinic twice with a friend but was unaware that she was taking a contraceptive pill until Child Y's elder sibling told her. When mother spoke to Child Y about this she said she was taking the pill to get rid of her spots.

5.11 Turning to the contact from Child Q in January 2017, he sent Child Y a friend request on Facebook, which was deleted soon afterwards. Before the request was deleted, Child Y took a screen shot of it and sent it to her elder sibling who told her to tell mother about it, which she did. Mother said that they should contact the police, but Child Y again begged mother not to do so. Mother said Child Y had not

told her father even though she had been with him at the time she received it the friend's request. Mother rang father to tell him what had happened.

5.12 Mother said she respected Child Y's wishes and did not contact the police. She added that Child Y was very upset following the contact from Child Q but appeared to begin to feel better over the next few days.

5.13 The family said that they had recently become aware of a further contact with Child Q. This took place in a park. They were not sure when this happened but Child Y was with two of her friends when Child Q began shouting abuse. One of Child Y's friends had disclosed this to them. (It is not known if this contact with Child Q relates to her disclosure to CAMHS that she had seen Child Q in Paragraph 4.63)

5.14 Turning to Child Y's friendship with Adult P, mother said Child Y had told her about this. The family knew of Adult P as he worked in a local shop. Mother said that the friendship struck her as odd as he was older. Mother said that she tried to ban Child Y from seeing Adult P, but that Child Y did not accept this. She described her daughter as being quite angry from around November 2016, and mother added that she found it difficult to cope with this behaviour. This led to Child Y spending a few nights staying at her elder sibling's house. Mother said that she couldn't get to the bottom of why Child Y was so angry.

5.15 When the police became involved Child Y told them that the relationship was platonic, but mother said that she did not believe her daughter. Shortly afterwards a social worker visited, and Child Y was said to be worried about this.
Mother said she did not know a lot about Child Y's friendship with Adult P. Child Y's friends have since disclosed to her that whilst Adult P appeared to be "lovely in his texts", he abused her over the phone. Child Y's elder sibling commented that it seemed like Adult P was manipulating Child Y and would ring her and demand she walk to McDonald's to get him food and bring it to him at the shop where he worked. Child Y would oblige. Mother reiterated that she kept telling Child Y to stay away from Adult P.

5.16 Mother added that things were also not going too well at school at this time. The school said that they were going to keep an eye on Child Y's progress. Mother and her elder sibling said she didn't really talk about being put on report but that she probably didn't see it as a "big thing".

5.17 As the conversation with mother and other family members drew to a close, it was suggested by one family member that Child Y "tried to hide things" and had tried to block the sexual assault out of her mind. She seemed to feel that she could only confide in her friends and the school child welfare officer. Her elder sibling says

she noticed that in early 2016 Child Y began cutting herself on her legs which she described as "more like cat scratches" as they weren't deep cuts. The elder sibling said that she felt that Child Y began cutting herself as a reaction to the sexual assault. Her elder sibling said that she spoke to Child Y and she stopped cutting herself. Her elder sibling added that Child Y had tried to conceal the cuts by wearing long pants to cover her legs.

5.18 When asked if anything more could have been done to help Child Y, the family felt that the court process could have been faster, that there should have been more support from CAMHS with different options offered in order to find an approach which suited her better. They added that the school nurse should have been in touch about the concerns raised in the health questionnaire. They said that there should have been more communication from the police who should have spoken to Child Y's mother rather than her paternal grandmother.

5.19 Mother has read this final report with which she expressed herself satisfied. She said she had nothing further to add. Father was offered the opportunity to read the final report but did not respond.

6.0 Analysis

6.1 In this section of the report the following terms of reference were will be addressed:

- Were indicators of unmet need, risk and/or compromised parenting appropriately identified by practitioners through assessments and any disclosures?

- Were service responses to indicators/disclosures of unmet need, risk and/or compromised parenting in line with single and multi-agency policy?

- Were service responses provided in a timely manner to promote the child's welfare?

- What role did management oversight play to enhance the quality of practice?

Were indications of unmet need identified by practitioners and responded to in accordance with policy? Were service responses provided in a timely manner to promote the child's welfare?

6.2 Following the sexual assault in October 2014, Child Y needed support. At the age of twelve she had been subjected to a sexual assault by someone she regarded as a close family member in a location where she expected to be safe.

6.3 Disclosing the sexual assault, which the perpetrator Child Q put pressure on her not to do, also had implications for her family. The perpetrator Child Q and his sibling had lived with Child Y's paternal grand parents for many years under a Special Guardianship Order. As far as Child Y was concerned, they were very close family members. However, the sexual assault brought Child Q's relationship with Child Y's family to an end and it is understood that Child Q's sibling later left the family. Child Y's parents were no longer living together at the time of the sexual assault but it appears that this event placed her parent's relationship under even greater strain and ultimately led to a rift between Child Y's mother and Child Y's paternal grandparents.

6.4 Little insight into how Child Y was feeling in the aftermath of the sexual assault can be gleaned from the chronologies provided to this review by the agencies which came into contact with her despite the fact that sexual abuse is categorised as "significant harm". There were said to be "no concerns" about her general health and wellbeing at the SARC. (Paragraph 4.4) She was described as being in "good spirits" during a joint home visit by children's social care and the police in the days

following the sexual assault. (Paragraph 4.9) Child Y was described as "vulnerable/intimidated" on the Vicman record created by the police. (Paragraph 4.12) The C&F Assessment completed by children's social care described Child Y as "upset and scared about what is going to happen next". (Paragraph 4.15) And when the SARC manager rang Child Y's mother to check on her welfare, Child Y was described as "doing OK", and having "no problems". (Paragraph 4.17) Significantly this information about Child Y's emotional state was provided not by Child Y herself but by her mother. A feature of this case is the extent to which agencies appeared to rely on mother to articulate Child Y's feelings.

6.5 Additionally, the support offered to Child Y following the sexual assault also appears to have been quite limited. No referral appeared to have been considered to an independent sexual violence advisor or advocate (ISVA) whose role is to provide practical and emotional support to survivors of sexual violence. Typically, the ISVA would work with partner agencies to try and keep the survivor informed throughout the criminal justice process, support and empower the survivor to have their voice heard and make informed choices and accompany the survivor to important appointments. Specialist ISVAs for children – known as ChISVAs - are also available.

6.6 The review has been advised that whilst no ChISVA referral was considered when Child Y went to the SARC, a ChISVA referral was under consideration at the point at which the SARC manager rang Child Y's mother in late October 2014 (Paragraph 4.17) and was ruled out because mother indicated that further support for Child Y was not required at that stage. It is unclear whether a ChISVA referral was specifically offered and declined at this point. In any event it does not appear that Child Y herself was directly offered the services of a ChISVA and the potential benefits explained to her in order that she could have been supported to make an informed choice.

6.7 Child Y was not referred to victim support services by the police. There is an opportunity to initiate a referral to victim support at the point at which the crime report is completed but the box for victim support was not ticked. As stated in Paragraph 4.6 the police have advised this review that victim support was verbally offered and declined by Child Y's mother during a joint home visit by police and children's social care. This offer and the declining of it was not recorded by the police or children's social care. There is no indication that Child Y was directly involved in this interaction.

6.8 Child Y's school was not informed about the sexual assault by any agency with knowledge of it. Nor was the school invited to participate in the strategy discussion which took place in mid October 2014 (Paragraph 4.8 and 4.9). However, the school inadvertently learned of the sexual assault the following day when Child Y's elder

sibling came to collect her from school and disclosed that Child Y had been sexually assaulted. This information was shared with the school's senior leadership team because it was necessary for them to authorise Child Y's collection from school by a family member who was not on their list of contacts for Child Y. Had the school been invited to participate in the strategy discussion, they would have been much better placed to consider what action they should take to support Child Y. However, once the school became aware of the sexual assault, the absence of any follow up whatsoever is perplexing and practitioners and managers from the school were unable to suggest why there was such an absence of professional curiosity and exercise of the duty of care they owed to Child Y. The school has advised the review that at the time safeguarding concerns were recorded only within paper log books maintained by individual members of staff which may have prevented concerns being appropriately shared and escalated.

6.9 Having become aware of the sexual assault, actions which the school could have considered included making contact with the police, liaising with the school nursing service, and contacting Child Y's mother in order to ascertain whether Child Y had any support needs which the school may have been able to meet or make suggestions as to how such needs might be met. It was possible that the sexual assault on Child Y had not been reported which would have placed an obligation on the school to make a safeguarding referral. As the school appears not to have asked any questions, they would not have known whether the assault had been reported or not.

6.10 The school missed a further opportunity to consider Child Y's support needs following the sexual assault when Child Y told the school's pastoral manager that a peer had made a comment about the sexual assault in early November 2014. (Paragraph 4.18) The school dispute that this represented a missed opportunity to consider Child Y's support needs.

6.11 The school should have been contacted as part of the process by which the C&F Assessment was competed by children's social care in late October 2014 but this does not appear to have been the case. (Paragraph 4.15)

6.12 A further route by which the school should have formally become aware of the sexual assault was through contact with the school nursing service which was notified of the incident in late October 2014 via a PVP report sent to them by the police. (Paragraph 4.13) The school nurse who received this information drew up a plan to "await further contact from children's social care" and scanned the PVP onto Child Y's electronic care records. The school nursing service accept that the response to this notification was insufficiently proactive and that it should have triggered contact with the SARC to ensure appropriate support had been offered to Child Y

and her family following her trauma. Had such an enquiry revealed any absence of support offered, actions should have been taken to obtain appropriate support and offer this to Child Y.

6.13 The school nursing service had not been invited to participate in the mid October 2014 strategy discussion although the health representative within the MASH, from the same organisation as the school nursing service, had participated.

6.14 At the time of this incident, the school nursing service advise that a clinical pathway for the management of PVP reports was in place for health staff to refer to. The pathway placed responsibility on health practitioners such as school nurses to use clinical judgement to analyse the information contained within the report and plan for further care as appropriate. Whilst it may be entirely plausible for there to be no health actions arising from a PVP (although not in this case), the rationale for any such decision should have been clearly evidenced within the health records. This did not happen in this case. A plan to merely "await contact" from another service is not considered to be a robust plan which ensures the health needs of a child are met.

6.15 The school nursing service has also advised this review that the school nursing service was in "*business continuity*" as a result of staffing shortages at that time. Business continuity is a process which involves the identification of core functions which are a priority to resource and other functions which are of lesser priority and may no longer be resourced or may be handled in a less resource-intensive manner. This review was initially advised that the adoption of a "for information" approach had been authorised by management as part of business continuity arrangements. The school nursing service has since advised that this information is incorrect and, in any event, business continuity arrangements should not have prevented a more substantial response to the notification of the sexual assault on Child Y.

6.16 Another response to business continuity was a management decision to cancel school drop-in clinics during this period. It is assumed that this decision may have contributed to a striking lack of contact between Child Y's school and the school nursing service. The school nursing service has advised that school liaison was still in place and that there should have been regular contact with the school at this time although this case indicates no evidence of this.

6.17 The school nursing service emerged from business continuity in September 2016. (Blackburn with Darwen LSCB has advised this review that they were not advised of the school nursing business continuity arrangements at Board level or in their quality assurance returns which are the method by which the LSCB collates performance and quality assurance information. In the return agencies are

specifically asked about the implications for business continuity of their performance data.)

6.18 The C&F Assessment completed by children's social care for Child Y represented a further opportunity to ensure she was offered appropriate support. However, the assessment identified no further safeguarding concerns and the outcome was "no further action" on the grounds that Child Y had an "excellent support network and all the adults involved with Child Y are acting appropriately and with her best interests as their focus". It is difficult to see how such an optimistic assessment could have been arrived at given the implications of the sexual assault for Child Y's wider family. Children's social care acknowledge that further exploration of the emotional needs of Child Y and the impact of the sexual assault should have been undertaken. They say there was also an absence of analysis of the role of Child Y's father, given that the assault took place at the home he shared with Child Y's paternal grandparents. Additionally, there is no evidence that referrals were made or signposting information shared with Child Y and her parents. Children's social care state that there was, and remains, an expectation that the relevant team manager would have challenged the limitations in the assessment but that this did not happen. There is no indication that either the Child in Need (CiN) or Child and Family Assessment (CAF) processes were considered following the C&F Assessment completed at Section 47 Children Act level.

6.19 Child Y's GP was not invited to participate in the mid October 2014 strategy meeting but became aware of the sexual assault when they received a letter from the SARC. (Paragraph 4.16) The GP did not contact Child Y or her parent to ask if she needed support. The Clinical Commissioning Group (CCG) advises that the GP would have assumed the provision of support by the SARC. The GP did not raise the issue at the next appointment with Child Y. The CCG advises that had the consulting GP seen an active alert in Child Y's patient records this may have prompted further enquiry. However, no visible alert had been placed on Child Y's records to inform others within the practice that there was a live concern when accessing her patient records.

6.20 The GP now feels that the practice could have made contact with the SARC to clarify the nature of the assault and that the incident should have triggered a "significant event" meeting. These meetings take place when cases are reviewed at practice meetings or on a case specific individual basis. A significant event meeting is triggered when a concern or issue is raised internally at the practice or externally. The GP practice has a policy/protocol around significant events. Had the "significant event" meeting taken place the health visitor could have been the link into school health services in terms of raising concerns.

6.21 It has been recognised that it would be best practice for the GP to revisit safeguarding issues at the patients' first presentation after an event if the safeguarding concerns are highlighted in the patient's records – which they were not in Child Y's case.

6.22 Child Q was not charged with the sexual assault on Child Y until July 2015 which triggered an offer of support to Child Y by the youth justice service the following month. This offer was initially made by letter to Child Y's mother who did not respond.

6.23 The August 2015 safeguarding referral by youth justice arising from concerns that Child Y was in a sexual relationship with Young Person R who had been recently convicted of a sexual assault on another child (Paragraph 4.26) appears to have enabled agencies to become aware that Child Y needed support.

6.24 When contacted by children's social care in early September 2015, mother said she felt that Child Y needed someone independent to open up to. Children's social care also contacted Child Y's school to advise that Child Q was due to be sentenced shortly and that this was causing Child Y "significant distress". This prompted the first intervention by the school in response to the October 2014 sexual assault with the school child welfare officer meeting Child Y and her mother to discuss what support the school could offer. Prior to that meeting Child Y's mother took her daughter to their GP who referred her to CAMHS after hearing that Child Y had been experiencing flashbacks and panic attacks following the October 2014 sexual assault. Child Y's mother subsequently told the school child welfare officer that Child Y was struggling emotionally and not sleeping properly. Child Y herself later told the child welfare officer that she was feeling upset and struggling with what was going on with the forthcoming court case.

6.25 The first recorded indication that mother might also be having a difficult time was when a restorative justice worker visited Child Y's home in mid September 2015 and was advised that both Child Y and her mother were "struggling emotionally". Child Y subsequently told the school child welfare officer that she had been very upset to find her mother crying in the early hours of the morning because of the "current situation". (Paragraph 4.68) The child welfare officer offered mother support from the school but there is no indication that other support options were discussed with her although mother is recorded as saying she was in touch with "victim support" which is assumed to have referred to the support offered by NPS.

6.26 Child Y experienced further distress as a result of the trial and sentencing of Child Q which was completed in late September 2015 and asked the school child welfare officer for further sources of support in addition to CAMHS. The school has

advised the review that Child Y was signposted to unspecified agencies which did not include the school nurse.

6.27 It was around this time that Child Y made her first recorded mention of suicidal ideation (Paragraph 4.43) which she reiterated to CAMHS on her first appointment which took place in early October 2015 – almost a year after the sexual assault.

6.28 Child Y attended seven scheduled CAMHS appointments between October 2015 and February 2016. Thereafter, two appointments were cancelled by mother, an appointment then took place at which Child Y struggled to focus, a further appointment was cancelled by mother before the final appointment took place at which Child Y was considered to be calmer and an improvement in her symptoms noted. It may have been prudent to schedule a further appointment to gain assurance that the improvements noted had been sustained after a period of appointment discontinuity.

6.29 CAMHS has advised the review that the decision to discharge was made in conjunction with Child Y and her mother. Various options were discussed including re-referral if Child Y experienced further difficulties. The case was not seen as complex and was considered to have progressed well with Child Y engaging in therapy. Child Y said she was feeling better. CAMHS feel that there was no rationale to have continued therapy. (In her contribution to this review, mother appeared dismissive of the value of the service provided by CAMHS although CAMHS records indicate that mother may have been sceptical of the benefits from the outset as she is recorded as commenting that she wanted to "shake Child Y" out of it, as the sexual assault had happened a year ago and talked of wanting Child Y to "move on".)

6.30 *The impacts of child sexual abuse: A rapid evidence assessment* (July 2017) which was commissioned by the Independent Inquiry into Child Sexual Abuse (IICSA) found that being a victim and survivor of child sexual abuse (CSA) is associated with an increased risk of adverse outcomes in all areas of victims and survivors' lives. (1)

6.31 Areas of her life in which Child Y appeared to experience adverse outcomes were "emotional wellbeing, mental health and internalising behaviours" where she suffered emotional distress, PTSD, anxiety and depression; "externalising behaviours" such as risky relationships with Young Person R and Adult P; "interpersonal relationships" appear to have become less stable particularly with her father and paternal grandparents; "socio-economic" specifically lower education attainment which led to her being placed on report by her school just prior to her death and "vulnerability to re-victimisation" which is also evidenced by her contact

with Young Person R and Adult P in which her vulnerability appears to have been exploited by the males concerned.

6.32 Tellingly for this case, the study also found that the risk of CSA victims and survivors attempting suicide can be as much as six times greater than in the general population. (2)

6.33 Additionally, the study found that the impacts experienced by non-offending parents – and, in particular, mothers – as a result of their children's CSA victimisation "can mirror those outcomes experienced by victims and survivors". Additionally, it was found that parents "can find it challenging to support a child who has been victimised at a time when they themselves might be struggling to cope with the emotional and practical strain following CSA". "This can create a vicious circle in which the support that parents are able to provide to their child is compromised, thereby reducing the child's chances of experiencing resilience or recovery". (3)

6.34 In Child Y's case the indications of this "vicious circle" are evident in the difficulties experienced by mother which agencies only gradually became aware of. Father – who decided not to contribute to this review – appears to have responded to the challenges of supporting Child Y by distancing himself from the situation.

Were indications of risk identified by or disclosed to practitioners, responded to in accordance with policy?

6.35 *The impacts of child sexual abuse* found that victims and survivors of CSA may be more than four times more likely to experience sexual assault in adulthood compared with those who had not experienced CSA. (4) The study noted that sexual revictimisation could also occur in younger childhood and adolescence. And one study also highlighted CSA as a potential risk factor for also experiencing child sexual exploitation (CSE).

6.36 When Young Person R disclosed that he was in a relationship with Child Y which was suspected to be sexual, this prompted a referral by youth justice to children's social care. (Paragraph 4.26) Young Person R had recently been convicted of a sexual assault on a child under 13. Children's social care responded by contacting Child Y's mother in order to try to establish the facts and ensure that mother was able to safeguard Child Y. On this occasion, information was shared with Child Y's school who then offered support to her. Young Person R was registered as a pupil at the same school although his education was taking place through an alternative provision away from the school site. It is unclear if any plan was put in

place to safeguard Child Y should Young Person R have reason to be present on the school site.

6.37 Within five days of their initial contact with mother, children's social care appear to have closed the case before mother re-contacted them to report concerns of harassment towards Child Y from Young Person R and his family. Children's social care placed the onus of reporting the matter to the police on mother who decided against this course of action following representations from Young Person R's family. Child Y's mother provided a different account of events to this review saying that it was Child Y who had implored her not to report the matter to the police after she (Child Y) had been threatened via Facebook by an uncle of Young Person R.

6.38 The impression gained is that the potential seriousness of this referral was not fully appreciated by children's social care. Child Y was a thirteen year old girl who had been sexually abused by Child Q ten months earlier. Indications had emerged that she was struggling to cope with the impact of this sexual assault and the ongoing court proceedings. It was suspected that she had been "in a relationship" which may have been sexual with a recently convicted sex-offender. Additionally, they became aware of some harassment by the sex offender's family. The possibility that an extremely vulnerable Child Y may have been groomed by Young Person R did not appear to be considered and on the basis of two telephone conversations with mother, children's social care concluded that she was able to safeguard Child Y. Of the "underlying CSE risk factors" from Blackburn with Darwen's CSE toolkit, "history of abuse including familial child sexual abuse", "emotional and/or mental health difficulties" and "sexual activity at an early age" were present or suspected to be present.

6.39 During the course of this contact between children's social care and Child Y's mother the focus appeared to shift away from any risks that Young Person R might present to Child Y towards the latter's disclosures that she was struggling to cope with the impact of the October 2014 sexual assault and the consequent court proceedings.

6.40 It is of interest to note that in the school records Young Person R is described as Child Y's "ex-boyfriend" which does not appear to be an appropriate way to describe a relationship between a vulnerable 13 year old girl and a young male who had recently been convicted of sexually harmful behaviour towards a person under the age of 13 years. Normalising this relationship by referring to Young Person R as Child Y's "ex-boyfriend" suggests a lack of awareness of the dynamics of sexual exploitation and may offer a partial explanation of why the school did not offer support to Child Y when it became aware of the October 2014 sexual assault.

6.41 The school's child welfare officer has contributed to this review and has said that in using the term "ex-boyfriend", she was simply quoting Child Y.

6.42 When Child Y was first seen by CAMHS in early October 2015 there does not appear to have been any consideration of a referral to children's social care or use of that agency's "advice and consult" offer following Child Y's disclosure of previous self harm, suicidal ideation and vulnerability to, and arising from, sexual abuse. (Paragraph 4.53)

6.43 Had a referral been made it is assumed that children's social care may have gained a degree of assurance that Child Y was accessing support from CAMHS. However, a referral may have presented an opportunity to conduct a further assessment which may have shed light on mother's ability to safeguard Child Y given the emerging indications that her (mother's) mental health may have been adversely affected by the sexual assault on her daughter. In their contribution to this review CAMHS questioned the practicality of referring all cases involving suicidal ideation to children's social care although in this case additional risk factors were present that indicated unmet needs for Child Y.

6.44 CAMHS acknowledge that they discussed the possibility of contacting the CSE team with Child Y's mother who said she wanted to talk to Child Y before making a decision. It was planned to revisit this issue at the next session with Child Y but this appears to have been overlooked. Having reflected on their decision making, CAMHS have concluded that, with the history of a previous sexual assault and Child Y's own admission that she had sex because all her friends were doing it and wanted to fit in, these may have been indicators of risk of child sexual exploitation to be explored further.

6.45 Some of Child Y's replies to the school nursing service health questionnaire completed in May 2016 raised concerns about her emotional health and wellbeing which were not followed up on. (Paragraph 4.89) It would have been good practice for the school nursing service to liaise with pastoral staff at Child Y's school to ensure she had access to appropriate emotional support. Contact with Child Y's GP and CAMHS were also options. The school nursing service has confirmed that follow up actions for individual children were not the subject to any business continuity limitations. If follow up action was discounted for reasons of confidentiality, then the analysis and rationale behind this should have been recorded and it was not.

6.46 There is no indication that Child Y's non-attendance at the appointment offered as a follow up to the questionnaire generated any further action by the school nursing service. The service advises that the standard operating procedure (SOP) for the school health needs assessment questionnaire states that "the legal and ethical

view of the Trust is that in most cases Year 9 pupils themselves should be regarded as the primary decision makers about whether to participate or not." This is in relation to the young person's ability to make decisions around completing the questionnaire and does not relate to the decision to attend a clinical appointment. The school nursing service suggests that is possible that the school nurse understood this to mean that the young person had made the primary decision to refuse contact. The SOP further states that children at year 9 and above (as in Child Y's case) were more likely to satisfy Fraser guidelines around competence to consent to or refuse treatment but that any concern relating to competence should be further assessed. Child Y had disclosed an episode of self-harm and her answers on her questionnaire indicated that she was struggling emotionally. Whilst this is not an unusual presentation in a year 9 pupil, the lack of any further documented exploration or analysis of these issues leaves unanswered questions regarding Child Y's competence to refuse intervention relating to her emotional health difficulties.

6.47 Nor is it evident from school nurse records that Child Y's reports of self-harm and emotional difficulties were considered in the context of a young person who had been the victim of a sexual assault and the further conflict this may have raised for Child Y due to the fact that the perpetrator of the assault was another young person and a family member. The questionnaire also suggested that Child Y had had a previous negative experience with health care provision. She had answered "no" to the following questions regarding her most recent contact with health professionals; 'Were you given enough information?" "Did you understand everything you were told?" "Do you feel that you were listened to?" This may also have influenced Child Y's decision to attend the offered school nurse appointment. It is not known to which contact with health professionals Child Y was referring. In the recent past she had had substantial contact with CAMHS as well as contact with her GP, A&E and the SARC.

6.48 The time lapse between Child Y's completion of the questionnaire and the follow up appointment was almost seven weeks. Guidance at the time was that any follow up was a matter for clinical judgement, but should be before the end of that cohort – in this case between Easter and Summer. New guidance based on a "risk sensible approach" is that for high risk cases – which this would have been considered to be – follow up should be within two working days of the review of the records.

6.49 When Child Y's "relationship" with Adult P came to the notice of agencies in early January 2017 the initial police investigation was limited. The College of Policing guidance (5) states that CSE can encompass a range of different offences including sexual activity with a child under 16 and that CSE investigations require a proactive approach. The police made contact with Child Y's school which neglected to inform

the police that she had been sexually active and that she had been worried that she might be pregnant recently. When the police interviewed Child Y and her mother the information elicited appeared to be taken at face value and the risk to Child Y was assessed as standard although this was later increased to medium by police officers based in the MASH. The decision that an interview of Adult P was unnecessary as Child Y had not disclosed a sexual relationship, did not appear to be consistent with adopting a proactive approach to investigating CSE. No immediate safeguarding concerns were noted and a PVP was submitted.

6.50 When the PVP was received in the MASH no checks with health services were requested by the team manager at that point as it was anticipated that these checks would be carried out as part of the forthcoming C&F Assessment. However, these checks had still not been carried out prior to the home visit to complete the C&F Assessment. (Paragraph 4.119) Had they been requested, the usual checks would have been A&E attendances, GP and school nurse. Sexual health checks which would have alerted children's social care to Child Y's engagement with the sexual health clinic would not be undertaken as standard unless specifically requested by the MASH team manager. The sexual health clinic has identified that they should have made contact with children's social care after Child Y disclosed the 2014 sexual assault on their first presentation to the service. Such a contact would have alerted children's social care to the fact that Child Y was accessing services from the sexual health clinic.

6.51 There was a lengthy delay in the case leaving MASH (13 working days as opposed to the target of two working days) and the expected joint home visit with a CSE team worker did not take place. The home visit to commence the C&F Assessment did not take place until a month after Child Y's relationship with Adult P had been made known to agencies. In addition to the underlying CSE risk factors mentioned in Paragraph 6.38 the high risk CSE factor of "relationship with significantly older adult" was now suspected to be present.

6.52 When the PVP in respect of Child Y's "relationship" with Adult P reached the school nursing service it was scanned onto Child Y's electronic record. The action plan recorded by a community staff nurse was to await the outcome from the MASH assessment. School nurse 5 was electronically tasked "for information only" at that time. After reviewing the tasked information, the school nurse decided that no further action was necessary. There is no evidence that this information was considered in the light of earlier information about Child Y, including the sexual assault, nor is there evidence that case weighting was reassessed. (The school nursing service was no longer in business continuity measures by this time but the response to the PVP appeared to be consistent with the limited approach taken during the business continuity period which suggests that factors other than

business continuity may have contributed to the general passivity of school nurse responses noted in this case.)

6.53 The school nursing service has observed that there were fifteen entries recorded in the electronic records for Child Y during the period from April 2014 until her death and that eight separate members of staff made those recordings, including four qualified school nurses and three community staff nurses. At no time was a case load weighting review completed which should take place whenever a new need is identified. The case weighting is determined by the anticipated level of school nurse involvement in the case.

6.54 Additionally, the school nursing service state that Child Y remained in the "Corporate Pot" and as such never had a named health professional overseeing her case which would have been triggered if a higher level of case weighting had been calculated. The service adds that whilst having a named health professional may not have changed the course of action offered by school health services, it would have ensured that one health professional had an overarching knowledge and understanding of Child Y's evolving needs and may have resulted in a more individual and holistic approach to her care.

6.55 No agency was made aware of the contact that Child Q initiated with Child Y via Facebook in January 2017. (Paragraph 4.93) Child Y's family decided not to report this matter at the time but say that she seemed very upset about the contact. This may have been an event which significantly increased the risk that Child Y could intentionally harm herself. In *Suicide by Children and Young People* (6) researchers concluded that the circumstances that lead to suicide in young people often appear to follow a pattern of cumulative risk, with traumatic experiences in early life, a build up of adversity and high risk behaviours in adolescence and early adulthood, and a "final straw" event which is said to take place in the three months prior to death.

6.56 This "final straw" event may not seem severe to others, making it hard for professionals and families to recognise suicide risk unless the combination of past and present problems is taken into account. The unreported contact from Child Q may have been such a "final straw" event.

Were indications of compromised parenting identified by practitioners and responded to in accordance with policy?

6.57 Throughout the period covered by this serious case review, agencies appeared to hold the view that mother was able to effectively safeguard Child Y and that the open dialogue between mother and daughter assisted her in doing this. Agencies appear to have accepted what they were told by mother and Child Y about the openness of communication at face value. And when information came to light which challenged the view held by agencies, they did not appear to question their assumptions about mother's ability to safeguard Child Y.

6.58 Mother acted as a gatekeeper in deciding whether to accept or decline services and also appeared to be the decision maker over whether to report matters to agencies. There appeared to be insufficient exploration of why services were declined and assurances about the strength of Child Y's family support network were accepted at face value despite the likely strain that the October 2014 sexual assault appeared likely to impose on family relationships.

6.59 Mother would have been in a stronger position to safeguard Child Y if agencies had shared relevant information with her such as her daughter's responses to the health questionnaire overseen by the school nurse service and the indications of suicidal ideation which her school, CAMHS and her GP became aware of.

6.60 There was limited appreciation of the impact the sexual assault on Child Y may have had on mother and no consideration of the implications of this for her ability to safeguard Child Y from harm. The almost complete absence of father from the picture appears to have gone unnoticed.

What role did management oversight play to enhance the quality of practice?

6.61 Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. This duty includes management oversight through having a designated professional lead and appropriate supervision and support for staff for example. However, management oversight played only a limited role in enhancing the quality of practice in this case.

6.62 The 2014 C&F Assessment had a number of deficiencies. The assessment required further exploration of the emotional needs of Child Y and the impact of the

sexual assault; lacked analysis of the role of Child Y's father; omitted referrals and/or signposting for Child Y and her parents. Children's social care's expectation that the relevant team manager would have challenged these limitations was not met. (Paragraphs 4.15 and 6.18)

6.63 When the senior leadership team of the school became aware of the sexual assault on Child Y they did not provide any direction on actions which the school could have considered including offering support to Child Y. (Paragraphs 4.10 and 6.9)

6.64 The decision by the school nursing service leadership to adopt business continuity measures for the school nurse service resulted in some changes to the way in which that service operated for a time which appear to have been communicated to some partners but were not communicated to Blackburn with Darwen LSCB. (Paragraphs 6.15 to 6.17)

6.65 School nurse service case load weighting did not happen when new needs were identified for Child Y and as a result, the allocation of her case to a named professional did not take place. (Paragraphs 6.53 and 6.54) These omissions appear to have gone unnoticed and unchallenged by management.

6.66 The workload pressures which contributed to the absence of the CSE team from the 2017 C&F Assessment of Child Y do not appear to have been picked up on by management. (4.100)

6.67 When Child Y accessed sexual health services for the first time there were a number of departures from expected practice. (Paragraph 4.80) However, the nurse concerned did discuss the case with a nurse manager but the details of this discussion went unrecorded. (Paragraph 4.81)

6.68 The police investigation of Adult P's "relationship" with Child Y was limited as was the assessment of risk. Although the police officers in the MASH intervened to raise the risk level there was little indication of supervisory oversight of the investigation. (Paragraph 4.95)

6.69 Child Y's GP practice missed opportunities to assess her vulnerabilities to sexual exploitation in her last attendance as well as during her earlier presentations with cystitis. The absence of a visible flag in Child Y's patient records appears to have been a factor in this. It is unclear what role the GP partners and the practice manager in Child Y's GP practice played in exercising oversight to enhance the quality of practice. It would be of value for the CCG and the GP practice to reflect on this question.

7.0 Findings and Recommendations

7.1 Deaths from intentional self harm in children aged 10 to 14 have been included in published suicide statistics only relatively recently due to the very small numbers involved. In 2014, which is the latest year for which data is available, there were six deaths of girls between the age of 10 and 14 where death was as a result of intentional self harm and a further five deaths where intent could not be fully determined. So the suicide of Child Y at 14 years and nine months was a rare event.

7.2 However, the sexual abuse suffered by Child Y as a twelve year old appears to have significantly increased her risk of death by suicide. "Abuse or neglect" is one of the ten common themes in suicide by children and young people and the risk of victims of child sexual abuse attempting suicide can be as much as six times greater than in the general population.

7.3 This tragic case therefore represents an opportunity to consider how single and multi-agency responses to Child Y could have been improved in order to enhance suicide prevention efforts. Working with families to provide support to vulnerable children is considered to be key to suicide prevention. (7) The work to support Child Y in the wake of the sexual assault in October 2014 was characterised by incomplete multi-agency working, insufficiently probing assessments in which information was accepted at face value and a general lack of awareness of the potential impact of child sexual assault on the victim and their families.

Independent Sexual Violence Advisor support

7.4 Child Y was not offered the support of a ChISVA. The review has been advised that this was under consideration when the SARC manager rang Child Y's mother to check on her daughter's welfare. (Paragraph 4.18) Mother's assurances that no further support was required at that point were accepted and a referral to ChISVA was not offered.

7.5 Had Child Y been offered, and accepted, the support of a ChISVA, that service would have been well placed to help Child Y access earlier and perhaps more joined up support than she received and would have been able to support her through the court process in particular the partial success of Child Q's appeal which appears to have caused her considerable distress.

7.6 It is not known whether the absence of a referral to ChISVA in Child Y's case is typical of cases in which children and young people are victims of sexual assault in Blackburn with Darwen. The LSCB may wish to seek assurance that where a child or young person is a victim of sexual assault, they are offered a referral to a ChISVA.

Recommendation 1

That Blackburn with Darwen LSCB obtains assurance that when a child or young person is a victim of a sexual assault they are offered a referral to a Child Independent Sexual Violence Advisor.

Inclusiveness of Strategy Discussions

7.7 It was entirely appropriate to hold a strategy discussion following the sexual assault on Child Y in October 2014. However, participants were limited to children's social care, the police and the health representative in the MASH. Child Y's school, the school nurse service and her GP were not invited to participate nor the outcome of the discussion shared with them. Had the strategy discussion been more inclusive it may have led to a more holistic approach being adopted and increased the likelihood of Child Y being offered appropriate support. It might also have led to earlier and more active engagement from Child Y's school and the school nurse service. Child Y's school did not appear to have been formally informed of the sexual assault until August 2015 although there were other factors in this communication deficit.

7.8 It is challenging to ensure that strategy discussions are appropriately inclusive but the technology exists to overcome the difficulty in promptly arranging a meeting at which every relevant agency is physically represented. It is understood that following an earlier SCR, processes have been put in place to ensure the inclusiveness of strategy meetings including the use of teleconferencing. However, the LSCB may wish to seek assurance that this new process is delivering on inclusiveness of strategy discussions and the appropriate sharing of the outcomes of such discussions.

Recommendation 2

That Blackburn with Darwen LSCB obtains assurance that strategy discussions are sufficiently inclusive and that outcomes of such discussions are appropriately shared.

Quality of children and family assessments

7.9 C&F assessments were conducted by children's social care in response to the sexual assault of Child Y in 2014 and the concerns over Adult P's "relationship" with her in January 2017. Although the latter assessment was incomplete at the time Child Y took the overdose which would prove fatal, neither assessment was satisfactory. The 2014 assessment did not fully explore the emotional needs of Child

Y and the impact of the sexual assault, there was no analysis of the role of her father and there was no evidence that referrals were made or signposting information shared with Child Y and her parents. Despite these omissions, the assessment went unchallenged by supervision. The 2017 assessment also excluded Child Y's father, was not informed by contact with relevant partner agencies and the opportunity to jointly conduct the assessment with the CSE team was not taken.

7.10 As a result of the lack of depth of analysis in the 2014 C&F Assessment, an over optimistic view was taken of the support Child Y may require and her file was closed without consideration of managing the case under CiN or CAF arrangements. The LSCB may wish to seek assurance in respect of the quality of C&F Assessments, in particular the depth of analysis, contact with relevant partner agencies, consideration of the role of the father and the extent to which assessments are challenged by supervisors. This review has been advised that the absence of a CSE assessment by the CSE team, which should have accompanied the 2017 C&F Assessment, has been addressed by the introduction of a system by which a CSE episode is triggered by the MASH team manager which automatically brings such referrals to the CSE team manager's attention and prompts allocation to a CSE worker for a specialist CSE assessment. The LSCB may wish to seek assurance that this system is working effectively.

Recommendation 3

That Blackburn with Darwen LSCB obtains assurance in respect of the quality of child and family assessments, in particular the depth of analysis, contact with relevant partner agencies, consideration of the role of the father and the extent to which assessments are challenged by supervisors.

Recommendation 4

That Blackburn with Darwen LSCB obtains assurance that the system by which CSE referrals are brought to the attention of the CSE team manager is working effectively.

Joint working between the School and School nurse

7.11 Joint working between Child Y's school and the school nurse service was entirely absent in Child Y's case. Contact between the school and school nurse service should have taken place after both parties became aware of the October 2014 sexual assault on Child Y, when concerns arose over Child Y's relationship with sex offender (Young Person R) in 2015, when the school nurse administered health

survey disclosed concerns about Child Y's emotional health and wellbeing in 2016 and when concerns arose about Child Y's contact with Adult P in January 2017.

7.12 The school nurse service did not appear to feature in the school's thinking. For example, when Child Y asked the school welfare officer about sources of support in addition to CAMHS, the latter did not consider directing her towards the school nurse. A factor in this disconnect between the school and the school nurse service was the fact that the latter service had entered business continuity measures as a result of staffing shortages for much of the period covered by this review. The health trust providing school nursing services did not inform the LSCB of the decision to adopt business continuity measures which involved temporarily ceasing some activities such as school drop-ins. However, throughout the period covered by this review, including the period when the service was in business continuity and the period after it emerged from business continuity, the response to all concerns about Child Y was essentially passive. Time after time, the plan formulated by the school nurse service was to await contact by other agencies. The various contacts about Child Y were handled by a series of different members of staff who appeared to treat each event in isolation. Opportunities to review Child Y's case and consider escalating it to a higher level of school nurse oversight were missed and these omissions went unchallenged by management.

7.13 Additionally links between the school, school nurse service and GP do not appear to have been particularly strong in this case. Had there been more effective communication and sharing of information between these agencies and CAMHS then an enhanced understanding of Child Y's needs might have been achieved through the noticing of emerging discrepancies in how Child Y and mother were presenting to agencies.

7.14 This review has been advised that Child Y's school introduced a programme of meetings with the school nurse every 4-6 weeks during which open safeguarding cases and any safeguarding concerns can be discussed. Although these meetings were introduced in November 2016 the PVP completed in respect of Child Y in January 2017 was not discussed.

7.15 The LSCB may wish to seek assurance from health trust providing school nursing services that the learning from this case is leading to a more proactive approach to managing risk and that links with schools have been renewed following the period of business continuity. It is understood that similar assurances have already been sought by the LSCB following earlier SCRs. In seeking assurance, the LSCB may wish to assure themselves that communication between schools and the school nurse service is a strong two way process. The LSCB may wish to remind partner agencies of the need to advise the board of any resourcing issues which

have a substantial impact on service delivery and which may necessitate the implementation of business continuity measures.

Recommendation 5

That Blackburn with Darwen LSCB obtain assurance from health trust providing school nursing services that the learning from this case and others is leading to a more proactive approach to managing risk and that links with schools have been renewed following the period of business continuity. In seeking this assurance, the LSCB may wish to assure themselves that communication between schools and the school nurse service is a strong two way process.

Recommendation 6

That Blackburn with Darwen LSCB reminds partner agencies of the need to advise the board of any resourcing issues which may have a substantial impact on service delivery and which may necessitate the implementation of business continuity measures.

The role of GPs in safeguarding victims of child sexual abuse

7.16 Child Y's GP was not involved in the strategy discussion which followed the October 2014 sexual assault. The GP quickly became aware of the sexual assault but no "significant event" meeting was held and the GP did not take the opportunity to check on how Child Y was coping with the implications of the sexual assault when she next visited the GP. Amongst the factors suggested for the issue not being discussed with Child Y was her young age – then 13 years old. And although the incident was recorded on Child Y's electronic patient record there was no visible flag placed in her records which would have alerted others within the practice that there was a live concern when accessing Child Y's records.

7.17 Whilst Child Y's GP practice's single agency action plan (see Section 8 of this report) provides assurance that they have reviewed the service they provide to victims of CSE, the LSCB may wish to seek assurance from the CCG that GP practices generally have reviewed the service they provide to the victims of CSA in the light of the lessons emerging from this case.

Recommendation 7

That Blackburn with Darwen LSCB obtain assurance from the Clinical Commissioning Group that GP practices generally, have reviewed the service they provide to the victims of child sexual abuse in the light of the lessons emerging from this case.

MASH Health Practitioners

7.18 The presence of a health practitioner within the MASH, from the same health trust as the school nursing service, did not appear to assist in facilitating timely and inclusive engagement and communication with relevant health practitioners in respect of the 2014 sexual assault or the 2017 concerns about Child Y's contact with Adult P. It is appreciated that the health economy is complex and various elements of the health economy may not always have compatible electronic system, but it seems reasonable to expect health practitioners in the MASH to act as a conduit for all of the health services involved in a particular case. It is understood that this issue has recently been addressed through new MASH practice guidance and a revised CCG contract with the health trust providing the specialist safeguarding nurses in MASH. The LSCB may wish to seek assurance that these new arrangements ensure effective communication and engagement between the MASH and relevant health services.

Recommendation 8

That Blackburn with Darwen LSCB seeks assurance that recently introduced arrangements to ensure effective communication and engagement between the MASH and relevant health services are working effectively.

Voice of the Child

7.19 Child Y was twelve years old when she was sexually assaulted by Child Q and three months short of her fifteenth birthday when she died. Despite her growing maturity, most agencies tended to communicate with her mother *about* her rather than communicating directly *with* Child Y. This effectively handed mother the role of "gatekeeper". In this role she frequently declined support for Child Y without Child Y's wishes apparently being ascertained by agencies despite the high level of concern for Child Y's welfare. Given the distress that mother may have been feeling, she may not have been ideally placed to make decisions about support for her daughter.

7.20 There was also a period during which the police regarded Child Y's paternal grandmother as the family spokesperson, which given her obvious conflict of interest as the special guardian of Child Q and his sibling, was unwise.

7.21 CAMHS succeeded in providing Child Y with a private therapeutic space and the sexual health clinic was also able to support Child Y on a one to one basis. However, these and other agencies who made direct contact with Child Y tended to accept what she told them at face value even when discrepant information was

available. For example, many agencies accepted the Child Y's assertion that she confided in her mother including matters of a sexual nature despite accumulating evidence that this was not the case.

7.22 Child Y appeared to develop a trusting relationship with her school's child welfare officer but the potential value of this was somewhat diminished by the school's safeguarding practices which included inadequate recording systems and a lack of awareness of the impact of child sexual abuse on the victim.

7.23 Insufficient consideration of the voice of the child is regularly highlighted in serious case reviews and is equally regularly the subject of recommendations. The practitioners and managers involved in Child Y's case absolutely recognised the need to listen to her voice. There seemed no lack of appreciation of the importance of this issue. Yet the voice of the child continues to receive insufficient attention. Practitioners and managers suggested that their work had become excessively process driven which had impacted on the extent to which the service they provided was tailored to the needs of the person.

7.24 Rather than make the type of voice of the child recommendation common in serious case reviews, such as auditing cases to check on the extent to which the voice of the child is present, it is suggested that when the learning from this case is disseminated to practitioners a strong focus of any briefing or training or workshops is a session in which practitioners and managers are asked to identify *what is stopping them from listening to the voice of the child*. Analysis of the answers to this question may yield some clues as to how this persistently challenging issue might be addressed.

Support for families of victims of child sexual abuse.

7.25 In this case agencies saw mother as the key figure providing support to Child Y in the period following the October 2014 sexual assault. It only gradually became apparent that the sexual assault and the surrounding circumstances were also having an effect upon her emotional health and wellbeing. It is possible that the sexual assault on Child Y may also have had an effect on father who appears to have responded by distancing himself from the situation.

7.26 As stated in Paragraph 6.33 *The Impacts of child sexual abuse* study found that the impacts of child sexual abuse on the parents – particularly the mother – can be profound and may actually mirror the impacts experienced by the child. As a result, parents may find it challenging to provide support to the child which can create a "vicious circle" in which the support the parent is able to give to their child is compromised, thereby reducing the child's chances of recovery. This serious case

review has benefitted from the strong engagement of practitioners and managers involved in Child Y's case. They found this research finding extremely revealing and felt that greater consideration should be given to supporting the parents of children who have been the victims of child sexual abuse and child sexual exploitation.

7.27 The LSCB may wish to review the support provided to the families of children who are the victims of CSA and CSE in order to identify whether further support is required in order to help parents support their children to cope with the impact of CSA and CSE.

Recommendation 9

That Blackburn with Darwen LSCB conducts a review of the support provided to the families of children who are the victims of CSA and CSE in order to identify whether further support is required in order to help parents support their children to cope with the impact of CSA and CSE.

Suicide prevention

7.28 Recognising suicide risk in children and young people is acknowledged to be extremely challenging for professionals. (8) Child Y's suicide texts strongly suggest that the October 2014 sexual assault by Child Q had a devastating effect upon her life. With hindsight, the delay in providing therapeutic support to Child Y following that sexual assault, the lack of recognition of the impact of that sexual assault upon Child Y's parents and the lack of practitioner awareness that Child Y's risky contact with Young Person R and Adult P might constitute "externalising behaviours" prompted by the October 2014 sexual assault represent opportunities missed.

7.29 However, practitioner awareness of potential suicide risk factors did not appear to be high, despite several agencies becoming aware of Child Y's suicidal ideation, and did not inform single or multi-agency decision making. Research suggests that this situation is not uncommon. (9) This case therefore presents an opportunity to both raise practitioner awareness and potentially develop an enhanced approach to suicide prevention amongst children and young people.

7.30 It is suggested that the learning from this case is widely disseminated in order to enhance practitioner awareness of potential suicide risk factors including self harm which research suggests is a crucial indicator of risk. The LSCB may also wish to make use of the learning from this case to help inform a review of suicide prevention services for children and young people.

Recommendation 10

That Blackburn with Darwen LSCB widely disseminate the learning from this case in order to enhance practitioner awareness of potential suicide risk factors.

Recommendation 11

That Blackburn with Darwen LSCB make use of the learning from this case and relevant research findings to inform the Blackburn with Darwen suicide prevention strategy for children and young people.

8.0 Single Agency Action Plans

Sexual Health Clinic

- Introduction to Safeguarding training Level 2 to be delivered to all client-facing staff as a refresher.

- To improve the frequency of safeguarding monitoring meetings.

- To improve recording of minute taking.

- To ensure that all new staff who work in a client facing role, have attended the agency's Introduction to Safeguarding Training prior to seeing clients alone.

- To complete a record keeping audit on 40 sets of Nurse 1's consultations to determine if any client records indicate that safeguarding concerns require further action.

- To implement peer review of records for all clinical staff following the agency's new peer review procedure.

- The agency's national monthly teleconferences to be held by the Designated Safeguarding Lead, and Head of Education and Wellbeing, to update all staff on safeguarding policies and procedures including any recent revisions, and time to be allocated for all staff to have the opportunity to dial in.

- To complete an internal investigation to establish the facts surrounding the failure to refer a previous historic abuse case to social care.

Children's Social Care

- In relation to sexual health referrals that MASH undertake checks with school nurse, GP and sexual health services.

Hospitals NHS Trust

- To ensure that where CAMHS identify children as being at risk of CSE that appropriate action is taken to safeguard the child.

- To strengthen safeguarding supervision for CAMHS from the Trust's Safeguarding team.

- Child Sexual Abuse / Child Sexual Exploitation risk indicators to be highlighted in patient records.

NHS CCG (GP practice)

- All practitioners within the practice to have an awareness of and the ability to act in identifying and protecting children who are at risk or experiencing sexual abuse.

- Review of GP Practice policy to include CSE.

- Criteria to be identified within the practice as to when to 'flag' or implement an alert onto a patients electronic records and the visibility of this with the practice on a *need to know basis.*

- Awareness raising within the practice of the need to further review and appropriately investigate when patients attend with an alert on their patient electronic record to highlight a sexual assault.

Community NHS Foundation Trust (School Nurse Service)

- Improve information sharing & communication by practitioners within the Child & Family Health Service with partner agencies.

- School Nurse Duty system to be reviewed.

- Risk Sensible Model to be continued to be embedded in practice.

- To improve adherence to the Case Weighting Tool SOP.

- School Health Needs Assessment (SHNA) SOP to be reviewed.

Police

- Police Officers when conducting investigations involving children should listen to and speak to the child and take into consideration the voice of the child.

- Child victims who are identified as being at risk of CSE or risky sexual activity should be assessed as High Risk when PVP risk assessments are submitted into the MASH. This will allow for information to be shared with relevant agencies and safeguarding to be expedited. This complies with current advisory criteria.

School

- School is to implement a mental health policy.

- School is to make informing and training staff in and around mental health and wellbeing a priority.

- School is to continue developing their electronic recording system for safeguarding supported by staff training.

- All safeguarding reports are now seen by the head teacher and senior staff and these form the basis of regular planning and action with the Child Welfare Officer and senior pastoral staff.

- Training has been delivered to pastoral staff on the impact of sexual assault and child sexual exploitation on children's lives so that they are aware of potential implications of these events on children and so ensure their response is appropriate to disclosures.

- A tier 2 information and sharing agreement has been signed between the school and school nursing service which formalises and standardises the information that will be shared between the school and the service.

- Protocols have been put in place so that outside agencies seeking information sharing from school will always be referred to the head teacher, senior staff or the child welfare officer to assess the level of information to be shared to ensure effective safeguarding and support for the child.

References

(1) Retrieved from https://www.iicsa.org.uk/key-documents/1534/view/IICSA%20Impacts%20of%20Child%20Sexual%20Abuse%20Rapid%20Evidence%20Assessment%20Full%20Report%20%28English%29.pdf

(2) ibid

(3) ibid

(4) ibid

(5) Retrieved from https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-sexual-exploitation/#investigating-cse-cases

(6) retrieved from http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf

(7) ibid

(8) ibid

(9) ibid

Appendix A

The process by which this serious case review was completed

It was decided to adopt a systems approach to conducting this SCR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

The following agencies contributed to this review:

- Sexual health clinic provider (sexual health and wellbeing for under 25s)
- Children's Social Care
- Hospitals NHS Trust (CAMHS)
- NHS Clinical Commissioning Group (GP practice)
- Community NHS Foundation Trust (School Nurse Service)
- Police; and
- Child Y's school.

Each agency completed a chronology of relevant contacts with Child Y and her family and an agency report in which they reflected on that contact and identified single agency learning. After these agency reports had been quality assured a practitioner learning event took place at which practitioners and managers involved in the case clarified what happened and why, identified significant practice episodes and potential learning themes.

The independent author then prepared an initial draft report which was subsequently shared with a recall practitioner learning event at which practitioners and managers commented on the draft report and went on to consider what needed to change in order to improve practice.

Child Y's mother contributed to the SCR and also commented on the final draft of the SCR report.

The independent author prepared a final report following consultation with the agencies which contributed to this SCR which was subsequently presented to Blackburn with Darwen LSCB.