BLACKPOOL SAFEGUARDING CHILDREN BOARD
SERIOUS CASE REVIEW

CHILD CB
## Contents

**Key: Family Members** .......................................................................................................................... 3

**Key: Acronyms** ......................................................................................................................... 3

**Introduction** ................................................................................................................................. 4

**The SCR: Process and Methodology** ................................................................................................. 4

**Independence** .................................................................................................................................... 7

**Serious Case Review Panel** ............................................................................................................ 8

**Confidentiality** ............................................................................................................................. 9

**Family involvement** .................................................................................................................... 9

**Staff involvement** ....................................................................................................................... 9

**Race, Language and Culture** ........................................................................................................ 10

**Summary of Child CB’s history** ..................................................................................................... 10

**Overview of events and agency involvement** .................................................................................. 11

**Analysis** ........................................................................................................................................ 11

**Consideration of Key lines of enquiry** ............................................................................................ 13

**Post Adoption Support and Interventions** ..................................................................................... 13

  - **Was Child CB enabled to understand his identity?** ................................................................. 13
  - **How well did professionals understand Child CB’s behaviour, attachments and identity anxieties?** ......................................................................................................................... 16

**Interventions** .................................................................................................................................. 35

  - **CAMHS Provision** .................................................................................................................... 42

  - **What was the impact of the move between geographical areas for Child CB?** ................. 44

  - **Was there one ‘trusted professional’ in Child CB’s life post adoption breakdown?** ........ 46
How effective was multi-agency working in ensuring a co-ordinated response to Child CB’s needs? .......................................................... 47

What was the interplay between medical diagnoses, medication and other therapies? .......... 49

Risk taking behaviour .......................................................................................................................................................... 51

How effectively did agencies understand and respond to risk taking behaviour? ............ 51

Responses to the risk of suicide ......................................................................................................................................... 54

How effectively did agencies respond to indications of low mood, self-harm and suicidal ideation? .................................................................................................................................................. 54

Was the immediate response to the suicide attempt on 15 December 2017 effective and did it fully consider his mental health? ........................................................................................................... 57

How did Child CB’s wishes and feelings influence assessments and responses? ............. 60

How did practitioners ensure that Child CB was listened to and understood? ............... 60

Further Analysis .............................................................................................................................................................. 62

Summary .............................................................................................................................................................................. 64

Learning and Recommendations arising from this Serious Case Review ....................... 65

References .......................................................................................................................................................................... 69
### Key: Family Members

<p>| | |</p>
<table>
<thead>
<tr>
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<tr>
<td>Child CB</td>
<td>Aged 17</td>
</tr>
<tr>
<td>Sibling 1</td>
<td>Now aged 16</td>
</tr>
<tr>
<td>F</td>
<td>Father</td>
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<tr>
<td>M</td>
<td>Mother</td>
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<tr>
<td>BF</td>
<td>Birth Father</td>
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### Key: Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<td>CASHER</td>
<td>Child and Adolescent Support and Help Enhanced Response</td>
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<td>IRO</td>
<td>Independent Reviewing Officer</td>
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<tr>
<td>SNP</td>
<td>School Nurse Practitioner</td>
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<tr>
<td>SS</td>
<td>Secondary School</td>
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<td>SW</td>
<td>Social Worker</td>
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<td>CSC</td>
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Introduction

1. The subject of this Serious Case Review (SCR) is Child CB.

2. Child CB suffered fatal injuries after jumping from the roof of a building in December 2017.

3. Child CB was aged 17 when he died.

4. In September 2014 Child CB was placed in accommodation using Section 20 of the Children Act 1989 when his relationship with his adoptive family broke down.

5. Child CB remained in the care of the local authority until his death.

6. This SCR focuses upon agency involvement with Child CB and his family in order to identify learning, good practice and missed opportunities to safeguard Child CB.

The SCR: Process and Methodology

7. The Independent Chair of the Local Safeguarding Children Board (LSCB) agreed on 30th January 2018 to commission a SCR concerning the tragic death of Child CB. The scope of this SCR was to cover the timeframe from September 2013 to 21st December 2017 which was the date of Child CB’s death. (It was agreed by the SCR Panel that any significant events prior to this date would also be included within the scope).

8. The Case Review Sub Group made a recommendation that the LSCB should conduct a proportionate, appropriate and participative SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning and good practice, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place.
9. The SCR was designed and led by Clare Hyde MBE, independent reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms Hyde developed a review model that would enable participants to consider the events and circumstances, which led up to the death of Child CB.

10. This formal process allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for LSCBs to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final SCR report or in the action plan as appropriate.

11. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from SCRs 2009-2010, (Brandon, M et al), calls for a limiting of ‘self-perpetuating and proliferation’ of recommendations. Current thinking about how the learning from SCRs can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.
12. An SCR Panel was convened of senior and specialist representatives from key agencies involved with Child CB and his family in the time covered, to oversee the conduct and outcomes of the review. All panel members were independent of the family and casework. The role of the panel was to assist the Independent Reviewer in considering the evidence, formulating the recommendations and quality assuring this report.

13. There was significant agency involvement with Child CB’s family and the following agencies were asked to provide a chronology and these were integrated into a combined chronology.

- Blackpool Council Children’s Services
- Blackpool Teaching Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Children and Family Court Advisory and Support Service (Cafcass)
- General Practitioner
- Greater Manchester Police
- Lancashire Care NHS Foundation Trust
- Lancashire Constabulary
- Manchester City Council Youth Justice Service
- North West Ambulance Service
- Residential children’s homes – one in Blackpool and one in Manchester
- Schools - three secondary schools, a Pupil Referral Unit, a Further Education (FE) provider and the Blackpool Council Virtual School
14. The Independent Reviewer reviewed the combined chronology in order to consider in detail the sequence of events and any key practice episodes that underpinned those events.

15. The SCR Panel agreed the scope of the SCR. The SCR Panel also considered key lines of enquiry. These included:

- **Post Adoption Support and Interventions**
- **Effectiveness of interventions**
- **Timeliness of interventions**
- **Service provision**
- **Assessments**
- **Risk taking behaviour**
- **Responses to the risk of suicide**
- **How did Child CB’s wishes and feelings influence assessments and responses?**

**Independence**

16. An independent chair, from a partner agency with no direct operational involvement with the family was agreed by the Local Safeguarding Children Board to chair the SCR Panel.

17. The Lead Reviewer, Ms Hyde was Chief Executive Officer of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston’s Review of Women with Vulnerabilities in the Criminal Justice System which was commissioned by the Government following the deaths of several women in custody.
18. Ms Hyde is currently working with LSCBs and their partners to improve safeguarding outcomes for children and young people living with domestic violence, substance misuse and parental mental illness and to support the development of a multi-agency response to children and young people at risk of sexual exploitation.

19. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair and Reviewer of several SCRs and a Domestic Homicide Review and has designed and led several Learning Reviews on behalf of local safeguarding children and adults boards.

**Serious Case Review Panel**

20. The SCR Panel met on a number of occasions between February 2018 and July 2018.

21. The overview report was ratified at the Local Safeguarding Children Board meeting on 7th September 2018.

22. The Panel comprised of:

- Clare Hyde  
  Head of North West Lancashire (Chair)  
  Independent Reviewer  
  HM Prison and Probation Service

- Designated Doctor for Safeguarding  
  Blackpool Clinical Commissioning Group

- Designated Nurse for Safeguarding  
  Blackpool Clinical Commissioning Group

- Head of Safeguarding  
  Blackpool Council

- Educational Inclusion Officer  
  Blackpool Council

- Named Nurse for Safeguarding Children and Adults  
  Blackpool Teaching Hospitals NHS Foundation Trust

- Counselling Team Leader  
  Blackpool Teaching Hospitals NHS Foundation Trust

- Service Manager  
  Cafcass

- Designated Doctor for Safeguarding  
  Fylde and Wyre Clinical Commissioning Group

- Clinical Pharmacist  
  General Practice representative

- Specialist Safeguarding Children Practitioner  
  Lancashire Care NHS Foundation Trust

- Review Officer  
  Lancashire Constabulary

- Business Development Manager  
  Blackpool Safeguarding Children Board
Confidentiality

23. Working Together to Safeguard Children 2015 clearly sets out a requirement for the publication in full of the overview report from SCRs:

24. “All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”

Family involvement

25. The independent chair and one other member of the SCR Panel met with Child CB’s parents in June 2018.

26. Child CB’s parents were able to share information and their reflections about Child CB’s life and how agencies had worked with them. Where relevant this is referred to within the body of this report.

Staff involvement

27. The staff who were involved with Child CB and his family participated in a Learning Event in May 2018. The Learning Event was attended by practitioners who had had direct involvement with Child CB and his family, in addition to the Independent Reviewer who facilitated the event and the BSCB Business Development Manager.
28. Following the Learning Event, the Independent Reviewer collated the outputs from the Learning Event and from the agency chronologies and began her analysis. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice.

**Race, Language and Culture**

29. Child CB was White British. His adoptive family are White British and their first language is English.

**Summary of Child CB’s history**

30. What is known about Child CB’s history is detailed below.

31. Child CB and his siblings were taken into the care of the local authority in 2004.

32. Child CB was aged 3.5 at the time. He and one sibling who was then aged 2 were adopted by the same family.

33. Child CB and his family first asked for help in respect of difficulties they were experiencing in 2009.

34. In September 2014 the adoption broke down and Child CB became accommodated by the Local Authority.

35. He moved from foster care (5 placements in total) to residential care firstly in Manchester and then to a residential placement in Blackpool in 2017.
Overview of events and agency involvement

36. Although the timeframe for this SCR was from September 2013 to 21st December 2017 agency records held historical information which is relevant to the case and this has been considered.

Analysis

37. The analysis is set out in response to the key lines of enquiry set by the SCR Panel which formed the terms of reference for the SCR. The analysis is informed by the chronological information provided by agencies and the views and contributions of the practitioners who attended the Learning Event. (Please note the responses to each individual key line of enquiry are presented in chronological order).

38. The analysis also takes particular account of and reflects what is known about the following issues which were relevant to Child CB’s life experiences:

39. The disruption (or breakdown) of adoptions and why this happens. The author of this report has drawn from the findings of a major 2014 UK study which included 390 adoptive parents caring for 689 children, most of whom were teenagers.

*Beyond the Adoption Order: challenges, interventions and adoption disruption* J Selwyn et al 2014

40. The mental health and wellbeing of children who have experienced adversity in childhood and what is known about the mental health and emotional wellbeing of children and young people who become looked after and/or adopted (quite often as a consequence of their adverse childhood experiences) and learning from other serious case reviews.
41. The impact of neglect and other adverse childhood experiences such as loss and physical abuse is well researched and provides a useful gendered focus on how childhood traumas can manifest throughout a person’s life. These include:

- Conduct disorders including anti-social personality disorder, border line personality disorder, oppositional defiance disorder
- Psychotic illness
- Attention Deficit Hyperactivity Disorder
- Post-Traumatic Stress Disorder
- Drugs and alcohol
- Learning disability
- Acquired brain injury
- Speech and language difficulties
- Physical health problems
- Suicide rate 8-12 times than seen in the community

42. The mental health of looked-after children is significantly poorer than that of their peers, with almost half of children and young people in care meeting the criteria for a psychiatric disorder (in comparison one in ten non-looked-after children and young people suffer from a diagnosable mental health disorder).

*Office of National Statistics, Mental health of children and young people in Great Britain, 2004 (August 2005).*

43. A Department of Health review on measures to prevent suicide in England noted that “looked after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems and at six- to seven-fold
increased risk of conduct disorders”. *Preventing Suicide in England: A cross-government outcomes strategy to save lives.*

44. The analysis also takes into account what is known about attachment. The term ‘attachment’ refers to the physical and emotional support which children depend on from the key adults who take care of them. Attachment theory says that children who are securely attached have higher self-esteem and empathy, and can deal with stress more effectively. Looked-after children are more likely to be affected by attachment difficulties which can have a negative impact on their mental health and subsequent behaviour.

45. What is known about the impact of adolescent drug use on mental health is also reflected in the analysis.

**Consideration of Key lines of enquiry**

**Post Adoption Support and Interventions**

*Was Child CB enabled to understand his identity?*

46. Identity formation begins in childhood and takes on increased importance and prominence during adolescence (Grotevant, 1997). Fundamentally, the act of establishing identity involves an adolescent answering the question, “who am I?” in relation to various different aspects of life and different contextual environments. This may have a significant impact on children who are adopted as their potential understanding of their life, which is dependent on knowledge of the self, family, and society, may be incomplete. Ultimately, when individuals form their identity, they often need to have coherent stories to create and understand the meaning of their
life and to link their identity to their past, present, and future. (with reference to Parenting Advice for Foster Carers and Adopters)

47. It follows that identity development may be more difficult for an adopted person because of the additional issues related to adoption, such as why he or she was placed for adoption, what became of the birth parents, does he or she have siblings.

48. Often accompanying these issues of identity are issues of self-esteem. A number of studies have found that adopted persons often score lower on measures of self-esteem and self-confidence (Borders, Penny, & Portnoy, 2000; Sharma, McGue, & Benson, 1996). This may reflect the fact that some adopted people may view themselves as different, out-of-place, unwelcome, or rejected. Some of these feelings may result from the initial loss of birth parents and from growing up away from birth parents, siblings, and extended family members. They also may be caused by an ongoing feeling of being different from non-adopted people.

49. It is not clear from the agency records what formal work was done with Child CB leading up to and in the years following his adoption to enable him to understand his identity as he grew up. It is recorded that some ‘life story’ work was undertaken with Child CB between the ages of 12 and 13 but by this time Child CB and his family were experiencing difficulties.

50. Prior to Child CB and his sibling being adopted by M and F they report that they were told that both children had suffered neglect and possible physical abuse. The impact of neglect on child development and potential future attachments or mental and emotional health issues was not discussed in any depth with M and F during or after the adoption process.
51. When M and F asked for help between 2009 and 2014 they said that professionals often made them feel as if their parenting was at fault and that they were not helped to understand the possible causes of Child CB’s difficulties. M and F did state that a CAMHS practitioner had been helpful and had explained attachment theory to them which increased their understanding of Child CB’s behaviour and their own responses to it.

52. This case highlights the complex and often considerable post adoption support needs of the whole family i.e. parents, adopted children, siblings and that these needs can change significantly over time.

53. We know from agency records that Child CB did not want others to know that he was adopted. He was extremely distressed when his younger sibling and another birth sibling (who had been adopted by a different family) joined his school in 2013 and other pupils were becoming aware of this.

54. Some of the practitioners who contributed to the Learning Event also stated that Child CB struggled with his identity and was distressed when he learned via social media that his birth father had had more children after Child CB and his siblings had been removed from his care.

55. Following Child CB becoming accommodated by the Local Authority in September 2014 there is no specific reference to therapeutic work carried out with Child CB which focused on supporting him with issues specifically relating to his identity however it was clear from conversations with the practitioners that some of them spent time listening to and discussing this issue with Child CB.
How well did professionals understand Child CB’s behaviour, attachments and identity anxieties?

56. Child CB’s overall wellbeing and behaviour was impacted upon by his attachment difficulties and his anxieties concerning his identity.

57. It is clear from the agency chronologies and from the accounts of some of the practitioners who contributed to the Learning Event that there was some understanding of the underlying causes of Child CB’s difficulties.

58. Attachment was identified as an issue in 2009 by a Children’s Social Care (CSC) Adoption Support Social Worker when Child CB’s behaviour was first reported as challenging by M and F and a referral to CAMHS was made.

59. The family attended an initial appointment with a CAMHS practitioner in October 2009 and the practitioner documented that Child CB may have attachment issues due to neglect by his biological parents.

60. The outcome of the CAMHS assessment was a suggestion to M that the family access post adoption support however M was reluctant to do so and CAMHS closed the case in February 2010 having received no response to attempts to contact M and F.

61. Between October 2009 and September 2013 there is no agency record of the family requesting or accessing support in respect of Child CB.

62. Child CB began secondary school (SS1) in September 2012 and his Year 7 records indicate that his behaviour was sometimes an issue.

63. Child CB’s attendance at SS1 however was not an issue and he was rarely absent. He appeared to have been able to build trusted relationships with school staff including the Pastoral Care practitioner and the School Nurse Practitioner (SNP) who demonstrated good understanding of some of his difficulties.
64. In September 2013 Child CB was seen by a paediatrician in an epilepsy clinic following a referral by his GP for dizzy spells. During the appointment M stated that she was concerned that there had been some behaviour issues at school and that Child CB could get angry. M felt that this could be due to some of the children making fun of him for being adopted. No medical needs were identified and the paediatrician referred Child CB to the community clinic so that a more in-depth psychosocial assessment (and a review of the dizzy spells) could be carried out.

65. This suggests that the paediatrician understood that the underlying causes of Child CB’s difficulties were not physical.

66. Also in September 2013 M made contact with the Post Adoption Support Team following a physical altercation between Child CB and F following which Child CB had been found by his parents with a dressing gown cord tied around his neck and it appeared that he had tried to asphyxiate himself (Child CB denied that this had been his intention).

67. This incident led to a strategy discussion between CSC, Child CB’s school and the adoption team. During the assessment which followed Child CB stated that F had pushed him however no S47 enquiry was instigated.

68. By 17th September 2013 an assessment concluded that ‘Relationship issues to be addressed through therapeutic plan. Child in need plan to be developed. Business proposal for commissioning specialist service to be drafted by the adoption team’.

69. On 30th September a Child in Need Plan was in place and this identified that ‘Child CB would access CAMHS, and a referral to ‘Theraplay’ would be made to improve relationships, Life Story work to be completed with Child CB, parents to be provided with advice and guidance in respect of attachment and adoption’.
70. This plan clearly recognised that Child CB was experiencing attachment and identity difficulties and that his parents needed support.

71. However Child CB’s behaviour continued to deteriorate at school and at home and his distress increased (it was during this period that his siblings joined his school and were discussing their adopted status with other pupils).

72. In November 2013 Child CB and M and F attended an appointment with CAMHS and it was agreed that further support would be offered however there is no record to indicate that there were further appointments offered and Child CB was discharged from CAMHS in February 2014 (the reason for the discharge is not recorded).

73. In March 2014 Child CB telephoned emergency services and stated that he had taken an overdose of ibuprofen and co-codomol. He was admitted to hospital and was seen by a CAMHS practitioner on the ward. He was discharged later that day and a follow up appointment was made with CAMHS for 5 days later.

74. At that appointment Child CB was seen by a CAMHS practitioner with his mother. Child CB reported that he felt his mother was "smug" when she said things and insulted his birth mother. A risk management plan was agreed for safety at home. Child CB stated that he was unsure if he would engage with CAMHS again but would consider it. M stated that she would like support.

75. It was agreed that a further appointment would be offered with the CAMHS family therapist.

76. On 3rd April 2014 Child CB was taken to A & E by a family friend after stating that he wanted to harm himself. He was again admitted to hospital.

77. Child CB was discharged home to the care of his parents on 8th April and the family were seen again by CAMHS on 10th April where it was recorded that ‘Child CB and
parents attended follow up ward appointment…. Child CB reports that his Dad gets angry in his face and can push and poke him. Mother reported that she feels unsafe at home as Child CB can be unpredictable. Safety plan discussed and has CAMHs partnership appointment’. This information was not shared with CSC.

78. On 25th April a CSC record indicates that ‘The support from the post adoption support team ceased on the 22/04/2014 in order that CAMHs can begin work with the family via Family therapy (27/05/2014). Much work has been completed by post adoption services in relation to attachment, emotional responses to adoption/birth family. It has been identified that there is a real risk of adoption breakdown. M has been referred to Women’s Aid as a result of being subject to Child CB’s violent behaviour. Outcome of this assessment was case to close to CSC and a referral to Early Assessment Team (EAT) be made for any additional support’.

79. Child CB and his parents attended a CAMHS appointment on 28th April. Child CB stated that he did not want a relationship with his parents.

80. Child CB and his parents attended a further CAMHS appointment on 20th June 2014. Concerns persisted that the adoption was breaking down. Child CB requested to be seen on his own and reported that he no longer want to live with his parents. He felt they had let him down. He stated that he did not feel that there was any point attending CAMHS sessions if it was ‘all to do with staying with his adoptive parents’.

81. On 4th July 2014 Child attended a CAMHS appointment and was seen alone. It was recorded that ‘Child CB remains adamant he does not want to live with his adoptive parents. Child CB reports that he feels his parents don’t care or love him could not clarify why, appeared to be driven by the desire to get away from family home and could not recognise that he may contribute to some of the conflict. Child CB then
asked for session to end as he did not feel he was getting support to be removed and saw no point in further sessions’. The CAMHS practitioner discussed this with M and arranged a further appointment with both parents and the SW.

82. Throughout July 2014 there were incidents including a further referral to CSC by SS1 following an argument between Child CB and his mother outside school, Child CB going missing from home and absconding from SS1. This led to ‘Edge of Care’ support being put into place for the family. This is a CSC service that works with children and families where there is a risk of relationship breakdown that would result in the child becoming looked after.

83. On 29th July 2014 during a home visit by the ‘Edge of Care’ team, Child CB disclosed that he had argued with F over his pierced lip which resulted in F grabbing him by the shoulder and punching him with a clenched fist in the hip. As a result of this a Strategy Discussion was held and Child CB underwent a safeguarding medical which concluded that Child CB’s injuries were consistent with his account of being punched.

84. The CSC records state that ‘It is believed the situation is now untenable with frictions in the home resulting in situations where there is a risk of physical harm to Child CB and to incidents where Child CB could be criminalised for incidents involving his mother. The outcome recorded was that the concerns were substantiated but not judged to be at risk of significant harm. Consent to be obtained from Senior Manager to accommodate’.

85. Throughout August and September 2014 there were further violent incidents in the family home and Child CB was allegedly assaulted by F and in turn was allegedly abusive to M.
86. During the same period CSC were making efforts to find a suitable foster placement for Child CB.

87. On 22nd September 2014 Child CB’s first Foster Placement began.

88. In summary from as early as 2009 until he became a Child Looked After in 2014 Child CB was exhibiting his distress and difficulties in behaviours which manifested as aggressive, self-harming and suicidal.

89. During this period of time before the adoption broke down, not all practitioners demonstrated that they understood Child CB’s anxieties and identity issues and crucially it appears that he himself did not feel understood for example he told the SNP in March 2014 that he “had not wanted to engage with CAMHS previously because he felt like he was being told something was wrong with him rather than being asked what he wanted”.

90. During 2013 and 2014 professional focus was often on how to support M and F to manage Child CB’s behaviour rather than recognising that Child CB’s behaviour was a manifestation of his distress. There were interventions which took place with the specific intention of focusing on Child CB’s attachment and identity anxieties however it is not clear how their effectiveness was measured.

91. Child CB undoubtedly suffered significant emotional and physical harm during the period of time that efforts continued to be made to stop the adoption breaking down and he was also at risk of harming others.

92. This next section of the report focuses on the period of time from which Child CB became accommodated by the Local Authority until his death.

93. Child CB was fostered by 5 different foster carers (one was a ‘respite’ carer therefore intentionally short term and he did not stay for more than a few hours at
another foster placement) between September 2014 and October 2016. It is not
clear from agency chronologies how well each foster carer understood Child CB’s
difficulties and the impact this had on how well they were able to respond to and
cope with the behaviours which resulted from them.

94. It is apparent from the agency chronologies however that Child CB’s difficulties
continued throughout his time in foster care with one hospital admission in May
2015 when he reported feeling suicidal and a further admission in August 2016
which followed him drinking household bleach and telling his foster carer that he
wanted to kill himself.

95. Following the August 2016 admission Child CB and his SW attended an appointment
with a consultant psychiatrist. The consultant psychiatrist agreed that Cognitive
Behavioural Therapy would be helpful but also prescribed medication which was
Fluoxetine, Risperidone and Circadin\(^1\). Following this appointment the consultant
psychiatrist diagnosed ‘significant attachment disorder, recurrent depressive
disorder, social anxiety and challenging behaviours’.

96. This diagnosis (and the prescription of medications) was significant and is an
indication of how difficult foster carers would have found it to understand and
manage Child CB’s needs and behaviours.

97. It is not clear from agency chronologies how well the pattern of failed attachments
was recognised and responded to by practitioners or by the foster carers
themselves. It is also unclear whether Child CB was helped to recognise and
understand this pattern and he was very distressed when two of the foster
placements ended.

\(^1\) The prescribed medication is described in detail in para. 234-241.
98. The practitioners who contributed to the Learning Event spent some time considering the shortage of specialist/appropriate foster placements in the Borough (and nationally) and also discussed the capacity and willingness of foster carers to care for children and young people who share Child CB’s life experiences and difficulties.

99. Child CB began attending another secondary school (SS2) in September 2015 which coincided with a change in foster carer (this move was out of Borough and also necessitated a change of health provider).

100. By November 2015 Child CB was stating that he was unhappy at the new school.

101. A Child and Family assessment was completed in March 2016 to reassess Child CB’s current needs and to address concerns surrounding placement breakdown/contact with birth and adoptive family. The assessment identified the patterns in Child CB’s behaviours in relation to the breakdown of foster placements but it is not clear how (or if) interventions were put in place to address this as a manifestation of Child CB’s attachment and identity issues.

102. Child CB’s fourth foster placement broke down following an incident during which Child CB was arrested in possession of a knife at the foster carer’s home. He was under the influence of a ‘legal high’ at the time. There were increasing concerns surrounding alcohol and drug misuse at this point (Child CB had been severely intoxicated on two occasions and also admitted to being a regular cannabis user).

103. In summary, two of Child CB’s potentially long term foster carers were managing Child CB’s difficult behaviour and his mental and emotional distress. The placements subsequently broke down and were unable to offer him stability. The underlying
causes of his behaviour and distress which led to the placements breaking down remained unaddressed as he moved into residential care.

104. In October 2016 Child CB began his placement in a Manchester Children’s Home (MCH). This placement lasted until August 2017 which was the longest period of time Child CB spent in a placement.

105. It is apparent from the information contained in the chronology provided by the MCH and from the contributions made by practitioners at the Learning Event that staff there were able to build trusted relationships with Child CB and demonstrated understanding of his underlying attachment and identity anxieties.

106. As well as managing Child CB’s behaviours and responding to his day to day needs the staff co-ordinated interventions to try and address some of Child CB’s needs. For example Child CB accessed the ‘in-house’ counsellor for 4 sessions until he then disengaged.

107. It is of note that during his time as a resident at the MCH Child CB refused all appointments with CAMHS and did not attend the majority of other health appointments which were made for him nor did he during his time at the MCH state that he wanted to kill himself or make any attempt to do so.

108. This suggests that this was the most settled Child CB had been since before the breakdown of his adoption despite the fact that there were many incidents of challenge and behavioural and relationship difficulties for him during the same period.

109. On 2nd December 2016 during his placement at the MCH information was shared with Child CB by his SW about his birth father. Later on the same day Child CB left the home and on his return staff had suspected that he was under the influence of
alcohol. Child CB passed out and paramedics were called. Child CB was recorded to have been ‘abusive to paramedics, rude to staff, tried to leave hospital but escorted back in, returned to home 3am has food, chats to staff re his past- quite emotional goes to bed 4.14 checked on several times through the night’.

110. There is nothing in the information provided by the MCH or by CSC which explicitly connects the sharing of information about his birth father with Child CB’s intoxication and hospitalisation later on the same day. In other words the understanding of cause and effect was not demonstrated and Child CB was not therefore helped to explore why he had responded in the way he had.

111. In March 2017 an assessment of need was completed by CSC. The outcome was to look at supporting Child CB into semi-independent accommodation. Following the assessment of need the analysis stated 'Although Child CB presents as confident and mature, my analysis would be that this is how he would like to present however he has low self-esteem and still suffers from emotional problems. He can be absolutely deliriously happy one minute and change to being abusive and out of control. I feel Child CB needs further input with CAMHS however he is refusing to attend.' This analysis presents a ‘picture’ of Child CB’s behaviour and presentation but does not demonstrate understanding of the root causes of Child CB’s difficulties or put into place alternatives to CAMHS despite acknowledging that he needed ‘further input’.

112. Whilst Child CB was a resident in the MCH he attended two schools.

113. He attended the first school (SS3) as a ‘guest pupil’ and was temporarily excluded on several occasions during the 3 weeks he attended. His behaviour was aggressive towards other pupils and staff. There is nothing in the agency chronologies which records how Child CB felt about the exclusions or the impact they had on him.
114. Child CB began as a permanent pupil at the third school which was a Pupil Referral Unit (PRU) on 6th February 2017 and remained a pupil there until June 2017. In March 2017 his school report stated that Child CB was ‘Working at grades - Maths, C; English, C; Science, C. 'Valued member of the group and contributes in all lessons.' 'Recently nominated for a The Manchester College Award for 14-16 year old students.' 'If Child CB continues to work at his current rate I have no doubt that he will do well in his GCSEs.'

115. A day after his report was issued Child CB’s behaviour began to deteriorate in lessons and he was excluded for one day following him being rude, aggressive and threatening towards a member of staff on 21st March 2017.

116. There were further incidents of disruptive, rude and threatening behaviour during May 2017 but they did not lead to exclusions.

117. Despite these incidents on 1st June Child CB was awarded the ‘Most Outstanding Pupil Award’ by the college of which the PRU was part.

118. Whilst there is no record in the PRU’s chronology to indicate that specific work was carried out with Child CB, in respect of the underlying causes of his difficulties, the fact that he achieved significant success there and responded well to staff suggests that they were able to manage his anxieties and other behaviours. This in itself suggests that the staff who worked with Child CB had a good level of understanding about his attachment and identity anxieties and how his behaviours might be affected by them.

119. Throughout July and August 2017 discussions were held with Child CB about his move to semi-independent living arrangements (he was by then aged 16) and the prospect of this caused him significant anxiety.
120. Shortly after these discussions (during which Child CB stated that he would rather be placed in a foster home) he began to say that he wanted to return to Blackpool and a move to a children’s home in Blackpool (CHB) was arranged and took place on 22nd August 2017.

121. It is of note that on the evening of his first day in this placement, Child CB and another young male resident (Child X) returned to the home together and were under the influence of cannabis.

122. It was apparent from reading the chronology provided by the CHB and from the accounts of staff who attended the Learning Review that Child CB’s anxiety about moving towards independence was increasing. Staff understood this and it was noted that Child CB often sought staff out for reassurance.

123. Many care leavers feel ill-equipped to deal with the responsibility of managing accommodation, maintaining education or finding work and the challenges of accessing services and systems that are complex and often inflexible. Their experience contrasts with that of most young people, a fifth of whom remain living with parents until at least age 26 and most of whom receive practical and emotional support, retaining the option to return home for short or long periods of time long after they move out. (Research in Practice, 2017)

124. The anxiety and pressure experienced by Child CB in relation to his move to semi-independent and independent living was discussed in some detail by the practitioners who contributed to the learning event. The disparity between children in foster care who may stay in their foster placements until the age of 21 (or beyond in some cases) and those in residential care who move to semi-independent living arrangements from the age of 16 or 17 was noted.
125. The CHB staff understood that this was causing Child CB increasing anxiety. A record from the CHB states ‘This was significant to Child CB when he was interviewed prior to his 17th birthday by the housing officer who wanted to arrange tenancy training for him. Staff became aware that Child CB’s anxiety levels increased. Child CB explained to staff following the interview with housing that he was not fully aware that he would be having his own tenancy before he was 18 and this made him very anxious’.

126. In September 2017 Child CB was enrolled at College and disclosed to them that he was a Child Looked After and he was allocated a pastoral mentor.

127. During August and September 2017 Child CB reported that he was having difficulty sleeping. He was also noted to be using cannabis regularly.

128. By the end of September Child CB’s behaviour was becoming problematic at college. His attendance had fallen and he was unmotivated.

129. On 1st October it was noted by a staff member at the CHB that Child CB was still pre-occupied with how he would cope with independent living and that it was at the ‘forefront of most of his thinking’.

130. During September, October and part of November 2017 Child CB was in a relationship with a young woman. The relationship was volatile and at one point the young woman told Child CB that she was going to kill herself. This caused Child CB significant distress. The relationship ended following several ‘crises’, including an altercation between Child CB and her father.

131. At one point in October 2017 the relationship ended briefly and Child CB told staff that he was having panic attacks, felt anxious all the time, was in low mood and
tearful. (The relationship resumed shortly afterwards and finally ended in November 2017).

132. Child CB spoke to a GP via telephone on 20th October 2017. Child CB advised that he had stopped taking his medications "late last year" (i.e. 2016) but now symptoms have recurred. The GP restarted fluoxetine and risperidone (4 weeks of each were issued) and asked Child CB to make a review appointment when he collected the prescription.

133. By the end of October 2017 Child CB stated that he wished to move back to Manchester and continued to be anxious and agitated.

134. On 3rd November Child CB admitted to a member of staff at the CHB that he was using cannabis as a way of managing his anxiety. He was offered a referral to a substance misuse service but this was declined.

135. By 9th November 2017 Child CB’s attendance at college had fallen further to 62% because of his anxiety and poor sleep.

136. Also on 9th November Child CB confided in a member of staff at the CHB that he had self-harmed the prior evening.

137. On 10th November staff received a telephone call from M and F to arrange a visit with Child CB. Child CB agreed to this. (Child CB had contact with M and F in July 2017 and this was recorded as having been positive).

138. On 18th November Child CB told staff that he had again self-harmed. Staff noted that the incidents of self-harm coincided with cannabis use. The CHB chronology notes that ‘Staff discussed again with Child CB the impact on his mental health that smoking cannabis could have. Child CB was not ready to listen and didn’t agree to the effects such as paranoia and disrupted sleep patterns’.
139. Child CB further self-harmed on 20\textsuperscript{th} November 2017. He had been issued with a formal warning by the CHB concerning cannabis use on the same day.

140. On 21\textsuperscript{st} November a staff member at CHB contacted CSC and shared information that Child CB is presenting with ‘low mood, not really engaging and superficial self-harmed last night. However when staff ask how he is he reports he is fine although he has stated he does want to see GP to look at an increase in medication. Reviewed case notes, recent split with girlfriend, move of area (uncertainty if right decision)’. It was agreed that Child CB would be monitored hourly and staff would ‘explore feelings and offer distraction techniques, if any indication of suicidal thoughts/unable to keep himself safe - advice provided to present at A&E or call ambulance if refuses. Urgent GP appointment to be made tomorrow.’

141. On 22\textsuperscript{nd} November 2017 Child CB was visited by M and F and he was noted to have been preoccupied by fears that his ex-girlfriend’s dad was going to beat him up (Child CB had sent abusive or threatening text messages to her). Immediately following this visit Child CB left the CHB and returned later under the influence of substances.

142. The staff at the CHB emailed the SW on 23\textsuperscript{rd} November to request that he was referred to the ‘ADHD Clinic’ (Attention Deficit Hyperactivity Disorder). It is not apparent from the agency chronology what the rationale for this was. CSC forwarded the email to the CLA Nurse who responded by telephoning the CHB and advising that a referral to the Single Point of Access for mental health services would be more appropriate.

143. On 27\textsuperscript{th} November Child CB was visited at the CHB by a housing officer. It was unfortunate that the SW who was also due to be present was prevented from
attending. Child CB was therefore seen alone by the housing officer who was
arranging ‘tenancy training’ for him.

144. On 28th November Child CB went to meet his parents for a meal. He was caught
smoking cannabis by staff at the CHB later that day and was asked to move off site.

145. By 30th November Child CB’s attendance at college had fallen to 53%. The college
had arranged with Child CB’s Guardian and Child CB a ‘Fitness to Study’ meeting
however Child CB stated that he would not attend. (Fitness to Study is the college
process for supporting students whose attendance or progress at college is being
affected by long-term medical conditions. The aim of a Fitness to Study meeting is to
identify how best college can support a student with a long-term medical condition
so they can keep up to date with their studies. At the meeting, support needs are
identified and any additional support/reasonable adjustments are put in place).

146. On 1st December following a key work session with a staff member from the CHB it
was recorded that ‘Child CB felt that he was not in control of his life and was
struggling with anxiety and depression. He was offered the mental health crisis team
number and staff asked him to call them which he declined as he said he had a GP
appointment on 7th December’.

147. On the same day Child CB rang his social worker to ask him about the possibility of
his friend’s mum fostering him in Manchester. He was unable to contact the SW
after 2 calls so spoke to a duty SW who advised that Child CB give SW’s phone
number to the potential foster carers.

148. During this time it was noted by staff at the CHB that Child CB was increasing his
use of cannabis and was often in the company of Child X when he did so.
149. In early December 2017 Child CB’s SW left his position and his replacement was not due to start in post until 8th January 2018. During a key work session with Child CB on 6th December Child CB was advised that he could contact an advocate about not having a social worker but did not wish to do so nor did he want to complete a goal and support plan. It was noted that he was agitated and anxious.

150. On 7th December Child CB was seen by a GP (supported at the appointment by the CHB staff). He admitted to the GP that he had been having suicidal thoughts and that he had self-harmed. He said that he "wants to die but does not want it to be painful or messy". After talking to the GP he agreed to access Youtherapy for counselling. The GP also prescribed propranolol. Child CB’s prescriptions at this point were Fluoxetine, Risperidone, and Omeprazole and Domperidone.

151. A member of staff from the CHB took Child CB straight to Youtherapy and Child CB spoke to a counsellor and agreed to return on 15th December. Child CB is recorded as saying that he ‘felt a bit better after talking to the counsellor and agreed to keep going’.

152. On 8th December 2017 a staff member at the CHB discussed with Child CB the use of cannabis and how it would be affecting his mental health. She repeated suggested referrals to the Young People’s Substance Misuse Service, to contact Mental Health Crisis team or speak to the GP, all were declined by Child CB. It was noted that Child CB appeared very low in mood and that he was taking all of his medication but was still using cannabis daily. (He continued to smoke with Child X despite numerous warnings from staff).

153. By 12th December 2017 Child CB was adamant that he would not return to college stating that he would look at alternatives in January 2018.
154. On 13th December 2017 Child CB attended an appointment at Youtherapy and was seen by a counsellor with his support worker from the CHB. The agency chronology records that ‘He reported feeling low in mood. He felt like he wanted to die but did not feel like he was able to kill himself. He said nothing specific had happened recently but he felt anxious and low. He reported that he just wants to stay in bed, has split up from his girlfriend recently and didn’t want to go to college. Reported some of her friends have threatened him, he wasn’t concerned about the threats but was worried he would retaliate so he was staying away. Did not want to take support services numbers and said he would speak to support workers in placement as he trusts them’. A further appointment for initial assessment was planned for 15th December.

155. This was the second occasion upon which Child CB was seen by a counsellor from the Youtherapy service.

156. On 14th December Child CB was visited by an advanced practitioner (social worker) and a Social Work Assistant. They discussed moving back to Manchester with him and said that it could take approximately 16 weeks to do a family needs assessment for fostering purposes. They talked with Child CB about how he was feeling and said they would call back the day after.

157. Child CB was visited soon after this by an 18 year old female who stayed until the CHB curfew of 11.00pm. Child CB was ‘acting boisterous. His mood seemed to have changed as he had been very low during the day’. Staff observations noted that Child CB and Child X appeared "high" but there was no smell of cannabis. Child CB left the CHB at 1.22am without informing staff that he was going out and at 1.30am the CHB manager received calls and texts from an unknown female stating that Child CB had
written a suicide note and was heading for a building where he was going to kill himself by jumping off the roof. The CHB Manager immediately alerted staff to check his whereabouts and to check his room for a suicide note. The note was discovered and 999 was called immediately. The further response to this suicide attempt is covered elsewhere in this report.

158. On 20th December 2017 Child CB attended an assessment appointment with a Youtherapy Counsellor. Child CB discussed his past and recent thoughts of suicide but said he felt better that day. The Counsellor discussed counselling and what it could offer and Child CB agreed to attend the next appointment.

159. Also on 20th December Child CB attended a consultation appointment with his GP. The consultation notes record: ‘Problem: Suicidal ideation (review). Still feeling extremely low. Unsure what he might do. Some anxiety, but main complaint is his low mood. No real plans for the future, states he might go to college and get a job, but no idea at present in which area etc. Good eye contact. Brief short answers. Seems rational. Recent risky behaviour. Review in due course. In the meantime increase his fluoxetine from 40 to 60, mentioned to his support worker (over the phone) as they keep the meds. Prescription for fluoxetine and risperidone’.

160. An administration note records that the GP spoke to Single Point of Access (for (adult) mental health services) SPA regarding Child CB and was advised that he was attending Youtherapy. It was agreed that if Youtherapy ‘find that he is unmanageable they will refer him to SPA’.

161. On 21st December 2017 Child CB and Child X had a serious argument which resulted in threats and violence and the police were called by staff at the CHB. It was noted at approximately 11.30 pm that Child CB smelt of alcohol and appeared to be under the
influence. The police left the CHB at 11.44 pm and Child CB then left the CHB at 1.22 am telling staff that he was going for a walk. He subsequently took his own life. (The response to Child CB leaving the CHB is discussed elsewhere in this report)

162. In summary the placement at the CHB represented a period of significant anxiety and pressure for Child CB. The challenges he faced occurred almost daily and included his troubled relationships with his girlfriend, his peers within the CHB (particularly with Child X) and at college and with his parents.

163. It was during this same period that Child CB’s use of cannabis increased significantly and the impact of this on his mental health was a concern to staff. The effect of using cannabis whilst taking other ‘mental health’ medications is discussed elsewhere in this report.

164. All of these challenges were in addition to what the staff at CHB recognised as extreme anxiety about his transition to independent living and his ability to cope with this.

165. The staff at CHB recognised the underlying causes of his anxieties and that his use of cannabis may have been exacerbating them and made attempts to engage Child CB with support for his mental health (with limited success) and for his substance use which he rejected.

166. In effect this left staff at the CHB ‘fire-fighting’ almost daily incidents which often involved a crisis point for Child CB.

Interventions

167. This section provides an analysis of interventions including:

- Overall effectiveness in achieving stated aims
• Timeliness
• Reviews
• Contingency plans

168. Between 2013 and 2014 interventions (which included work carried out by the Post Adoption Support team and CAMHS) focused, in the main, on preventing the breakdown of the adoption.

169. In that sense interventions were not effective as the adoption did breakdown after a 12 month period of escalating physical and verbal and emotional abuse which included alleged assaults against Child CB by F and alleged assaults by Child CB against M.

170. Throughout this period of time Child CB consistently told professionals that he did not want a relationship with his parents and that he wanted to leave the family home. There were incidents reported by Child CB of his parents making fun of him for attempting suicide and being unkind about his birth mother which were an indication that Child CB was suffering emotional harm.

171. A Child in Need plan was put into place in September 2013. This plan set out that Child CB would access CAMHS; that a referral to ‘Theraplay’ to improve relationships would be made and that life story work was to be completed with Child CB. It also set out that M and F would be provided with advice and guidance in respect of attachment and adoption.

172. The Child in Need Plan was appropriate at this stage however by January 2014 there were clear indications that Child CB’s behaviour was deteriorating and his distress increasing which was also an indication that the outcomes set out in the plan were not being achieved and that a review was required.
173. In April 2014 following Child CB’s admission to hospital for risk of self-harm the SNP made a referral to CSC reporting that the family were ‘in crisis’ and the adoption was breaking down. The SNP reported several incidents of Child CB being violent and concerns about how his parents dealt with his behaviour including their use of physical chastisement and restraining. The SNP reported that she and a staff member from SS1 had been attending Child in Need meetings with a post adoption SW and parents but she was concerned that things were escalating. The SNP reported that she was aware of Child CB’s A and E attendance (feeling that he was going to self-harm) and that she had also sought advice from the hospital’s Safeguarding Team.

174. This was a clear and appropriate referral to CSC. The SNP also spoke to Paediatric Liaison\(^2\) at the hospital to share concerns and to advise that she had made a referral to CSC. The SNP also shared that Child CB had stated his father had physically restrained and/or assaulted him due to escalating behaviour.

175. On 4\(^{th}\) April 2014 a Safeguarding Medical was completed and bruises consistent with the explanation Child CB had given were noted. There is no information in CSC records to indicate that this led to a strategy meeting and no information regarding the outcome of the medical is contained in Child CB’s medical notes.

176. Child CB was discharged to his parents’ care on 8\(^{th}\) April 2014. A Safeguarding Nurse telephoned the SW to clarify whether he could be discharged home as he was medically fit and was advised that it was ‘fine for him to be discharged home to his

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\(^2\) Paediatric liaison is provided by the safeguarding nurse who is on duty and is to ensure that there is effective two way communication and sharing of information between hospitals and community services which enables children and their families to receive appropriate care and support.
parents and the assessment will continue’. The SNP was also informed of Child CB’s discharge.

177. Given that this was the third time in 2 months that Child CB had attempted suicide or indicated that he wished to harm himself and that a safeguarding medical had noted bruises consistent with Child CB’s allegations of an assault; the discharge home without a Strategy Meeting taking place was unsafe. There is no indication that interventions and contingency plans were considered and put into place to address the risk of physical and emotional harm or risk of suicide.

178. In June 2014, which was within 8 weeks of his discharge home, Child CB alleged that F had assaulted him by punching his head and banging him into a wall during an argument.

179. A S47 enquiry was carried out following the allegation. The outcome of this was that the assault could not be confirmed as the incident had not been witnessed. However no safeguarding medical took place. CSC records state ‘It was clear there had been an argument between Child CB and F but it was not felt this fell into the realms of significant harm. The incident was witnessed by sibling who stated he didn't witness Child CB being hit in the face by F. Assessment to be undertaken and Child in Need plan to be developed. A referral was also to be made for Family Group Conference and Women’s Aid to complete a visit to the home address. School and school nurse spoken to in respect of the S47 Enquires. No medical convened, however both School and School Nurse state they do not believe Child CB would fabricate due to his nature. Child CB was seen and spoken to at school in relation to the incident. Information was shared with CAMHS’.
180. The focus of professionals’ considerations appeared to be whether or not a physical assault had taken place and whilst this could not be confirmed it was clear that Child CB was suffering ongoing emotional harm but this does not appear to have been given equal focus.

181. CSC records indicate that a Child in Need Plan was in place by 19th June 2014 however the assessment (referred to above) carried out by CSC did not conclude until July 2014. It is difficult to see therefore how this plan and the proposed interventions were based upon a thorough analysis of risk and need.

182. Between July and August 2014 Child CB was reported missing from home on 2 occasions and also absconded from school. CSC records indicate that the Child in Need plan was to continue.

183. A Child in Need meeting took place on 17th July 2014 and it was agreed that a referral would be made to Edge of Care for support. The SW was to refer to family group conference and mediation support. Child CB declined to attend the family group conference and there is no record to indicate that mediation was made available or taken up. In other words the interventions that were planned do not appear to have taken place.

184. Following Child CB becoming a child looked after in September 2014 it is difficult to see from CSC and other records which interventions were carried out as direct work with Child CB.

185. Following a self-harm (or possible suicide attempt) in August 2016 Child CB received a diagnosis of significant attachment disorder, recurrent depressive disorder, social anxiety and challenging behaviours. It is difficult to ascertain from agency records how this significant diagnosis was translated into interventions or led
to a review of plans (including his placement and support that his foster carers may have needed).

186. Interventions which were planned specifically to address Child CB’s emotional and mental health needs were (on the whole) to make referrals to CAMHS but once Child CB became a child looked after he did not voluntarily attend a planned CAMHS appointment and would not engage with the CAMHS practitioner who attended the MCH in order to see him. (CAMHS interventions are referred to in more detail elsewhere in this report).

187. School, college and the MCH and CHB provided daily interventions which had immediate impact e.g. persuading Child CB to remain in school, accompanying Child CB to medical appointments, providing emotional support and reassurance.

188. However a significant number of these interventions were unplanned and were often in response to Child CB’s behaviour, anxiety and distress.

189. In that sense the ‘daily’ interventions were based on a clear understanding and analysis of need but it is difficult to see how what was learned from the daily patterns of risk and need were reflected in formal plans for Child CB.

190. For example it was apparent that the planned move to independent living for Child CB was causing him extreme distress and anxiety and Child CB sought reassurance from the CHB staff about this. It is also recorded that Child CB’s SW and the CHB manager shared concerns that Child CB would not cope well and that his mental health needs remained un-addressed.

191. This did not lead to a reappraisal of risk and need or a review of the plan to move Child CB into independent living arrangements.
192. Although Child Looked After (CLA) Reviews took place on a regular basis they were not always effective at reviewing progress and putting into place contingency plans. For example in August 2015 Child CB was discharged from CAMHS. This was an unsettled period for Child CB and his patterns of behaviour strongly suggested that an intervention was required and that his foster carer at that time also required support. No alternative to CAMHS was proposed and no support put in place for his foster carer.

193. A further example is that at the CLA Review of 3rd November 2015 which Child CB attended alongside his foster carers, school, school nurse and CSC; discussions were held regarding CAMHS closing the case with no recommendations of support. ‘It was identified that Child CB had three changes in social worker since the 22nd July 2015 and that although his care plan was one of long term foster care, this placement would be reviewed in six months and could possibly lead to a placement move’. This was a lack of long term stability and planned interventions to support his emotional and mental health needs or identify support for his foster carers.

194. When Child CB had moved back to Blackpool Child CB’s Independent Reviewing Officer (IRO) visited him for a pre CLA Review meeting. Child CB shared that he was questioning whether he had made the right choice in returning to Blackpool stating that ‘the grass is always greener’. Given that the last Child and Family Assessment was completed in March 2016 and the high level of anxiety this planned move to independent living was causing Child CB an updated assessment may have provided a clearer understanding of Child CB’s needs.

195. Also of note was the overall length of time it took the local authority to begin care proceedings for Child CB. This was highlighted in November 2016 when a Guardian
was appointed for Child CB at the beginning of care proceedings. The Guardian expressed concern that it had taken two years for proceedings to be brought, during which time there had been several foster placement breakdowns leaving Child CB ‘treading water with no proper plan’.

196. In summary there were a large number of assessments which took place during the timescale of this SCR and these often led to interventions being put into place. The effectiveness of the interventions and Child CB’s lack of engagement does not appear to have led to reconsideration of how his ongoing mental and emotional health needs could be met.

CAMHS Provision

(NB. 3 different CAMHS services were involved in this case)

197. CAMHS provision is given specific consideration within this analysis as it was a potentially important source of help and support for Child CB, his family and his foster carers.

198. Child CB was referred to the CAMHS service as early as 2009 and CAMHS are mentioned a total of 193 times in the multi-agency chronology covering the period 2009 to 2017. (As a comparator Children’s Social Care are mentioned 161 times in total).

199. The CAMHS service is an NHS service which provides assessment and treatment to children and young people for their emotional, mental and behavioural difficulties.

200. In March 2015 the Department for Education and the Department of Health jointly published new statutory guidance on Promoting the health and well-being of looked-after children. The guidance recognised that almost half of children in care have a
diagnosable mental health disorder. The guidance also recognises that CAMHS is an important source of help and support for children in care.

201. Prior to Child CB returning to Blackpool in 2017 a referral to CAMHS seemed to be the default plan when considering responses to his emotional and mental health needs. However Child CB did not engage well with CAMHS in the way that it was offered to him; even when a CAMHS practitioner visited the MCH in an attempt to see him.

202. This reluctance to engage could have been due in part to Child CB’s perception that CAMHS had not listened to him and that his earlier visits to CAMHS had been to tell him what was ‘wrong’ with him and to ensure that he stayed with his parents.

203. Given the high level of risk and need in leaving Child CB’s mental and emotional health needs unmet, an urgent reconsideration by whom, how and when a service was provided should have been considered. Looked-after children are best supported when professionals collaborate and services are tailored to the needs of the individual; in this case a high risk young person who rejected ‘mainstream’ mental health services.

204. Child CB did access counselling or therapeutic support via the MCH ‘in-house’ counsellor and just before his death with a Youtherapy counsellor.

205. This demonstrates that he was able to engage (albeit briefly) with mental and emotional health services and this could have prompted a reconsideration of how support should be offered to him on a longer term basis.

206. The CAMHS practitioners involved with Child CB work within an established ‘system’ and did make efforts to engage him within the confines of the ‘system’.
207. There are examples across England of CAMHS teams which work in different ways to provide a service to children in care however the fundamental learning from Child CB’s case is that CAMHS was repeatedly offered, rejected and re-offered to Child CB and this did not prompt a reconsideration of how his significant mental and emotional needs could be met.

**What was the impact of the move between geographical areas for Child CB?**

208. Once Child CB moved back to Blackpool there was an immediate difference in what would have been available to him had he remained in Manchester as children and young people can access CAMHS until they are 18 but only until they are 16 in Blackpool. (This should change in Blackpool in April 2019 when CAMHS is planned to be open to children up to the age of 19)


210. The above report refers to the November 2014 Health Committee report on CAMHS which revealed problems throughout the system from early intervention to the transition to adult services. The Committee concluded that “there are serious and deeply ingrained problems with the commissioning and provision” of CAMHS.

211. Some of these problems relate to access to and eligibility for CAMHS and the Committee recommended that looked after children should be able to access CAMHS in a ‘timely manner’ and up to their 25th birthday if necessary.
212. Child CB’s mental and emotional health difficulties escalated upon his return to Blackpool and he was not able to be referred to CAMHS because he was over 16 (a referral was made to the Youtherapy service however and Child CB did engage with this service briefly before he died).

213. This ‘cut off’ point for access to a child and adolescent services at the age of 16 does not recognise that the period of transition from childhood to adolescence for many children can be characterised by confusion, a lack of coordination and participation. It is known that mental health needs become more acute as children progress through adolescent years and that this can become critical as they are leaving care. Yet it is then that they would also have to transition from CAMHS to adult mental health services and possibly lose the continuity of relationships with CAMHS practitioners. At present when a child reaches 16 there should be a carefully planned transition to adult services. This includes meetings to discuss the young person’s issues following a referral into adult services and a gradual transfer of care.

214. For children in residential care as opposed to foster care this age limit is all the more inequitable as they face the additional pressures of moving into independent or semi-independent accommodation right at the moment they can no longer access CAMHS.

215. Other differences were noted between the two areas’ school exclusion and other policies and in particular how Blackpool’s policy and practice specifically relate to children in care. There is no record to indicate how school exclusions impacted upon Child CB but they may well have increased his anxiety and distress.

216. There are lessons to be learned about how information was shared when Child CB moved between placements and between geographical areas.
217. In particular information was not immediately shared about the risk of self-harm and suicide with either residential care provider which in turn meant that the police in both Manchester and Blackpool were also not immediately informed that Child CB was extremely vulnerable. This is particularly important if a child or young person who is ‘flagged’ as at high risk of self-harm goes missing from home or school and how the police prioritise such children.

218. Communication between CSC and CAMHS as he moved area was also an issue and led to ‘waste’ in the system with CAMHS not being aware that Child CB had moved to Manchester or when he subsequently returned to Blackpool.

219. Residential service provision does not appear to have created issues for Child CB when he transferred to the CHB from Manchester in the sense that emotional and practical support continued to be offered to Child CB by staff at the CHB on a daily basis.

**Was there one ‘trusted professional’ in Child CB’s life post adoption breakdown?**

220. Forming trusted relationships must have been extremely difficult for Child CB because he experienced a rapid change in foster carers, a change in SWs, a change in schools and moved from Blackpool to Manchester and then back to Blackpool within a very short period of time. This would undoubtedly have exacerbated his attachment and identity difficulties.

221. Despite this Child CB did demonstrate that he could form trusted relationships with professionals for example with the SNP and other staff at SS1.
222. Child CB had a period of relative stability whilst at MCH and achieved several personal goals (and an academic award) whilst he was there which indicates that he had at least one trusted relationship.

223. Child CB also sought out staff at the CHB for advice and support and was able to confide in them when he had self-harmed.

224. However there was not one single professional with whom Child CB had frequent, close contact that remained ‘with him’ throughout the period of time considered by this serious case review.

How effective was multi-agency working in ensuring a co-ordinated response to Child CB’s needs?

225. Child in Need (CIN) arrangements were the forum for multi-agency working between 2013 and 2014.

226. Agency chronologies refer to the plans setting out what work / support was needed for Child CB and his family. This included life story work and work with M and F around attachments and identity issues. It is not clear from the records who carried out this work or how they contributed to the subsequent CIN meetings.

227. On occasion multi-agency work was not fully inclusive; for example only SS1 and the post adoption Social Worker contributed to the crucial assessment which took place following Child CB’s admission to hospital following the third incident relating to self-harm/ suicide. CAMHS did not contribute and were unable therefore to share their assessment that Child CB was at ‘high risk’ of further harm.

228. When Child CB was in foster care there appears to have been no co-ordinated multi-agency response to address Child CB’s ongoing attachment, anxiety and
identity difficulties or any additional support needs of his foster carers in meeting his needs and coping with his behaviour.

229. Whilst Child CB was in residential care there was ongoing multi-agency working which included residential care staff, health, education and CSC. Some of this work was in response to crisis points and other incidents.

230. One major impact on Child CB’s mental health and emotional wellbeing was his use of cannabis particularly when he returned to Blackpool and it was noted that he was using it regularly.

231. There is nothing to suggest that multi-agency discussions were held in respect of this. For example there was no discussion with the police by either CSC or the CHB to consider whether or not the supply of drugs from a neighbouring house could be disrupted and whether or not there were alternatives to repeating offers of referrals to a substance misuse service to Child CB.

232. It is also not clear that any discussions took place or that any advice was sought in respect of the potential interplay between cannabis and Child CB’s prescribed medication.

233. Assessments of risk and need were carried out regularly whilst Child CB was in residential care but it is difficult to see how they translated into long term multi-agency planning. Child CB remained at high risk of self-harm especially in the time he spent at the CHB and yet one of the principle causes of his distress, which was his planned move to independent living, was not reassessed despite an acknowledged risk that he would find this difficult to cope with.
What was the interplay between medical diagnoses, medication and other therapies?

234. In August 2016 Child CB was diagnosed for the first time by a psychiatrist as having a significant attachment disorder, recurrent depressive disorder, social anxiety and challenging behaviours.

235. Following this consultation the psychiatrist prescribed Child CB with Fluoxetine, Risperidone and Circadin as well as agreeing that Cognitive Behavioural Therapy (CBT) would be appropriate.

236. In November 2016 Child CB was also prescribed zopiclone.

237. In December 2017 Child CB was prescribed propranolol.

238. The prescribed medications are described by the NHS as:

- Fluoxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). It is often used to treat depression and sometimes obsessive compulsive disorder and bulimia. It usually takes 4 to 6 weeks for fluoxetine to work and common side effects include feeling sick, headaches and trouble sleeping. They are usually mild and go away after a couple of weeks.

- Risperidone is an antipsychotic medicine sometimes prescribed to treat episodes of mania or hypomania.

- Circadin is used to treat sleep disturbances and is not licenced to treat people under the age of 55. Circadin is sometimes used to treat the symptoms of ADHD in children. Its effectiveness as a sleep aid or as a treatment for ADHD in children is not robust.

- Zopiclone is a type of sleeping pill that can be taken to treat bad bouts of insomnia. The NHS states that this medication is not suitable for people under
18. It is usually prescribed for just 2 to 4 weeks. Common side effects are a metallic taste in a person’s mouth, a dry mouth, and daytime sleepiness. The advice is also not to drink alcohol whilst taking zopiclone. Having them together can make a person go into a deep sleep where they find it difficult to wake up.

- Propranolol is a beta-blocker (beta-adrenoceptor blocking agents) and works mainly by decreasing the activity of the heart by blocking the action of hormones like adrenaline. They are often prescribed to treat heart and circulation problems and less commonly to treat anxiety. Side effects can include insomnia and depression.

239. The potential side effects of the medications are not insignificant and in some cases (as with Propranolol) may have increased Child CB’s disturbed sleep patterns and depression.

240. Whilst the agency chronologies show that Child CB did not take his medications on a regular basis (and did not take them at all for long periods of time) the potential side effects of using cannabis, alcohol and other substances alongside the prescribed medications does not appear to have been considered by practitioners. It does not appear from the agency chronologies that Child CB’s use of cannabis and alcohol was shared with his GP by Child CB or by practitioners.

241. In summary; CB was prescribed a significant amount of medication aimed at addressing the impact of his mental health conditions. Ongoing supervision of this treatment proved difficult due to the engagement issues described elsewhere in this report but would normally be desirable to monitor their effectiveness and safety. Furthermore whilst these medicines may have helped manage the impact and consequence of CB’s attachment disorder they would not in themselves have dealt
with the underlying problem – which required engagement with other therapeutic approaches.

242. Child CB’s psychiatric assessment of August 2016 diagnosed significant attachment disorder, recurrent depressive disorder, social anxiety and challenging behaviours.

243. However a note following a psychological assessment which was carried out in January 2017 to inform care proceeding stated ‘Placement suitable, they also have semi independence. Look towards semi independence after GCSEs and established friendship group. Look towards contact real father, letter off father first prior to GCSEs. Review of medication, won’t engage in therapy and the psychologist agrees he doesn't need therapy, or medication’.

244. The contradictory psychological assessments must have been confusing for Child CB but there is nothing on record to show how this was discussed with him and what his feelings were about either assessment.

245. There is also nothing within the agency chronologies to suggest that the latter assessment was shared with health practitioners and how it influenced prescribing and other health care decisions.

Risk taking behaviour

How effectively did agencies understand and respond to risk taking behaviour?

246. Child CB’s risk taking behaviour was sometimes within the realms of ‘common’ but nonetheless concerning teenage behaviour for example returning home late, drinking alcohol and smoking cannabis.
247. The agency response to ‘common but concerning’ teenage behaviour differs between children in care and those who are not with every incident of late return home or returning home intoxicated recorded and shared for looked after children.

248. There were occasions upon which Child CB’s alcohol consumption placed him at significant risk however and these incidents were crisis incidents and responded to appropriately. It is not clear from agency records how information about the risks of such high levels of alcohol was shared with Child CB, or how his use of alcohol was ‘mapped’ against crisis points in his life. For example Child CB was hospitalised after consuming high levels of alcohol on the same day he discovered via social media that his birth father had had more children.

249. The agency response and in particular the criminal justice response to Child CB on the occasion he was in possession of a knife in his foster carer’s home resulted in Child CB being convicted of a criminal offence.

250. At that point in time Child CB was highly vulnerable and extremely distressed. The Howard League for Penal Reform published a briefing in July 2017 which highlighted the issue faced by children in care “In some cases children in care are at risk of being criminalised. Challenging behaviour must be recognised for what it is. Children’s homes and police ought to respond sensitively so that children do not have their life chances blighted by an unnecessary criminal record.”

251. However it is also the Crown Prosecution Service and the judiciary who must be aware of the impact of the criminalisation of looked after children and take this into account in their decision making.

252. Child CB’s increasing use of cannabis when he returned to Blackpool was notable.
253. There appeared to be a degree of tolerance of the use of cannabis and/or alcohol by Child CB and others who were resident in the CHB. Whilst the use of cannabis and alcohol was not allowed on the premises, staff were aware that Child CB (and Child X) were visiting a neighbouring house to access drugs.

254. It is not clear from the agency chronologies whether or not there was a multi-agency response to this for example work with the police to investigate and disrupt potential drug dealing from the neighbouring house.

255. Child CB’s increasing use of cannabis as a coping/self-medicating mechanism and his deteriorating mental health and disengagement from education may have been linked.

256. Research has consistently shown the negative effect of cannabis use on mental health and other adverse impacts. The Royal College of Psychiatrists produced a leaflet on cannabis use which states “Even though cannabis can produce relaxation, if higher amounts are consumed, it can have the opposite effect by increasing anxiety. Some cannabis users may have unpleasant experiences, including confusion, hallucinations, anxiety and paranoia, depending on their mood and circumstances. Some users may experience psychotic symptoms with hallucinations and delusions lasting a few hours, which can be very unpleasant. Even though these unpleasant effects do not last long, since the drug can stay in the system for some weeks, the effect can be more long-lasting than users realise. Long-term use can have a depressant effect and reduce motivation.”

257. Child CB was repeatedly offered a referral to a substance misuse service which he declined. He was also advised by staff at the CHB that cannabis was having an adverse effect on his mental health.
258. Addressing Child CB’s use of cannabis should have been a priority focus in multi-agency plans and in the analysis of risk and need.

Responses to the risk of suicide

How effectively did agencies respond to indications of low mood, self-harm and suicidal ideation?

259. On 25th March 2016 Child CB was taken by ambulance to hospital following him taking an overdose of ibuprofen and co-codomol. He was seen by a CAMHS practitioner the following day whilst still in hospital and discharged the same day.

260. The hospital shared this information with the SNP but do not appear to have shared the information with CSC. It is also not clear that the SNP shared the information or discussed this incident with CSC.

261. On 3rd April Child CB attended A & E with a friend of M’s stating that he felt like harming himself. He was admitted to an adolescent ward.

262. The SNP had telephoned both CSC and the hospital on the same day to discuss her concerns about the escalation of risk and shared information that Child CB had told her that F had hit/restrained him and he subsequently underwent a safeguarding medical.

263. Child CB was visited on the ward by a SW but is recorded as having refused to engage.

264. Child CB was discharged from hospital to his parents care on 8th April.

265. A CSC record of the 25th April 2014 records ‘that the support from the post adoption support team ceased on the 22/04/2014 in order that CAMHS can begin work with the family via Family therapy (27/05/2014) Much work has been
completed by post adoption services in relation to attachment, emotional responses to adoption/birth family. It has been identified that there is a real risk of adoption breakdown. M has been referred to Women's Aid as a result of being subject to Child CB’s violent behaviour. Outcome of this assessment was case to close to CSC and a referral to Early Assessment Team (EAT) be made for any additional support’.

266. The decision to close the case to CSC followed an assessment which had included only SS1 and the post adoption SW. The decision and the way it is recorded makes no reference to the outcome of the safeguarding medical or to managing the risk of suicide and self-harm.

267. Following that decision Child CB and his parents were effectively left without support or any other intervention (other than an initial CAMHS appointment on 28th April 2014) and on 18th May 2014 M contacted CSC stating that Child CB’s behaviour was out of control and the family felt at risk from him. M presented as very distressed and reported that he was physically and verbally abusive towards her stating that ‘he is on Facebook claiming his parents are abusing him, whereas she reports that they are fearful of him’. The outcome of this contact was a referral to EAT for checks, prior to identification of support for family in crisis.

268. On 10th August 2016 following his admission to hospital after claiming to have drunk bleach, Child CB was assessed by a CAMHS practitioner. The practitioner recorded that ‘Child CB Disclosed previous self-harm and admissions to hospital. Has been under Blackpool CAMHS but hadn’t found it helpful. Declined appointment with psychiatrist. States low in mood has symptoms of anxiety/panic attacks. Denies any suicidal intent. Admits cannabis use and drug use in the past. Denies current use. Poor sleep. Poor appetite and difficulty concentrating. Very few coping strategies.'
Discharged back to foster care - appointment made with consultant which Child CB agreed to look at medication. Follow up appointment with CAMHS practitioner made for one week. Child CB signed a Consent to Share Information. Liaison with Social Worker and information and key contact numbers given if he feels he needs support before his appointment. Care plan completed. Risk assessment completed.

**Considered to be at high risk of further harm to himself** - at present has stopped self-medicating with drugs and denies thoughts to harm himself.

269. CSC were aware that Child CB had been admitted to hospital for this third episode of self-harm/ attempted suicide (the foster carer had informed them), however no strategy meeting was called although it is clear from agency records that CMAHS shared their assessment with CSC that Child CB was at high risk.

270. Child CB was discharged from hospital and there was no further planned CSC contact until a CLA Review which took place 2 months later in October 2016.

271. It is difficult to see how this was an appropriate response to the assessed high risk of Child CB further self-harming.

272. Following the August 2016 admission and Child CB’s move to residential care in Manchester he did not disclose that he had self-harmed or discuss suicide until November 2017 when he self-harmed at CHB.

273. Child CB disclosed that he had self-harmed 3 times during November 2017. This was a period of time during which he was facing several pressures which are described elsewhere in this report. Staff at the CHB noted and recorded Child CB’s cannabis use and contacted the SW to request an urgent mental health referral.
Was the immediate response to the suicide attempt on 15 December 2017 effective and did it fully consider his mental health?

274. The immediate response to Child CB’s suicide attempt was effective in that the CHB Manager succeeded in engaging him when he answered her telephone call. At this point he was on the roof of a building. The CHB Manager recalls that she talked calmly to Child CB to let him know that he was loved and to keep him engaged. Child CB ended the call. By this point the police had arrived and managed to ‘talk him down’.

275. The Police records state ‘Lancashire Police received a telephone call from staff at CHB stating that Child CB, a resident, had left the home feeling depressed and stating that he was going to go to the multi-storey car park. Police Officers attended the Car Park where Child CB was sat on a ledge on the top floor of ****. Officers engaged Child CB in conversation and he came off the ledge fairly quickly. He was escorted by officers from the car park where officers were joined by care staff from CHB. Child CB agreed to attend Blackpool Victoria Hospital voluntarily in order to undertake a mental health assessment. Police escorted Child CB to hospital where he was left in the care of the hospital and care staff. The care staff stated that they had found a note left by Child CB in the home stating that he was going to kill himself by jumping off the roof of ****’.

276. The CHB record of what followed states ‘The police and staff took Child CB to hospital where he waited to be seen until approx. 4.00am. He eventually discharged himself as he was not willing to wait any longer. Child CB disclosed to manager the next day that he had been planning this for a week. At A & E the police spoke to reception, Child CB became agitated at the length of time that he had to wait, staff
persuaded him to stay until 4.00am but A & E could not give staff a time estimate for Child CB to be seen. The receptionist referred to another member of staff and he was advised that they would not be long in seeing him and could he wait a little longer. Child CB wanted to leave at 4.00am, staff could not prevent him from leaving.

Reception asked Child CB if he was discharging himself and Child CB agreed. Child CB and staff were advised to contact the Child and Adolescent Support and Help Enhanced Response (CASHER) team later in the day. Child CB said he was tired and embarrassed’.

277. The practitioners who contributed to the Learning Event and the SCR Panel members spent some considerable time considering whether or not Section 136 of the Mental Health Act (MHA) could have been used in this case.

278. The police can use Section 136 of the MHA when a person is in public. Police can use this section if they believe a person has a mental illness and needs care or control. This section of the MHA relates to moving or holding someone in a ‘place of safety’. A place of safety can be a person’s home, hospital or a police station. The police can move people from one place to another.

279. Whilst in a ‘place of safety’ a mental health assessment is carried out and a person can be kept on this section for up to 24 hours. This can be extended for 12 hours. After the mental health assessment a person may stay in hospital under a different section of the Mental Health Act.

280. In Child CB’s case the police officers who attended were reassured that Child CB was in a safe place as they left him in the A & E department with staff from the CHB.
281. When Child CB refused to wait to be seen, staff from the CHB and/or A&E could have recalled the police and considered the use of Section 136 (or other Mental Health act powers) to detain him until he had undergone an assessment.

282. CB was in the department for 2 hours and it is unclear if he was waiting for an assessment from the medical team or the mental health team (this service is provided by Lancashire Care Foundation Trust). At the time of the incident a paediatric “did not wait” protocol was in place following recommendations from a Children Looked After and Safeguarding Children Care Quality Commission (CQC) inspection in May 2017, it is not evident that this protocol was followed, as he was over 16 years. However, as he was under 18 years his attendance was followed up immediately the same morning via the paediatric liaison service (described earlier in the report).

283. A strategy meeting was held between the Police and CSC on 15th December and a decision made to undertake S47 enquiries.

284. Information was shared during the strategy meeting that Child CB had told the CHB Manager that he had planned his suicide for a week. It was also noted that Child CB had been ‘under CAMHS’ but that he was no longer eligible for CAMHS because he was 17. It was noted that Child CB would be attending a GP appointment the same day and an appointment would be made for him to access Youtherapy or SPA (consideration was also given to whether he could be detained under the Mental Health Act). Practical arrangements were also discussed in respect of monitoring Child CB’s safety and whereabouts. It was also noted that after he had self-discharged from hospital Child CB had continued to inform staff at the CHB that he
intended to kill himself. It does not appear from the agency records that Child CB’s regular use of cannabis was discussed.

285. In summary, this was a serious pre-meditated suicide attempt made by a young person with a history of previous attempts and self-harm who was still stating that he wished to kill himself. Effectively at this point in time Child CB was not receiving any mental health interventions and had a history of rejecting or not fully engaging with support or interventions offered to him.

How did Child CB’s wishes and feelings influence assessments and responses?

How did practitioners ensure that Child CB was listened to and understood?

286. The practitioners who contributed to the Learning Event described Child CB as very bright and engaging and as a young person who was very particular about his appearance. It was apparent from listening to them that Child CB was, at times, also able to communicate his wishes and feelings.

287. There are several examples throughout the lengthy agency chronologies which demonstrate that Child CB was sometimes listened to and understood.

288. There were also, as previously discussed, practitioners with whom he was able to form trusted relationships and the agency chronologies record Child CB’s own words on occasion.

289. There are other examples; for instance when a SW visited Child CB in hospital in April 2014 when he expressed that he might harm himself he refused to speak to her. No further attempt was made to speak to him and yet the assessment
concluded and a CIN plan was developed which effectively could not reflect Child CB’s wishes and feelings.

290. A further instance was the management of the crisis point for Child CB of his birth siblings becoming pupils at his school. Plans do not appear to have been influenced by Child CB’s wishes and feelings despite him being very clear about the cause of his distress.

291. It is also clear that there were occasions upon which Child CB himself did not feel listened to or understood and this was particularly apparent during the period of time that attempts were being made to prevent the breakdown of the adoption.

292. One further critical issue for Child CB was the planned move to independent and fully independent living (by the age of 18). Despite his extreme anxiety about this and despite the SW’s own opinion that he would not cope well there was no re-consideration of this plan. In essence his legitimate concerns were listened to and understood but this did not lead to a change in plan for him. It is difficult to know what impact this had upon him.

293. There were also examples of practitioners ensuring that Child CB’s voice was heard in multi-agency arenas. One practitioner who was able to form a trusting relationship with Child CB was the SNP at SS1. She shared her concerns about the risks to Child CB within the home on more than one occasion. She also challenged the decisions and actions of other practitioners when Child CB had alleged an assault by F. In other words the SNP had listened to and believed Child CB and remained focused on him and the possible underlying causes of his behaviour and distress.

294. There were also many occasions upon which practitioners had to balance Child CB’s perfectly understandable, age appropriate frequent changes of mind about where he
wanted to be or what he wanted to do especially in respect of his post-school plans and moving from Manchester to Blackpool and then wishing to return to Manchester with what was believed to be in his best interests.

Further Analysis

295. Stability is important for any child, and unwanted moves or school changes and the disruption they can bring can be particularly difficult for children in care. Stable relationships and a secure environment provide a sense of belonging and identity. Where there is instability, relationships with trusted adults and other children suffer which can compound existing attachment and identity issues.

296. The Children’s Commissioner for England Stability Index 2018 indicates that that older children – especially those entering care from the age of 12 to 15 – are most at risk of instability, and may need extra support to prevent placements breaking down.

297. The breakdown or disruption of an adoption rarely if ever happens ‘out of the blue’. Adoption provides a stable family for many children who are unable to return home. Adoptive parents commit themselves and their resources to children who need the same kind of family experiences as any child, but often also need much more due to their often traumatic early childhoods. Given what we now know of the challenges and impact on adoptive parents and the pain and distress of young people who struggle to live in a family, efforts to improve pre adoption ‘preparation’ and post adoption support should be a priority within adoption teams.

298. Similarly the capacity and willingness of foster carers to provide therapeutic and stable placements for children who share Child CB’s vulnerabilities is an issue which
contributes to the lack of stability for children and further compounds existing
attachment and anxiety difficulties.

299. Serious Case Reviews provide useful analysis of cases involving suicide nearly all of
which related to adolescents, and the majority related to boys. The analysis of SCRs
identified a number of warning signs that a young person was considering suicide.
These are listed below and those which applied to Child CB are in bold type:

- **disclosures of suicidal feelings** - often verbal, but also letters, suicide pacts or
  pieces of creative writing
- **change in sleep patterns** - sleeping more or less than usual
- **change in appetite** - eating more or less than usual
- **sudden mood swings** - in some cases a notable uplift in mood preceded a suicide
  attempt
- **feelings of hopelessness, rejection or being a burden to others**
- **self-neglect** - often signalled by a decline in personal hygiene and appearance
- **self-harm** - often through deliberate cutting, but also aggressive acts such as hitting
  walls
- **withdrawing from family and friends and stopping engagement with support
  services**

300. There are other important indications of suicide risk which also applied to Child CB
and these include:

- Previous suicide attempts
- Substance misuse / increased substance misuse
301. These warning signs present a useful way for practitioners working with children and young people to reflect on overall patterns of behaviour and changes in behaviour.

Summary

302. Child CB had a very difficult start in life. The impacts of his early experiences of neglect and possibly abuse were manifest in some of his behaviours and difficulties.

303. The breakdown of his adoption followed at least 4 years of escalating difficulties for him and his family and happened when he was facing all of the additional challenges that adolescence brings.

304. Child CB had many vulnerabilities and they were often compounding. These have been detailed throughout this report and included:

- Adverse childhood experiences
- Removal from birth family
- Diagnosed significant attachment disorder, recurrent depressive disorder, social anxiety and challenging behaviours
- Breakdown of his adoption
- Becoming a looked after child as an adolescent
- Breakdown of foster placements
- Drug and alcohol use
- Transition from care to semi-independent/ independent living
- His age and his gender

305. Child CB had expressed his thoughts that he wanted to die and had made a serious attempt to take his own life on at least one occasion before he actually did so.
306. His mental and emotional health had deteriorated rapidly following his return to Blackpool and this report has detailed the pressures and difficulties he was facing.

307. There is a strong likelihood that the method he chose to help him deal with these pressures and difficulties i.e. cannabis and alcohol compounded this deterioration and this was also an important indication that his distress was increasing.

308. There is no doubt that Child CB was cared for and loved by his family and by the practitioners who worked with him and the author wishes to express her condolences and thank them for their courage and honesty in sharing their experiences and their views during this review.

309. However there is also important learning from this review which will be applicable to other children and young people in Blackpool and this is detailed below.

Learning and Recommendations arising from this Serious Case Review

a. Given what is known about the difficulties faced by children and young people who share Child CB’s vulnerabilities and the transition to semi or fully independent living it is recommended that BSCB review existing arrangements for care leavers with specific regard to the statutory guidance (Children Act 1989 Volume 3, January 2015) which states, “No young person should be made to feel that they should leave care before they are ready. The role of the young person’s IRO will be crucial in making sure that the care plan considers the young person’s views”. In other words, IROs have a critical statutory role and responsibilities in ensuring young people’s successful transitions to adulthood. The IRO should therefore be consulted prior to a planned move and, as soon as possible following, an unplanned move. They should ensure that the care plan considers the young person’s views. Whilst these
recommendations will be enhanced by the new provisions contained within the Children and Social Work Act 2017, including the extension of support to all care leavers to 25 years of age (from April 2018), the Local Authority should review sufficiency in respect of appropriate provision for care leavers to include staying close options.

b. The results of the systematic reviews and meta-analysis confirm that suicide attempts are more than three times as likely in children and young people placed in care compared to non-care populations. Within this cohort suicide rates differ between boys and girls with boys more at risk. Targeted, gender specific interventions to prevent or reduce suicide attempt in this population (and those at risk of becoming looked after children) may be required. It is recommended that BSCB and partners review current suicide prevention strategies in order to ensure that they specifically recognise and respond to the additional vulnerabilities of CLA.

c. It is recommended that BSCB and partners seek assurance from partners about the way in which CAMHS is offered to children and young people who share Child CB’s vulnerabilities (some of whom may be CLA) including the age at which a child or young person can access CAMHS and the transition to adult services. (This should take into account the acknowledged view that childhood ends at the age of 18). There are examples of effective practice from elsewhere in England which show that, for example, co-locating CAMHS practitioners within CLA teams has been successful in engaging children and young people who have previously rejected services.

d. It is recommended that health and social care commissioners review what therapeutic (and other) services are available for CLA or for those who share Child CB’s vulnerabilities recognising the inherent difficulties in engaging children and
young people who may have severe attachments disorders and that this are reflected in how services are designed and offered.

e. The known suicide risk factors for children and young people which are detailed in this report, together with the warning signs that a young person may be considering suicide, should be included in ongoing staff development and training and reflected in assessments, analysis of risk and need and supervision.

f. The BSCB and partners should seek assurance that the preparation, training and ongoing development and support of foster carers enables them to offer long term, stable and therapeutic placements to children who share Child CB’s vulnerabilities. This review should in particular, reference what is known about Adverse Childhood Experiences (ACES) and attachment and identity.

g. The BSCB and partners should similarly review what support and development arrangements are currently in place for adoptive parents and adopted children and for those who wish to adopt children who share Child CB’s vulnerabilities including Adverse Childhood Experiences, attachment and identity and consider ongoing support for whole family/ individual family members which recognises periods of challenge and transition such as adolescence.

h. The BSCB and partners should seek assurance that cannabis use (and other substance misuse) is currently responded to in the CLA cohort of children and young people. This should include a specific focus on the impact of cannabis and other substances on mental health and other outcomes for children and young people, the potential interactions of cannabis with prescribed mental health (and other) medications and what single and multi-agency responses are possible.
i. The BSCB should share the learning from this Serious Case Review with the Pan Lancashire Suicide Prevention Operational Group and seek assurance that suicide prevention measures are in place (or under consideration) in publicly accessible buildings.
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