A Serious Case Review Commissioned by Blackburn with Darwen Safeguarding Children Board under Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006

‘Lola Grace’

December 2018

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1 Introduction and context

1.1 Purpose and circumstances of the serious case review

1. The Blackburn with Darwen Safeguarding Children Board (BWDSCB), together with the people who have worked on this serious case review, extend their sincerest condolences to the family and friends of Lola Grace[1]. Her death has had a profound impact on her family and her friends as well as for the people who worked with her in different places and organisations.

2. The serious case review was commissioned prior to the changes to the legislation and national guidance in July 2018 for conducting reviews[2]. It follows the tragic death of 17 year old Lola Grace in December 2017. The review examines the involvement of over 20 organisations from February 2015 until December 2017. Details of those organisations and their role is described in section 6. The timeline of the review's analysis includes the response to self-harm, evidence of child sexual exploitation and the use of the Mental Health Act 1983 to provide treatment to Lola Grace, the arrangements for inpatient care and for home support and placements, including assessments by mental health and children's social care services. This includes how risk assessments were conducted and the process for managing the risks and the needs that Lola Grace presented. The methodology and terms of reference are described in section 6 at the rear of the report.

3. Lola Grace was a friendly, caring and approachable girl who liked to sing, dance and listen to music as well as reading books especially fantasy stories. Lola Grace enjoyed dance, gymnastics and ice skating and participated in a local drama club. She is described by her school as a 'bright and capable girl' whose attendance at school was initially good but had declined as she struggled with the various difficulties in her life that are described in this report. She found it increasingly difficult to describe, express and process a range of complex emotions and thoughts associated with anger, sadness, anxiety and low mood.

4. Lola Grace had two older siblings and one who was younger. She lived with her mother until she was 15 when she became looked after, initially as a

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[1] The family suggested the name Lola Grace for the purpose of this report and for respecting their request for confidentiality and privacy.

[2] Local safeguarding children boards were required to undertake a serious case review when a child had died or had been seriously harmed and abuse or neglect was either known or was suspected and there was cause for concern as to the way the authority, the local safeguarding children board or other relevant persons had worked together.

voluntary arrangement before a care order was made in June 2016. The family are white British.

5. Lola Grace did not have contact with her birth father during the time of events examined by the review and his whereabouts are not known to the review. The man whom Lola Grace believed was her father until she was 13 (male 2) lives in another part of the UK having been separated from Lola Grace's mother for several years.

6. A couple who have been friends of the family for several years were significant adults for Lola Grace. When arrangements were being made for Lola Grace to live away from home Lola Grace harboured a strong wish to be cared for by this couple who continued to have regular contact with Lola Grace. Although the couple were assessed as potential family and friend carers for Lola Grace, the assessment concluded that it would not help Lola Grace and could undermine work that was being planned to help with her self-harming behaviour.

7. Many different people became involved with Lola Grace between February 2015 and December 2017. It is clear that Lola Grace found this very difficult. She formed a strong relationship with the counsellor at her school who provided support through to when Lola Grace had to leave the school to go to college. Lola Grace had self-referred herself to the counsellor in February 2015 prior to her first presentation at the hospital emergency service following an overdose. A mental health practitioner at the community child and adolescent mental health service (CAMHS) also had contact with Lola Grace for much of the time that this serious case review examines. That involvement started after Lola Grace was first admitted to hospital following the overdose in February 2015 and ended when Lola Grace was transferred to adult mental health services when she became 16.

8. The report describes the significant difficulties and considerable trauma in Lola Grace's short life. Mother says that the various traumas and difficulties in the family began to have an impact on Lola Grace from about 2010. Mother says that matters reached a crisis point in 2014. Together with her siblings, Lola Grace was subject of a child protection plan (category of neglect) and was a child in need (CIN) prior to February 2015 when this review begins its detailed analysis. During her adolescence, Lola Grace became increasingly vulnerable to self-harm and sexually exploitative relationships.

9. Lola Grace had expressed suicidal intentions at various times prior to her death. Some of her self-harm reflected impulsive actions, whilst on other occasions it occurred following a degree of prior thought and planning. The reason for referring to such research is to draw on relevant information as it relates to children and young people who die as a result of self-harm. The

following chapter of this report summarises the extensive history of self-harm prior to Lola Grace's tragic death.

10. The review is aware that Lola Grace was registered as an organ donor in November 2017. None of the services working with Lola Grace were aware of this until the disclosures of information following Lola Grace's death.

1.2 General context about self-harm and the relevant legal frameworks

11. The rates of self-harm by young people have increased in the UK and are amongst the highest in Europe. Any professional, whether in universal, targeted or specialist services, working with children and young people is therefore likely to encounter self-harm as part of their routine working life.

12. Death from an act of self-harm remains the second most common cause of death among young people and 16-17 years olds are at the greater risk of completed suicide.

13. Self-harm is linked with mental distress and disorder. It is defined as an act of self-poisoning or self-injury irrespective of any motivation or degree of suicidal intent (ideation). Self-harming behaviour occurs because of a range of factors where for example the intention is to reduce internal feelings of conflict or tension, be a distraction from an intolerable situation, is the communication of distress or difficult emotions or represents some form of self-punishment. Self-harm is a manifestation of emotional distress rather than being a primary disorder of its own.

14. The 2014 adult psychiatric morbidity survey (APMS) study[3] found that young people aged 16-24 are more likely to report suicidal thoughts than any other age group, with young women in this group having the highest level of suicidal thoughts than any other group.

15. Girls and young women are more prone to self-harm, and commonly it is a reflection of difficult personal circumstances such as disrupted relationships within the family, exposure to trauma such as the loss or serious illness of a significant person, economic or social deprivation with some form of mental disorder. Misuse of alcohol or drugs can be an aggravating factor. Although self-harm is more prevalent amongst girls and young women, the prevalence of suicide is higher amongst the boys or men who do self-harm.

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[3] McManus, S., Hassiotis, A., Jenkins, R., Dennis, M., Aznar, C., & Appleby, L. (2016). Chapter 12: Suicidal thoughts, suicide attempts, and self-harm. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital

16. The National Confidential Inquiry's 2017 study in regard to suicide by children and young people[4] identified common themes in the lives of young people who die as a result of self-harm. The deaths usually follow a combination of previous vulnerability such as those found in Lola Grace's life. The study identified a number of measures at national and local levels to reduce suicide by children and young people. This included support for children who are bereaved especially by suicide and a later more flexible transition to adult services, neither of which were available to Lola Grace. Traumatic experience in early life, dealing with adversity and evidence of risk behaviours in adolescence and a recent stressful event were identified as the key common factors in children and young people who died as a result of self-harm with an intention to die.

17. A Scottish study of self-harm[5] describes how the context of a person's life and their character may protect them from suicide and give them resilience to deal with adverse circumstances. Problem-solving and social adjustment skills, high levels of reasons for living, optimism, participation in sporting activities, positive family and other personal relationships, and engaging with their community may modify the risks for self-harm becoming lethal.

18. People who repeatedly self-harm, such as Lola Grace was doing from February 2015, are at a higher and more persistent risk of suicide[6]. For adolescents, self-harm can be a reflection of 'transient distress' or an escape from a 'terrible state of mind'[7] rather than an indication of severe pathology. Motivations can change from incident to incident as witnessed in Lola Grace's self-harming and be confused and unknown to the person at the time of the incident of self-harm. Self-harm can become habitual or even addictive[8] and can have a contagious effect with young people[9]. It is a factor in not placing children into an environment with other young people who are known to be self-harming. Young people who self-harm who are living in a residential setting have been reported to be at higher risk that peers living in the

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[4] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.
[5] Appleby, L., Shaw, J., Kapur, N., et al (2008) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Lessons for Mental Healthcare in Scotland. The University of Manchester (http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/reports/scotlandfullreport.pdf)
[6] Owens, D., Horrocks, J. & House, A. (2002) Fatal and non-fatal repetition of self-harm. Systematic review. British Journal of Psychiatry.
[7] Hawton, K., Rodham, K., Evans, E. (2006) By Their Own Young Hands. Deliberate Self-harm and Suicidal Ideas in Adolescents. Jessica Kingsley.
[8] Csipke, E. & Horne, O. (2008) Understanding self-harm. SANE (http://www.sane.org.uk/uploads/understanding-self-harm.pdf) accessed 6th April 2018
[9] Hawton, K., Rodham, K., Evans, E., et al (2002) Deliberate self-harm in adolescents: self report survey in schools in England. BMJ,

community[10]. Professionals working in specialist mental health setting understand this and it is evaluated when considering admission and length of stay in specialist inpatient units for example.

19. The treatment and care of young people at risk from significant self-harm involves many different professional disciplines, legislation and codes of practice and even ethical frameworks which are described in the relevant footnotes throughout the report.

20. Inevitably there is a high degree of complexity for children, their families and the various professionals in navigating the best pathways to recovery for a child with a significant level of self-harming behaviour.

21. Although the use of medication and of skilled physical, psychological and therapeutic health care is important in helping treat symptoms of self-harm, it is by no means the total remedy, primarily offering some amelioration of the symptoms and physical consequences rather than causal factors. Researchers and experienced professionals working in this very complex and difficult area understand all too well that it is dealing with the underlying factors through talking therapies that are fundamental to achieving effective outcomes. They also know that therapy requires the child to be in a secure, stable and consistent caring environment that is also attuned to the work being undertaken by different professionals. It is a factor that the historical patterns of self-harm and depression in Lola Grace's family represented a significant difficulty in this respect. This is not to suggest that Lola Grace's family did not love her and are not very distressed about what has happened; it is an acknowledgement that coping strategies that have been historically used by members of the family to deal with earlier trauma and adversity have left a legacy of behaviour that made it very difficult to achieve the stability needed for ongoing therapeutic work with Lola Grace.

22. The use of talking based therapy is not easy for children already going through great distress and making the transition through adolescence or for their families who can be baffled, confused and disorientated by behaviour that seems to be so counter intuitive.

23. In developing the most appropriate treatment, it requires an understanding about the capacity, insight and competency of the young person to understand and make sense of their circumstances.

24. Ideally it also requires the whole family having the capacity to be engaged in what can be a very difficult process that will test the emotional, physical and

[10] Mental Health Foundation (2006) Truth Hurts. Report of the National Inquiry into Self-harm among Young People. Fact or Fiction? Camelot Foundation

psychological limits of their resilience and understanding. Adults who have been victims of abuse in their childhood will for example be confronting their own emotional and psychological legacy. If as in Lola Grace's case, the family circumstances are such that it is not possible for the young person to live with the family or the family have difficulty in providing the consistency of care and response, the young person will face significant additional challenges in being able to use advice and help that is provided through the local authority and community CAMHS.

1.3 Mental health support and services for children

25. The delivery of CAMHS in local areas is through four tiers of provision and the report refers, for example, to community CAMHS or tier 4 (T4) or inpatient CAMHS as well the more generic references to CAMHS.

26. Tier 1 describes universal services found in education and primary health settings for example; tier 2 (T2) is targeted support for children with milder levels of difficulty or to specific groups at increased risk of developing mental health problems; tier 3 (T3) are specialist multi-disciplinary services. Because of the pace and escalation of Lola Grace's self-harm it is the two higher level CAMHS in conjunction with other services that worked with Lola Grace.

27. The three levels of community CAMHS are commissioned in local areas with varying combinations of input from clinical commissioning groups and local authorities across England. Tier 4 (T4) is the specialist day and inpatient services commissioned and case managed by NHS England that does not involve local statutory organisations such as the local authority or local health commissioners and is operated by different and often independent providers across England as in this case.

28. Children can be admitted to T4 in patient treatment with consent or they can be detained for the purpose of assessment and treatment if necessary. Section 2 of the Mental Health Act 1983 allows detention for up to 28 days. Section 3 of the Act permits detention for up to six months with the option to renew if the grounds for detention continue to be met. Lola Grace was never subject of section 3 detention because she was not judged to be suffering a condition or disorder that met the legal threshold for detention under the Mental Health Act. Whilst subject to any care and treatment under the Mental Health Act, the care and treatment is overseen and authorised by a responsible clinician (a doctor at consultant level) who will be working with a multi-disciplinary team of professionals. The responsible clinician will determine whether the patient continues to require care and treatment as a detained patient.

29. Many areas operate an arrangement where adolescents who are in need of mental health care and support will transfer to adult mental health services from late adolescence. In Blackburn with Darwen that is 16 years of age although this is changing; an implementation date is to be confirmed. This is the age at which a young person legally has mental capacity which has implications for example about how care and treatment is provided. As will be made clear in the final part of this report, national standards, supported by research and best practice, encourages local areas to avoid using fixed age criteria and to focus more on the particular circumstances and needs of the young person to determine the most appropriate response particularly in regard to issues such as self-harm[11]. This is a significant learning point from this review.

1.4 The legal framework for controlling risk and the restriction of children's liberty

30. The law about the circumstances and the places where a young person can have restrictions placed on their liberty is very important and relevant for making decisions about children with high risk behaviour. For example, the law makes clear that a young person cannot be held against their will without an appropriate court order and that they are also living in a place authorised for providing such care. Simply stated, a children's home for example cannot keep a young person in secure conditions because it is not authorised to provide that type of care.

31. A child can be subject to a detention under the Mental Health Act 1983 as described already and be cared for in a hospital that is regulated to provide such care. A child aged 13 or over can be cared for in secure accommodation if the legal criteria are met and a court agrees and makes an order. Younger children can be detained but this requires a procedure that involves authorisation by the Secretary of State.

32. The planning, delivery and review of care and treatment for vulnerable children such as Lola Grace is therefore subject of complex law and practice guidance described in two principle frameworks relevant to this review.

33. Firstly, the management of child protection, child in need and looked after arrangements generally come within the scope of children's legislation and is largely led by the local authority. The second framework is the care

[11] Transition from children's to adults' services for young people using health or social care services NICE guideline Published: 24 February 2016 https://www.nice.org.uk/guidance/ng43 p6 standard 1.2.3

programme approach (CPA) which covers the care and treatment provided to Lola Grace as a patient of the various mental health providers. That is largely led by a health professional; a responsible clinician when Lola Grace was an in-patient subject to section 2 of the Mental Health Act and then a care coordinator when she was discharged to the care of community mental health services.

34. The Children Act 1989 also describes particular duties and responsibilities in regard to safeguarding children from significant harm by virtue of section 47; local authorities, with the help of other organisations as appropriate, have a duty to make enquiries if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action.

35. Additionally the local authority has other duties to identify any child in need by virtue of section 17 of the Act. For any child in need the local authority should consider what services are required to help prevent any impairment of the child's health or welfare.

1.5 Child sexual exploitation (CSE)

36. Child sexual exploitation is a crime that blights the lives of children and young people with devastating and long term consequences that last into adulthood. National guidance highlights that children can be more susceptible to this abuse as a result of other factors in their lives. Experience of neglect, absence of a safe and stable home currently or in the past (domestic abuse, substance abuse, mental health and criminality), bereavement and loss of significant relationships, social isolation and being in care particularly with multiple or disrupted placements are aspects of Lola Grace's history that are described in the guidance[12].

37. Evidence from the national joint targeted area inspections in 2016[13] highlighted that vulnerable children benefit from building a trusted relationship with one adult, the importance of effective return from missing interviews, that variations in practice undermine consistent response and that good listening to children can be undermined if assessments are not of a good enough quality. There is additional research and practice evidence

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[12] Child sexual exploitation Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (2017) Department of Education

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/680088/Child_sexual_exploitation_gangs_and_children_missing_from_home_care_or_education_joint_targeted_inspection_guidance.pdf

available from the centre of expertise on child sexual abuse[14] and from the police inspectorate (HMIC)[15].

38. The significance of this review is therefore not just in regard to any learning as it relates to the particular circumstances of Lola Grace's tragic death but the opportunity it provides to examine learning in response to the challenge of preventing harm to children as represented by self-harm and child sexual exploitation in particular. These and other issues are explored in later sections for the report.

1.6 Family contribution to the serious case review

39. Lola Grace's mother participated in two face-to-face meetings as well as telephone discussions with the chair of the panel during the conduct of the serious case review. Mother has also provided written comments to the review which are summarised as follows.

   a) Relationships with different professionals; ranged from very helpful and tenacious to some being rude; for some professionals, mother did not like their decisions but she could understand their reasoning;
   b) Mother did not feel listened to by some professionals and said that this was a feeling that Lola Grace had as well;
   c) Mother felt blamed by some people for Lola Grace's difficulties;
   d) Professionals did not seem to put together patterns of behaviour or have any rationale for why Lola Grace engaged in risky behaviours or self-harmed;
   e) Mother was not convinced that enough attention was given to family history including mental health and suicide;
   f) Complaints did not lead to resolution of conflict/disagreement;
   g) Mother felt there was not enough consultation on important decisions; shared care was an empty concept for her especially after the care proceedings from early 2016;
   h) Significant professionals for Lola Grace ending their involvement & the attendant feeling of rejection that Lola Grace felt;
   i) Follow up from hospital, T4 and community based services was insufficient;
   j) Gaps in community mental health therapy services;
   k) Lack of CSE therapy and help for Lola Grace to develop an understanding about grooming behaviour by adult males and the risk of sexual exploitation and abuse.

[14] https://www.csacentre.org.uk/research-publications/key-messages/
[15] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/cse-assessment-criteria.pdf

40. Mother prepared detailed queries for several organisations as well as providing written commendations in regard to the valued work and relationships that were established with several different people working in those organisations. These have been shared with the respective organisations.

2 Summary of contact and significant events

41. Multi-agency support had been provided through child in need (CIN) and child protection plans prior to 2015 in response to a history of complex need and family circumstances under the category of neglect.

42. It is now known that before the first incidents of self-harm that professionals responded to in February 2015, there was already a history of several months of self-harming that had not been visible to Lola Grace's mother or been reported to anybody outside of the family. In late summer 2014 Lola Grace experienced a series of traumatic events. Lola Grace referred herself to the school counsellor in early 2015 with a letter from her mother explaining that Lola Grace had run away when her feelings had become painful and that she was experiencing intense moods but could not explain why. The first counselling session took place in early March 2015 after Lola Grace had also come to the notice of other services in regard to concerns about self-harm.

43. In late February 2015 concerns about Lola Grace self-harming were reported to the police when a friend reported receipt of text messages from Lola Grace to say that she was thinking about self-harm and suicide. The text message had included a photo of Lola Grace holding a knife to her throat. The police visited the family home to check on Lola Grace's immediate safety. Information was forwarded to children's social care services two days later as a medium risk vulnerable child report (Protecting Vulnerable Persons or PVP report) through the local Multi-Agency Safeguarding Hub (MASH), although there was a further delay in processing the referral by children's social care; by the time the referral was being processed Lola Grace had already been taken to the hospital emergency department following an overdose.

44. Lola Grace was taken to the hospital emergency department in late February 2015. Earlier in the day friends of Lola Grace had alerted school staff to Lola Grace having a large quantity of analgesics. The school spoke to mother who agreed that she would take Lola Grace to hospital. Lola Grace and her mother provided a history about the two incidents of self-harm within a week; this included the text message to the friend and taking the analgesic to school.

45. A mental health practitioner located with the local community CAMHS was allocated to work with Lola Grace. At this time Lola Grace was expressing a wish to engage with therapeutic work supported by mother. Involvement was for a keep safe plan including parental supervision of Lola Grace and preventing access by Lola Grace to medication and harmful substances at home. The mental health practitioner remained involved and a consistent point of contact with Lola Grace until she was subsequently transferred to

the adult community mental health team (AMHT or CMHT) when she became 16 the following year. Other mental health practitioners completed risk assessments and these were by different people.

46. Children's social care services subsequently completed the first of three assessments that were undertaken after February 2015.

47. Following a disclosure to teaching staff by Lola Grace that she had taken an overdose she was admitted to hospital. Children's social care was asked to participate in a meeting to discuss how Lola Grace could be discharged safely. The meeting discussed the various stressors in Lola Grace's life and on her family in general. The meeting agreed that Lola Grace would be on a waiting list for individual trauma based work and she was also placed on the waiting list for family therapy. Mother was also supported in making a referral for her own emotional wellbeing to a local community mental health service.

48. In early March 2015 the police were told by children's social care services that a 49 year old male friend of the family was sending text messages to Lola Grace that indicated potential CSE. A strategy discussion that involved the specialist CSE service agreed that an investigation would be undertaken. The specialist CSE service completed a CSE risk assessment. The police had not interviewed or placed any restrictions on the male before Lola Grace was admitted to hospital in late March 2015 having taken another overdose; this self-harm was the fourth incident since the first in February 2015. A risk assessment at the hospital resulted in a referral being made for Lola Grace's first admission to a T4 inpatient CAMHS unit which was also subject of delay meaning that Lola Grace remained on a paediatric ward. The purpose of the referral to the T4 unit was to help think through the most appropriate response to Lola Grace's on-going suicidal ideation, the limited protective factors and the recent revelations regarding the CSE.

49. The police continued to be informed about ongoing contact by the male with Lola Grace. He was arrested and interviewed under caution in late March 2015 and was made the subject of bail conditions and a section 2 notice under the Child Abduction Act 1984 that banned him from having contact with Lola Grace. Lola Grace was not interviewed until July 2015 after which the file of evidence was submitted to the Crown Prosecution Service (CPS) for a decision to be made about prosecution. The file was not reviewed for several months at which point evidential deficits were identified and referred back to the police. There was further delay and decision that no prosecution would be authorised was not made until early 2016. Further information and analysis is provided in the following chapter.

50. In April 2015 Lola Grace's aunt took her own life.

51. Lola Grace was at the T4 unit from late April 2015 to early July 2015. A detailed history was collated which included information about the different traumas and sources of stress that Lola Grace was dealing with. A diagnosis of adjustment disorder[16] took account of Lola Grace's responses to the various sources of stress and described a need for a stable and supportive environment for Lola Grace to help her develop better resilience and coping strategies.

52. A social work assessment was completed in June 2015 although did not include much information from other assessments such as at the T4 unit. The assessment confirmed that Lola Grace was a child in need. Arrangements began to find a family placement for Lola Grace. Initially this was done with the agreement of mother and Lola Grace. This coincided with the case being transferred to another social worker.

53. There were further significant incidents where Lola Grace put herself at risk of self-harm; for example she was found near to a railway line and there was evidence of self-cutting.

54. A third social work assessment in July 2015 was completed and provided information about risk that was discussed at a child protection conference in respect of Lola Grace and her siblings.

55. In late July 2015 the consultant psychiatrist for community CAMHS wrote to children's services confirming the consensus that Lola Grace's risk taking behaviour and self-harm were understandable in the context of her emotional difficulties; this reflected the assessment also of the T4 unit. Community CAMHS were of the view that Lola Grace's best interests were best served if she was placed with a foster carer; this was based on the level of emotional stress she was under. Community CAMHS acknowledged that Lola Grace's mother did not agree with the view of their practitioners that Lola Grace had a difficult emotional relationship with mother at times. Therapeutic work with Lola Grace was a 'holding operation' until Lola Grace was settled in a placement. Community CAMHS and T4 assessments both

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[16] Adjustment disorder is an abnormal and excessive reaction to an identifiable life stressor. The reaction is more severe than would normally be expected and can result in significant impairment in social, occupational, or academic functioning. Adjustment disorders are associated with high risk of suicide and suicidal behaviour, substance abuse, and the prolongation of other medical disorders or interference with their treatment. Adjustment disorder that persists may progress to become a more severe mental disorder, such as major depressive disorder.

agreed that Lola Grace's risk and self-harming behaviour were signs of ongoing distress. The consultant was unable to participate in the child protection conference.

56. Shortly after the child protection conference at the end of July 2015 Lola Grace was placed with a carer for a short 28 day placement pending a move to a longer term placement that was going through regulatory approval. The child protection plan (category of emotional abuse) and looked after children (LAC) arrangements brought the involvement of an independent reviewing officer (IRO). The child protection plan in regard to Lola Grace was ended in early September 2015 because she was subject of LAC arrangements.

57. There continued to be incidents of self–harm. In October 2015 the CPS reviewed the police file and found that there were problems with the evidence including a faulty disc. The specialist sexual exploitation team completed a CSE assessment in October 2015 which agreed that Lola Grace was at medium risk of CSE. The plan was for one-to-one work with Lola Grace to help her understand grooming behaviour and the risk of exploitation, referral for mother to PACE[17] services, for updates to be provided on the ongoing investigation of the male and to reduce the incidents of Lola Grace going missing from school.

58. The alleged perpetrator visited a police station in late October 2015 and admitted to contacting Lola Grace via social media. Officers interviewed Lola Grace at home and determined that although the message had been abusive it did not amount to witness intimidation and did not meet the criteria for harassment or malicious communication. He was released without any charge and information was forwarded to the CPS. The learning event was advised that electronic communication is not covered in the child abduction legislation that underpins the section 2 notices.

59. A second LAC review in late November 2015 was advised that no therapeutic work was being offered to Lola Grace either in regard to self-harm or the CSE. There had been a recommendation from the T4 unit that resilience building work and family therapy were required. In September 2015 community CAMHS were considering whether to discharge Lola Grace. An intervention by a senior manager in Children's Services made community CAMHS change their mind. The IRO used the escalation processes in regard to these

[17] Parents against child sexual exploitation (PACE) is a registered charity that helps parents to understand what is happening to their child and how parents can be the primary agents in helping their child disclose and break away from child sexual exploitation. PACE also provides training and guidance on best practice for organisations and professionals.

shortfalls in service. In December 2015 the decision was made to offer art therapy although there was further delay before the art therapy sessions were provided in April and May 2016 which Lola Grace accessed although these ended prematurely with staff sickness; no other therapy including family therapy was provided. Lola Grace continued to receive regular contact from the mental health practitioner.

60. Over the new year 2016 there was further suspected self-harm that involved Lola Grace spending a night in the hospital following a self-reported overdose.

61. Legal proceedings in the Family Court began in January 2016 although the decision to seek a care order had been made in November 2015. Some of this delay arose because the proceedings required social care to update their assessments. The Child and Family Courts Advisory Support Service (CAFCASS) became involved through a Children's Guardian being appointed. Within the context of the Family Court proceedings there was discussion about seeking a therapeutic foster placement although the details of what such a placement constituted and where it would be sourced from was not clarified.

62. In March 2016 the CPS decided that there was insufficient evidence to allow a charging decision to be made. A CSE assessment the same month agreed that Lola Grace remained at risk of CSE.

63. In May 2016 Lola Grace moved to a foster placement outside of the borough. The IRO and a senior practitioner visited the foster carer prior to the placement being made to provide information about the background and range of need presented by Lola Grace which also included providing the statutory forms of information for a carer. In spite of this, the foster carer has told the reviewers that she did not feel that she had been made aware of the full extent and history of Lola Grace or her self-harm.

64. In May 2016 there had been further incidents of self-harm; a particularly high risk incident involved the police locating Lola Grace in a tree with a noose. There were other incidents which included finding Lola Grace near to a bridge over a motorway.

65. By July 2016 the foster carer felt unable to provide safe care for Lola Grace. There continued to be incidents of Lola Grace going missing from placement which broke down in early August 2016 and Lola Grace moved to a children's home.

66. In October 2016 community CAMHS recommended that Lola Grace needed to have a placement with in-house therapeutic support.

67. In November 2016 Lola Grace was admitted for the eleventh time to hospital following self-harm. This coincided with Lola Grace being transferred from CAMHS to the adult community mental health services team (AMHT or CMHT).

68. In January 2017 Lola Grace was located on a railway line. A serious incident of harm was averted by slowing or stopping train traffic and removing Lola Grace from the railway line. The incidents involving trespass onto railway property brought involvement by the Transport Police (who had been involved in a previous incident) and who developed a risk strategy for responding to Lola Grace. Lola Grace was admitted to a T4 unit for the second time and stayed there for less than 28 days being discharged in early February 2017. Whilst at the T4 unit Lola Grace made a disclosure of inappropriate and potentially sexually exploitative relationships with older males. The T4 unit recorded that they passed the information to the specialist sexual exploitation team who do not have a corresponding record.

69. The AMHT care coordination had to change due to illness and the case was allocated to another care co-ordinator who was already working in excess of their expected caseload.

70. In March 2017 there was further information about Lola Grace being at risk from CSE involving different males. It is not clear that this was properly reported to and therefore recorded by the police; further information is included in the next section of analysis.

71. Lola Grace was declining contact with the new AMHT care co-ordinator which coincided with preparations being made for the school counsellor to begin helping Lola Grace move to college and for the involvement of the school counsellor to end.

72. After an escalation in the number and types of self-harm incidents Lola Grace was admitted to a T4 unit for a third time in early June 2017. She remained there until the middle of July 2017. Although there was discussion about identifying a bespoke care placement for Lola Grace and the T4 service repeated the call made by community CAMHS in October 2016 that Lola Grace should be in a care placement with in-house therapy, she returned to the children's home and was transferred to the semi-independent unit in October 2017 as her choice of placement. There is no record of anybody objecting or querying the placement decision at the time. The semi-

independent unit provider has said that they were not aware of the extent of Lola Grace's history and self-harm which is disputed by mother and the social worker.

73. In late November and early December 2017 Lola Grace did participate in an adult acute therapy service session (a form of CBT[18]) where she was thought to have engaged well and had been benefiting from her participation. It was considered that the risks had 'reduced significantly'.

74. There was further self-harm in November 2017 that involved the police. Lola Grace died in late December 2017.

75. There had been 130 incidents of self-harming behaviour or suicidal ideation, 13 incidents of Lola Grace being sexually groomed, of which there was evidence in two or three incidents of sexual abuse, and 33 occasions when Lola Grace had gone missing.

[18] Cognitive behaviour therapy (CBT) is a talking therapy and is one of those recommended in the guidance for responding to self-harm.

3 Analysis of professional contact and intervention

3.1 Examples of good practice

76. A serious case review highlights examples of good practice that help promote and encourage people undertaking some of the most complex work with children and young people. Examples include;

a) The clear measures and individual action taken in all of the services to respond to incidents of immediate risk which for example included suspending the normal operation of trains to allow Lola Grace to be safely brought from a railway track, spending time talking with Lola Grace when for example she had climbed onto a structure or tree, staying with Lola Grace when she was brought to the hospital emergency service; there are other examples;
b) The school counsellor's relationship with Lola Grace and her tenacity with different services;
c) The trial of a range of different therapies in a T4 unit to see which of those Lola Grace preferred or could best engage with;
d) Across social care, school and the placement providers generally, there was an effort to ensure that Lola Grace had the encouragement and was given access to positive activities that contributed to her emotional and behavioural development, identity and educational attainment;
e) Following the incidents of self-harm there was discussion on the service response that was required;
f) The CAMHS community services always responded to incidents by at least seeing Lola Grace face-to-face and involving a consistent nurse practitioner; this was aided by being in the same NHS Health Trust as hospital emergency and paediatric services and Lola Grace being under 16;
g) In some of the services there was a clear investment of time to build relationships that for example went beyond a legal minimum standard such as in the Child in our Care (CioC) service statutory visit obligations to a child being looked after;
h) The practice of an IRO to encourage Lola Grace to take more control of her LAC reviews and the attempt to move from just eliciting wishes and feelings to enabling Lola Grace to more actively participate in her LAC reviews;
i) The imaginative and empathetic manner in which some key practitioners tried to prepare and support Lola Grace at the point of transferring to a different service or to a different professional[19].

[19] However thoughtfully individual professionals ended their relationships there was a systemic gap in how the overall system of arrangements were not able to promote continuity of key relationships.

3.2 History and use of chronology for understanding the context for Lola Grace risk from harm

77. Many of the underlying factors for Lola Grace's distress and self-harm were long-standing; the history of abuse for important adults in Lola Grace's life and the impact that this had on those adults and their relationships; the patterns and dynamics within the family for how they dealt with distressing and traumatic events and information and how that contributed to the cycles of crisis combining with a limited ability to develop more resilient methods for dealing with adversity; the history of depression, self-harm and substance abuse in the family.

78. These were the significant elements of the family legacy that created the context for Lola Grace's presentation of behaviour, needs and risk during her adolescence. This is not blaming the family; it is acknowledging the very severe complications that faced the whole family and the people working with them.

79. Lola Grace's self-harm was recognised as a response to complex stressors (rather than it being a mental illness or disorder) as early as March 2015. The value of attempting to develop a therapeutic response was described by community CAMHS in early documentation. The initial plan to offer trauma based work and family therapy resulted in Lola Grace being placed on a waiting list from March 2015. The revelations of CSE, her continued self-harm resulting in emergency treatment and the general context of family related trauma resulted in community based therapy being postponed.

80. Although it was generally understood that Lola Grace was dealing with many difficulties in her life, the detail of the family history was not entirely and collectively known about across all of the key organisations although some people were better informed than others. The assessments in the T4 units provide the clearest written evidence seen by the review of history being systematically sought, recorded and analysed to inform the formulation of strategies of help. Some of this appears to reflect different practice; for example community CAMHS provided information in various correspondences to other professionals. It is apparent that both T4 and community CAMHS were agreed about the general drivers of Lola Grace's distress; the community CAMHS documentation and communication with other services was not as detailed as for example is seen in the T4 assessment and formulation. For example, a community CAMHS mental health practitioner set out the plan for working with Lola Grace in January 2016 as 'discuss with community CAMHS a range of new strategies to deal with difficult emotions' and 'formulated some useful staff responses when Lola Grace seeks support from care staff'. The T4 documentation was more detailed about the process of assessment being used to inform reflection and

formulation about the various drivers of risk and the potential therapeutic strategies for addressing them, although there was limited use outside of the T4 units.

81. The people who provided day-to-day care for Lola Grace when she became looked after had some of the least information given to them but were dealing with the day-to-day risk and incidents of self-harm.

82. Linked to the clarity of collective understanding about history and context was the absence of a clear enough integrated chronology to inform the respective services and people about significant events and incidents that occurred from February 2015 onwards. This would have been helpful in regard to the incidents of self-harm and the recurring evidence of CSE. The absence of a chronology that drew information together from the respective agencies meant that none of the professionals had a complete enough overview of the extent of risk associated with incidents or other information.

83. For example, distinguishing more clearly that some incidents of self-harm were impulsive whilst others were planned and involved differing levels of potential lethality. The first presentation for self-harm in February 2015 found no symptoms of depressive disorder whereas by 2017 Lola Grace was presenting with pervasive depressive symptoms which signifies different levels of concern about risk.

84. The absence of chronology in regard to incidents of CSE meant that each of those incidents was largely managed in isolation, compounded by the postponement of work by the specialist sexual exploitation team in response to concerns about Lola Grace's emotional and psychological health and concern about re-traumatising Lola Grace.

85. A chronology that was kept updated would have helped to identify escalating patterns of risk and associated drivers that are so important for risk assessment as well as highlighting significant delay and drift that could have given greater clarity and urgency.

3.3 Communication and engagement

86. Over 20 organisations had varying levels of contact and involvement during the time period examined by the review. This would have been overwhelming for any family or young person and represented a very complex set of arrangements to coordinate between different people and organisations. Apart from the school counsellor and the community CAMHS nurse practitioner (and day-to-day carers) most of the other personnel were not consistent contacts for Lola Grace or her family.

87. It was further complicated by the fact that when Lola Grace became 16 requiring a number of enforced transitions from child focussed services to adult services. There were also several changes of key personnel such as five different social workers in less than two years.

88. The logistics of managing communication and of sharing information across such a large, diverse and dispersed range of different people and locations are not to be underestimated. It is apparent that there was concerted effort by key people to keep each other informed about significant incidents. However the reliance on email and telephone communication could not provide enough of the structure to collate, analyse and coordinate the level of strategic response that was required at key moments. A great deal of this reflected systemic issues such as the different legal systems or frameworks for practice that individual professionals were trying to navigate that were under different co-ordination and leadership.

89. Lola Grace's mother reported that she felt as if some people blamed her for Lola Grace's self-harming. Some of this was mother's observations about the perceived attitude of some key professionals although it also reflects the reported experience and perceptions of families more generally who are naturally very distressed and stressed when their child is self-harming.

90. Information about some important decisions were not explained sufficiently to promote better understanding and engagement by Lola Grace and by her family. An assessment of the family friends as potential carers for Lola Grace was not supportive of Lola Grace's wishes and Lola Grace did not understand why; the couple were considered at a later stage as potential carers although arguably by that stage Lola Grace's level of risk had escalated. The rationale is not clarified and may reflect a degree of pragmatism in regard to what Lola Grace was willing to comply with for example.

91. There is no recorded evidence in information for the review about how the decision about no prosecution in regard to allegations and information about CSE was explained to Lola Grace and the family and there were gaps in conducting strategy discussions about how to provide Lola Grace with therapeutic help and support whilst not undermining criminal processes.

92. Family work to strengthen communication and to help resolve difficulties can be valuable in responding to self-harm. This was recognised in the initial assessment by community CAMHS in March 2015 when they initially placed Lola Grace on a waiting list for trauma based therapy and family therapy. This initial plan was quickly replaced by a referral to a T4 unit to seek help in developing a response to the escalating self-harm and context of Lola Grace's risk and self-harming behaviour. Art therapy was provided after several months and this followed representations being made by children's social care services.

93. The escalation from the initial identification of self-harm to admission to a T4 unit in April 2015 was very swift and was unusual in that there had been a relatively short history of contact through the community based CAMHS. Difficult judgements had to be made about how best to keep Lola Grace safe after the repeated presentations at the hospital in early 2015. One of the consequences of such a fast escalation was the lack of opportunity to build relationships with community CAMHS compounded by the reality that any involvement was going to be relatively short-lived because of the local transfer protocols for mental health support occurring at 16 and older.

94. The absence of community based therapy and treatment left a gap in developing the coping strategies and establishing the relationships that can help achieve better engagement. Several factors influenced this and included concerns about the stability of Lola Grace's home circumstances and networks, and professional opinion about the timing and efficacy of different models of treatment. For example there was concern that trauma based therapy would have been ill advised given the ongoing CSE investigation and Lola Grace's emotional instability.

95. There was misunderstanding about the information that some of the people providing day-to-day care for Lola Grace were working with. The foster carer for example reported that she was not clear about the reasons and circumstances for Lola Grace becoming looked after although there had been a face-to-face meeting and discussion involving the IRO and a senior practitioner. The foster carer says she was not aware of the full extent of Lola Grace's self-harming behaviour prior to the placement or the fact that Lola Grace had been subject to such intensive supervision by care staff (two to one care) prior to moving to the fostering placement. Similar comments were made by staff at the semi-independent unit where Lola Grace was living when she died.

96. Communication between the police and the CPS as well as with the family and other professionals was also the subject of significant delay. The school counsellor who was a significant professional for Lola Grace was not always kept up to date.

3.4 Assessment

97. The assessment of self-harm has to distinguish between people who have harmed themselves as a way of dealing with unhappiness and other emotional disturbances, which are directly related to and to some extent an understandable reaction to external circumstances, and those whose self-damaging behaviour is attributable to a psychiatric disorder and a resultant disturbed mental state. This is what was done in response to Lola Grace's

self-harm in determining that Lola Grace's response was not a mental disorder but was a response to sources of stress in her life.

98. The differentiation in regard to the drivers of self-harm is important not only in assessing risk but also in deciding a future management plan. For example, where someone is harming themselves in reaction to unhappy life circumstances, it is reasonable to assist them to address their problems in a less self-destructive way. In this context, talking therapy such as cognitive–behavioural therapy (CBT) can be helpful to address problems of difficult feelings (e.g. anxiety or depression/unhappiness). This was identified in the initial assessments by community CAMHS in March 2015 as well as in subsequent assessments and formulations at T4. A singular challenge confronting Lola Grace and those who worked with her was the limited range of protective factors that could help with her resilience.

99. Assessments by different care and health services were completed in parallel processes that reflect the legal and organisational frameworks within which the various professionals work; the Children Act 1989 and the Mental Health Act 1983 being the two major areas of legislation supported with associated codes of practice or statutory guidance and regulations. Although these were the key assessments there were other agency or incident specific assessments; these included the PVPs, missing from home interviews, CSE assessments, hospital child risk assessments, care home risk assessments and school risk assessments. As a looked after child, Lola Grace also came within the scope of leaving care arrangements. Although a pathway plan had been opened in August 2016, the assessment remained incomplete by December 2017.

100. Some of the assessments were more narrative in their style and content whilst others provided a clearer analysis that for example described the context of Lola Grace's self-harming behaviour and the various factors that indicated risk or potential resilience. For example, the assessments completed in the T4 units informed a formulation intended to guide the development of care plans to continue after discharge although were limited in their implementation. On one occasion there was a difference of professional opinion between the T4 and the AMHT services. It is an example of where corporate parenting could have been more effective with more assertive leadership of multi-agency arrangements.

101. Children's social work services had the statutory responsibility under the Children Act 1989 to initiate and to co-ordinate assessments to determine what services Lola Grace would require as a child in need and to also consider if she was at risk of significant harm. The first social work assessment in February 2015 after the first presentation of self-harm was started late. Workload capacity might well have been a contributing factor. At this stage no mental health assessments had been undertaken.

102. The following comments are not about any individual's practice but rather discuss the general approach and utility of the activity of assessment as it applied to Lola Grace's circumstances.

103. The first social care assessment was not just focussed on Lola Grace but included her siblings. The assessment includes information about the trauma of the sexual assault on Lola Grace's sister, the overdose by Male 2 in September 2014 and that Lola Grace had been provided with counselling in 2010 although does not include information regarding the circumstances for the counselling or any outcomes. The assessment mentions that Lola Grace has had a number of traumatic events in her life, although is limited in the record of evidence exploring the significance in the analysis of the assessment. The assessment describes mother providing love, emotional warmth and affection and that there was a strong attachment in the family rather than for example describing any of the children's particular attachment or the particular style of parenting. The assessment refers to the need to protect from 'unsafe adults'; the use of euphemism blunts clarity about the nature of risk and how it is understood. The assessment analysis includes no mention of the self-harm and there is limited reference to the risk from the adult male who was already on bail following allegations of sexual assault and abuse. There is little record of evidence of any direct or indirect input from other services to the assessment of risk. There is no mention of the assessments at the hospital emergency service and by community CAMHS and the T4 unit which would have been an opportunity to draw the assessments together to inform care planning for Lola Grace.

104. The second social care assessment completed in September 2015 appears to have been a copy and paste of the same reasons and circumstances for the assessment being undertaken. This may again reflect workload pressures or it might reflect a more fundamental issue that for example sees assessment as primarily a function of administration and compliance with procedure. The assessment does not describe in any detail the intervening history of self-harm presentations although there is a summary in the section on developmental needs. There is little detail about the circumstances of the incidents of self-harm or the triggers. There is reference to a 'potential sexual assault' that had effected Lola Grace's emotional welfare but no indication that Lola Grace had provided any information or about how this had impacted on her and how she was continuing to be subjected to contact from the alleged perpetrator.

105. As previously mentioned, the assessment is not specifically focussed on Lola Grace. The assessment includes reference to the T4 placement, but as previously, there is no information for example about the formulation and the discharge summary and recommendations made by the T4 unit. The assessment refers to the reasons for self-harming to be open to 'conjecture'.

The assessment refers to Lola Grace and sibling having 'chosen to make suicide attempts' inferring that these are the actions of choice or of free will. It also refers to Lola Grace not being at significant harm because 'appropriate help is always available'. The assessment also refers to allegations of potential sexual abuse rather than Lola Grace disclosing that she had been abused. The second assessment provides little recorded evidence of input by other services to the assessment of risk or analysis despite extensive involvement by several other people and organisations since February 2015.

106. The third assessment in January 2016 provided the first occasion when the assessment is clearly focussed on Lola Grace and the various needs and risk as they relate to her. It includes a description of how Lola Grace found social situations difficult and struggled to have reciprocal conversations even with people who have worked with her for several months and that she would prefer to avoid direct contact having discussions by text for example. It also describes the complexities of the relationships between the various family members and something of the longer term history and how that had an impact on the current circumstances and for example the difficulties that Lola Grace's self-harm represented. The difficulties that some adults in the family had in being able to model and demonstrate appropriate behaviour to regulate emotions for example and how this has created cycles of successive crisis. The assessment identified high risk indicators that included a history of being neglected, sexual abuse and unsupervised contact with a male, difficulties of family adults being able to prioritise Lola Grace's needs and their unrealistic expectations and understanding about Lola Grace's emotional ability contributing to Lola Grace being left unable to process difficult information. The assessment concludes that it would be unsafe for Lola Grace to return to her mother's care although does not consider the obstacles and problems of trying to place Lola Grace or the availability of a suitable placement. The assessment concluded that legal proceedings would be required which would allow the local authority to share parental responsibility with mother and to make decisions about the most appropriate care arrangements.

107. This third assessment, completed within the context of legal proceedings, is a much more complete collation of information and although there is little direct input from other services there is a clearer sense of information having been considered from other professionals and disciplines. The Family Court proceedings were a significant factor for this assessment achieving this different detail of analysis.

108. In February 2017 a psychological assessment and formulation was collated with Lola Grace whilst she was an inpatient at the T4 unit. The assessment provides a detailed summary of Lola Grace's history, a narrative about the family with a discussion about developmental considerations for Lola Grace and a discussion of Lola Grace's challenges and strengths. The assessment

includes a formulation to help provide the basis of understanding how Lola Grace's experiences, situations and challenges could have contributed to her current distress. The assessment includes recommendations to help Lola Grace on a daily basis with advice about general therapeutic and psychological help and support. It is a more detailed document in providing advice and guidance about going forward compared to other assessments for example by community CAMHS or AMHT. Although this reflects the fact that Lola Grace was an inpatient at T4, the evidence of assessment that has been provided for the review from community CAMHS is set out in relatively concise correspondence and for example makes reference to 'new strategies to deal with difficult emotions' without giving examples to help other professionals; likewise reference to 'formulating staff responses' are not explained in any more detail.

109. There were occasions when there was a difference of opinion between community AMHT and T4 mental health services. In February 2017 the AMHT care coordinator made a referral to the complex care consultation forum (CCCF). The request was for a formulation to guide work with Lola Grace. The clinical psychologist who wrote the psychological assessment and initial formulation was not at the meeting. The forum is a meeting to provide opportunity for discussion and agreement about plans for help in cases of high complexity and multi-agency involvement. It was an appropriate place to discuss Lola Grace's needs for support. There appeared to be a difference of opinion between different professionals about the most appropriate form of care for Lola Grace and the form of psychological therapies to be used which broadly contrasted between Dialectal Behaviour Therapy (DBT) skills based pathways generally available through the AMHT and trauma focussed work as recommended in the T4 formulation. The record of the discussion does not explicitly refer to the psychological assessment completed at the T4 unit. A CCCF addendum dated the 23rd February 2017 by the clinical psychologist at the AMHT states that the report had been considered; the addendum acknowledged that the report was thorough but that the AMHT felt that other considerations needed to be dealt with before recommendations could be carried through. The AMHT wanted to consider life skills or DBT work before engaging in the more detailed trauma based therapy as set out in the T4 assessment. The AMHT also felt that Lola Grace was 'not in a place' to begin trauma based interventions. The addendum also states that AMHT only offer time limited therapies. The addendum also stated that Lola Grace could be placed on an assessment waiting list. There is no record of discussion about the risk associated with the proposed action.

3.5 Voice of Lola Grace and understanding her needs, views and wishes

110. There was consensus that Lola Grace's self-harm represented her response to her complex life story. Understanding what children are thinking, feeling and wishing to happen is a fundamental part of professional practice.

111. There are examples of individual professionals developing important relationships of trust with Lola Grace although the number of different people and the changes contributed to Lola Grace having limited engagement for example with adult mental health services. There were many changes to personnel some of which reflected Lola Grace's chronological age (rather than her emotional and psychological development) dictating a transition to different services and coincided at moments of great crisis and confusion in her life. She was ill-prepared to make some of those transitions as a result of her emotional and cognitive development or the high levels of stress and distress she was dealing with.

112. Many professionals tried to find out about the views, wishes and feelings of Lola Grace. She developed important relationships with some; the school counsellor was somebody that Lola Grace sought out for advice and support. The community CAMHS practitioner and some of the social workers also had significant relationships with Lola Grace. The allocation of the same mental health practitioner from community CAMHS was intended to provide consistency and opportunity to develop trust and confidence. There was a clear effort to involve Lola Grace in important discussions that included assessments and meetings to review arrangements.

113. Thought and effort was given to how some important transitions were managed. This included for example consulting Lola Grace about how one of the social worker's introduced and helped to transfer the ongoing support with Lola Grace to another practitioner resulting for example in organising a cook off competition. The school counsellor was important in helping to facilitate consultation and the sharing of information with other professionals. The counsellor kept contact with Lola Grace during the summer school holidays. There was also clear effort by emergency response staff such as the police in trying to find out about particular sources of distress for Lola Grace when responding to the calls when Lola Grace had gone missing or had been located in potentially risky situations.

114. The treatment plans that were discussed from 2015 onwards acknowledged the importance of Lola Grace being given opportunities to talk particularly after the assessments at the T4 units. These were delayed for the reasons already described. The work with an art therapist offered the potential for Lola Grace to use her interest in drawing to help her communication and exploration of the various stressors in her life. Regrettably, apart from the

delay in organising community based therapy, the art therapy was disrupted when the therapist became unavailable due to illness. This potentially important aspect to Lola Grace's communication of difficult feelings and distress was therefore only used for a very limited period of time. This should not be read as a criticism of an individual practitioner but is a comment about the capacity of services to offer appropriate and tailored support. This is potentially significant given the difficulties that Lola Grace had in describing her emotions or feelings or initiating conversations about when she was feeling low. The inability to organise or to offer the therapies outside of T4 hospitals that formed part of the formulated treatment from late 2015 onwards was a significant gap in offering a substantial opportunity for Lola Grace's views, wishes and feelings regarding the various stressors in her life to be more adequately explored.

115. The number of people in contact with Lola Grace was probably bewildering and complicated further by the difficulty of any single professional being in a position to coordinate and oversee all of the various arrangements or to provide continuity. Although the social workers had clear legal duties and responsibilities in regard to Lola Grace when she was a CIN and was subject to a child protection plan and then became looked after, a separate set of people were responsible for managing arrangements under the Mental Health Act and a further set of criminal justice professionals were responsible for decisions regarding the investigation and charging decisions in regard to males who posed a risk to Lola Grace. The picture that emerges is primarily of different processes working separately in different silos to each other and of Lola Grace being left in limbo.

116. Even within single agencies such as children's social work services there were five different social workers allocated at different times. Given the significance of the social worker's role this represented a great deal of change and offered limited opportunity for Lola Grace to develop a relationship and perhaps contributed to a greater level of dependency and investment in her relationship with people such as the school counsellor who was a standalone professional with no immediate or day-to-day recourse to support as it related to her specific non-educational work in a school. The emotional demands that must have been placed upon this professional would have been significant.

117. The policy that children requiring mental health support at 16 and older are transferred to adult mental health services meant that there was a relatively short time horizon for community CAMHS to develop engagement and support. The service do not believe that it was an inhibitor to developing a relationship and engagement with Lola Grace. CAMHS had discussed whether to close their involvement in September 2015 just prior to Lola Grace turning 15 years old; this was challenged by children's services.

118. In regard to how it was relevant to promoting and hearing Lola Grace's voice, the adult mental health services struggled to develop any relationship with Lola Grace who did not want to engage with their service or with their people, some of whom made concerted efforts to begin a relationship with her. For much of the time that those practitioners were trying to reach out to Lola Grace, she was telling them that her main wish was for them to leave her alone. This coincided with the school counsellor also having to help Lola Grace disengage from her and to support Lola Grace's transfer from school into a local college.

119. Looking objectively at this accumulation of evidence about how services are organised (as distinct to the work of individual practitioners), it does not represent a sufficiently child focussed approach to delivering help despite the considerable efforts of the individual professionals.

120. This section began with a description of the efforts made by different people to promote Lola Grace's voice. There were important areas of Lola Grace's life where the consultation is not clear enough. For example, it is not always possible to see how Lola Grace was consulted in regard to some of the placement decisions. Particularly significant decisions included the ending of the longer term placement and the final placement in October 2017 at a semi-independent unit with very different levels of supervision and care for example.

121. Other important decisions included Lola Grace's strong wish to be allowed to live with a couple who were friends of her family. The couple were subject to an assessment that concluded that it would not be in Lola Grace's best interests to be placed with them. There was more than one reason which included concerns that the couple had struggled to show enough insight about Lola Grace's circumstances and the various stressors. The decision and reason were not sufficiently explained to Lola Grace.

122. Given Lola Grace's age when she became looked after, she had an established relationship with different networks of family and friends. There is no record of how the significance of these different relationships was explored. One of the carers felt that Lola Grace was never going to settle in a placement that removed her from living close to those networks.

123. There is no recorded evidence of advocacy being considered in helping to ascertain more clearly the wishes and feelings of Lola Grace. As a child looked after by the local authority, a child who was subject of a child protection plan and a child who was subject of detention under the Mental Health Act were all circumstances where legislation and guidance encourage the use of an advocate where there may be difficulties in communication. There will be some who will say that this would have only introduced yet another person to what had already become a very crowded circle of people

around Lola Grace and it would have depended on finding somebody with the requisite aptitude and skills to provide effective advocacy support. It does appear to represent a systemic area of underdeveloped practice.

3.6 Response to concerns about self-harm

124. It is now known that Lola Grace had been self-harming for several months before she presented at the hospital emergency service. Neither mother nor the school had seen any evidence of self-harming injury or behaviour and there had not been any contact or consultation with primary health.

125. The delay in consulting any professional about self-harm meant that there was very little opportunity to use lower tiers of early help or lower tier community CAMHS before the referral to more specialist in-patient services in April 2015. The fact that there was no pre-existing contact and relationship with community CAMHS was a complicating factor in managing transitions between community and in-patient CAMHS. Early help with self-harm can be effective in preventing further escalation of harming and provides an opportunity to develop relationships with local services. In truth, the complexity and extent of adversity and need in Lola Grace’s circumstances would have made higher tier intervention more probable but it would have been with the benefit of having tried to develop relationships upon which to build formulation and the development of help strategies and risk management.

126. Lola Grace’s self-harming behaviour could be impulsive on occasions and on others it represented prior thought and planning. Lola Grace often experienced strong impulses to end her life and had often taken action that placed her physical safety at risk on more than one occasion and serious injury was prevented by the intervention of other people. Outside of the T4 units it was not always evident that this was being considered in enough detail at least in the recorded assessments of risk and plans. Lola Grace’s emotional and psychological health could vary between high degrees of sociability and optimism and empathy for others through to her much bleaker feelings of hopelessness. Many of the risk assessments were influenced by how Lola Grace was presenting in the moment; this included on occasion within the T4 unit such as for example in July 2017 when there were concerns about whether Lola Grace was safe to discharge or not.

127. Lola Grace used her self-harm to help manage her distressing and painful emotions and to communicate this to other people. Consistent with this, Lola Grace often brought the self-harm or her intention to self-harm to the attention of other people before serious injury had occurred. She had left details of locations where she might be found and on more than one occasion she conspicuously procured the means to attempt self-harm such as

acquiring a length of cord that she gave up on request. On one occasion she engaged in a long discussion with a professional via the phone and provided details of her location.

128. Assessments of risk should take account of factors that either indicate elevated vulnerability or factors that indicate resilience or protective factors. Risk assessments were not always updated and there was a tendency for these to record action to be taken after a recent incident of self-harm or missing from home.

129. Attending hospital is not required for all incidents of self-harm. It should happen when a child or young person is considered to be at significant risk either because of the physical circumstances such as an overdose or significant injury or there is evidence of suicidal ideation which requires assessment by an appropriately qualified and experienced health professional. The purpose of a hospital admission is to assess the situation, reduce the risk as far as possible and engage the necessary follow up services. NICE guidance and the RCPS recommend that any child under 16 who presents at a hospital emergency service following self-harm should be admitted. Lola Grace was admitted or was offered and declined admission when brought to the hospital emergency service.

130. There were occasions when Lola Grace was not brought to the hospital following an incident of self-harm despite expressing suicidal ideation. It is acknowledged that on some of those occasions Lola Grace declined to be taken to hospital and was aged 16 and in law had mental capacity. Her capacity to make a specific decision (in this or other significant matters) was never assessed in accordance with the relevant codes of practice and case law and her refusal was not processed as potentially an indicator of elevated risk.

131. On the first occasion that Lola Grace presented at the hospital emergency service there should have been a referral to the MASH and children's social work services which is acknowledged by the respective services. A social worker was allocated to work with Lola Grace and as an open case there therefore did not require a further request for service. On every occasion there were certainly grounds for concern about the risk of significant harm. There was contact between the hospital and social work service and the management of care and follow up was principally operated through hospital and community health pathways.

132. Arguably, the manner in which the presentations for self-harm were managed created the latent conditions in which no single set of arrangements with a clear professional lead were established for the overall risk strategies and management. Matters were also further compromised by the fact that Lola Grace was being transferred to adult mental health services

and the attendant implications for a vulnerable child having her needs met alongside a much older user group.

133. As Lola Grace's self-harming behaviour escalated there was a consequential effort to restrict and limit the opportunity for Lola Grace to put herself at risk. It became a cycle of incident, response and reaction.

134. A crisis plan should include the coping strategies that help, any emergency contact numbers and information about how to access help both during and out of service hours. There is little recorded information about how such details were managed beyond contacting emergency services.

135. The final incident of self-harm that tragically killed Lola Grace was different. Her demeanour immediately leading up to the incident did not provide any indicators that could have been picked up to prevent what occurred.

3.7 Response to information about child sexual exploitation

136. Lola Grace was vulnerable to child sexual exploitation. Although some individual professionals sought to provide advice and help the overall response did not prove effective enough in preventing one particular adult male continuing to seek contact with Lola Grace and she seemed to lose confidence over time in reporting information.

137. The specialist sexual exploitation team is a multi-disciplinary service of health, social care and police who are the focus of CSE interventions in the local area and information about Lola Grace was shared with that service from March 2015. The specialist CSE health practitioners never had direct contact with Lola Grace.

138. The specialist sexual exploitation team attempted some individual work with Lola Grace in July 2015; this was paused in response to multi-agency concerns about Lola Grace's mental health and the perceived risk of re-traumatisation.

139. There were delays in completing the investigation work in regard to taking statements and there were further delays in the CPS reviewing the evidence. A significant factor was workload in regard to the volume of files being referred for a prosecution decision as well as issues in regard to the quality of the files being prepared. Measures have been taken to address this which include the organisation of lawyer surgeries and early consultation by the police with CPS to help ensure improved evidence quality in files submitted for a charging decision.

140. The review has not received any direct evidence that Lola Grace or her mother were given clear information from either the CPS or from the police about why the disclosures of CSE resulted in no action being taken through the court although has been told this was done by the CPS. The implications of the delayed investigation and of the eventual decision to not charge were not the subject of any discrete assessment of risk.

141. There was a delay between the initial report of the allegation in March 2015 and taking statements, first of all from the alleged perpetrator and then from Lola Grace. The police received information about the alleged perpetrator's contact with Lola Grace in early March 2015 although he was not arrested and interviewed until the end of March 2015 after a further disclosure was reported to the police. During the interview he read from a prepared statement making no further comment during the interview. Although there had been a plan to issue a section 2 notice after the first disclosure no such notice was issued. He was subject to bail with conditions not to have contact with Lola Grace.

142. There was a further and even longer delay before a decision was made in March 2016 by the CPS that no prosecution could be authorised on the basis of insufficient evidence that an offence had been committed. The review highlights that the long delay contributed to the hiatus in more effective work with Lola Grace in regard to the sexual abuse and probably contributed to Lola Grace feeling that it was either pointless or risky to report further unwanted contact from males.

143. The first contact with the Engage Team was in early March 2015 when a police officer who was part of the Engage Team undertook a joint visit with a social worker in response to information about the older male sending text messages to Lola Grace. This was the male who was subsequently given a section 2 abduction notice. The PVP risk assessment was completed over a week after the visit indicating a medium risk. A multi-agency meeting in late March 2015 at the hospital to discuss the community CAMHS assessment following Lola Grace's presentations with self-harm included information from the specialist sexual exploitation team regarding the contact by the male.

144. It was two days after the meeting that the police were contacted by the hospital paediatric ward to report their concerns about the continuing contact via mobile phone from the male to Lola Grace. The response was allocated to the specialist sexual exploitation team. A strategy discussion the following day did not involve anybody other than the police and children's social care services. The discussion shared information provided from the community CAMHS worker that the male who had been issued with a warning notice had tried to initiate sexual contact with Lola Grace. It was also noted that the male had access to other children in his extended family.

Although the strategy discussion resulted in a high risk PVP being recorded, there was no further action under the safeguarding protocols to coordinate further multi-agency risk assessment and management either in relation to the CSE or from the other risk to Lola Grace, including self-harm, who was at that stage in hospital following incidents of self-harm. A strategy discussion should also have considered if there was any risk indicated to other children.

145. In the middle of April 2015 there was further information reported by hospital nursing staff to the children's social work service and to the specialist sexual exploitation team that Lola Grace had told the mother of another child on the ward that she had been subjected to a sexual assault by the male.

146. Mother told children's social care services that the male continued to breach his bail conditions to not contact Lola Grace whom he was trying to make contact with via social media in May 2015.

147. In October 2015 a second CSE assessment was completed which assessed the level of risk to be medium. Although the plan identified that one-to-one work would be undertaken and a referral would be made to PACE[20] neither appeared to happen.

148. In January 2017 Lola Grace disclosed information to a staff member at the T4 unit that indicated inappropriate and potentially sexually exploitative behaviour from other older males. T4 staff discussed this with social care staff but there is no record of a referral being made to the specialist sexual exploitation team or to the police.

149. Ten days later further information was provided by the school regarding further contact via social media. No action was taken.

150. In mid-February 2017 following a statutory social worker's visit advice was sought from the specialist sexual exploitation team about potential CSE. There is no corresponding record of contact in the CSE Team about this or the contact in January 2017.

151. In late March 2017 an agreement was made between managers of the social care service and the specialist sexual exploitation team that therapeutic work would be offered to Lola Grace after she had asked for involvement. A worker was allocated and the first visit was made to Lola Grace almost a fortnight later in April 2017. The CSE assessment of medium risk that was completed highlighted that Lola Grace had disclosed 'a sexual assault against her'. The process and complications associated with any victim and especially children disclosing sexual abuse is discussed in the final

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[20] Parents against child sexual exploitation (PACE)

chapter of findings. Specialist practitioners working in services such as sexual exploitation services will know and understand that disclosures are subject to all sorts of difficulties.

152. The CSE risk plan in May 2017 agreed that Lola Grace would be offered five to six sessions of one-to-one work with the specialist sexual exploitation worker focussing on exploring and developing her understanding about consent and healthy/unhealthy relationships and strategies for staying safe. The involvement of the Engage Team extended beyond those five sessions.

153. During a mental health assessment in June 2017 at the T4 unit that Lola Grace disclosed being assaulted and raped by two males in a park within the context of explaining the recent involvement of the sexual exploitation service. This information was not discussed with anybody else. None of the services have an explicit record of a disclosure of rape being made by Lola Grace although it remains possible that this was information that Lola Grace did not disclose during the CSE assessment in April 2017.

154. An incident in early September 2017 when Lola Grace told a care worker that she was being blackmailed by two named males was not reported to the police. Lola Grace had disclosed to a worker at the specialist sexual exploitation service on a separate date that she had been in a car with two males and a female friend and that one of the males had attempted to initiate sexual activity.

155. Systematic approaches to sharing information about incidents and perpetrators is important in CSE because of the piecemeal manner in which young people will tend to disclose information. CSE will very rarely be disclosed in a single, coherent and comprehensive statement of information. It is acknowledged that all the practitioners were responding to complex incidents and behaviour that often had great immediacy such as significant self-harm. It reinforces the value of achieving more integrated and co-ordinated assessment and care planning.

3.8 Care planning using parallel pathways and legislation

156. The conduct of assessments in parallel rather than being a coordinated activity is reflected in the care planning and management arrangements. Meetings took place to review plans under social care management responsibility which after Lola Grace became looked after came within the scope of regulations and national guidance that for example requires an independent reviewing officer (IRO) to have oversight of arrangements and to chair meetings. Similarly, CPA meetings to review arrangements under the responsibility of a mental health practitioner working within the framework of the Mental Health Act and associated code of practice took place. Many of

these meetings did not involve respective representation from the different services. When invitations were sent they were often sent at very short notice or after the event.

157. There was delay in implementing important decisions. This included being able to access a bed in a T4 unit on two occasions, arranging therapy outside of T4 and the commissioning of placements.

158. The leadership of planning was hindered rather than enhanced by these parallel processes with different professionals having distinct and different statutory roles under the respective and separate legislation and practice guidance. For example the responsible clinician was the lead professional when Lola Grace was subject to the Mental Health Act for inpatient assessment and treatment; in discharging to the community a care coordinator employed in local mental health services had the responsibility for coordination and ongoing care and treatment. Alongside both of these roles, the local authority social worker was the lead professional for coordinating work on the CIN, child protection plans or looked after arrangements whilst the IRO had a distinct role and responsibility under law and guidance for oversight of arrangements being made for Lola Grace. The point has been made that aside from the difficulty of coordinating between local authority and health frameworks there were differences of views for example between community adult mental health services and hospital based services about the timing and format of therapeutic support for Lola Grace.

159. In addition to these processes there were additional decision making arrangements that were critical to Lola Grace's emotional well-being and safety. Decisions regarding what action to take in regard to the adult male about whom Lola Grace had disclosed sexual abuse was entirely separate to any other process.

160. Additionally, there was a gap between the assessment and care planning processes and the procurement of important resources such as therapy and placements for Lola Grace. This is not unique to either this particular case or to the local authority. However, the level of complexity represented by Lola Grace's needs and high risk behaviour meant that specialist and higher cost resources were likely to be required. The extent to which placement decisions were able to take sufficient account of the particular needs of Lola Grace raises questions about commissioning and procurement processes being linked to assessment and care planning.

161. The onset of Lola Grace's self-harming behaviour in 2015 meant that she was already relatively close to the age at which young people in Blackburn with Darwen have to transition to adult mental health services. This meant that in addition to the challenges already described in regard to the

coordination and leadership of arrangements there were also further complications represented by transfer and introduction of different and adult based services. This had implications for Lola Grace who had difficulty developing relationships in any event, and it also represented profound differences in terms of the ethos and model of therapy services that for example are on offer in an adult orientated service compared to a children and young people's service.

162. The focus of adult mental health services is less on the family and more on the adult patient participating for example in group based work. This was particularly profound for Lola Grace whose emotional and social development and skills meant that she had in many respects a child's vulnerability and the implications that had in participating in a service highly reliant on group based work with adults some of whom will have longstanding personality problems. Lola Grace consistently stated that she had no wish to work with the service despite the considerable effort of an individual mental health practitioner; this contributed to her continuing not having access to therapy outside of T4 units.

3.9 Action to keep Lola Grace safe

163. In general the immediate response to incidents of self-harm by Lola Grace ensured that she was located and was provided with the necessary care and treatment. Some of the incidents were such as in October 2015 when Lola Grace went missing from school and was located several hours later; this was followed up with good recording of the circumstances, assessment of risk and communication between the respective services.

164. There are examples of where the response was less effective. Less than a fortnight after the incident of missing from school Lola Grace went missing from her placement, and care staff had found a suicide note stating "*I don't know who will find this but I have come to the conclusion that I don't belong on earth anymore".* Less than two hours later Lola Grace was located by the police; she tried to run away from the officers who returned Lola Grace to her placement. Although her immediate safety had been achieved there was no PVP or missing from home report completed. There is no record of other services who were working with Lola Grace being aware of this incident.

165. An incident in April 2016 when Lola Grace left the care home without staff being aware and was subsequently picked up by a police patrol who returned Lola Grace safely to the care home was the subject of a police PVP report but no missing from home or return to home assessment was ever completed. Aside from the well documented concerns about Lola Grace's vulnerability there were issues in regard to circumstances under which Lola Grace was not noticed to be missing until the police arrived at the home; the police had also

had difficulty contacting the home prior to their arrival. There were other incidents of Lola Grace missing from home that were not followed up with a return interview and assessment.

166. Lola Grace continued to have unwanted contact from the 49 year old male. Comment has already been made about the delay in completing the investigation and then CPS reviewing the evidence to make a decision on charging. There was limited use of strategy discussions although there was a great deal of contact evident between different professionals using email and telephone. The absence of a structured and multi-agency discussion limited the opportunity to identify trigger events or changes in self-harming for example.

3.10 Use of restrictive practices in preventing harm

167. The use of any restrictive measures is subject of various laws that limits what any professional may do without proper legal authorisation of a court. Although the law gives protection for a one off act that prevents harm it does not allow day-to-day restrictions to be applied without appropriate approval.

168. The Law Society provides guidance on identifying when deprivation of liberty is being applied to a young person aged 16 or 17 who is legally presumed to have mental capacity[21].

169. Lola Grace was made the subject of significant and increasing levels of supervision and restriction. This runs counter to recommended practice that aims for collaboration. This is a significant area for thinking about how children's views, wishes and feelings are explored. Young people who are 16 and older have important legal rights in regard to where they will live, the nature of the care arrangements and the extent to which they are to be controlled or supervised.

170. The use of restrictive measures was motivated by a desire to keep Lola Grace safe from harm. From a therapeutic perspective, these measures would have been largely counter-productive as shown in the guidance and research already discussed at the start of the report and in the reaction of Lola Grace.

171. The fact that the measures were implemented with no proper legal mandate is concerning. It is a complex area of law and practice but at the heart of the issue is the principle that nobody can have their liberty restricted without proper recourse to the appropriate legislation and court. The law

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[21] http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

builds in important checks and balances that are designed to ensure that proper account is given to the needs, views, wishes and feelings of a person, including children, who are to be made subject of a restriction. The Mental Health Act could not be used to detain Lola Grace against her wishes unless she was assessed as suffering from a disorder that came within the scope of the legislation and code of practice; she did not. Another arrangement that Lola Grace could legally have been placed under would have been secure accommodation. This would have required the local authority to satisfy itself that the conditions set out in section 25 of the Children Act were met and an order granted by a court.

172. When Lola Grace was under 16 and not subject to a care order her mother could have authorised a deprivation of liberty but not when she became 16 or was made subject to the care order; the law has subsequently changed. The use of the deprivation of liberty process is an option for a child under 16 who is the subject of a care order but does require an application to be made to the relevant court under the Children Act 1989 for authorisation of this under the inherent jurisdiction of the court.

173. The evidence from this review is that the law in regard to restricting the liberty of young people is not sufficiently understood by practitioners working with children.

4 Findings for learning and improvement

174. This section of the report summarises the learning about systems, services and practice to emerge from the review and concludes with recommended action.

175. Key learning from the review includes;

a) Self-harm is the second most common cause of death among young people; it is an important and visible signal of distress needing sensitive and informed handling as demonstrated by individual professionals in this case; it also requires effective measures for identifying, recording and understanding the circumstances and drivers for any escalation over a wide spectrum of behaviour from occasional self-scratching through to behaviour that can be lethal, whether intentionally or not;
b) Self-harm is increasingly a behaviour that professionals across many different services will encounter and more frequently; their response is important in making a difference; early recognition and response is an essential part of preventative strategies that can assist in reducing progression to more serious harm; the support that can be provided by places such as schools is important; all non-specialist professionals need to feel confident and be part of wider well-coordinated multi-agency arrangements when self-harm is representing significant harm to the child;
c) Asking about self-harm does not increase the behaviour; gaining insight to the child's world and the contributory factors for their distress are a vital part of understanding and mitigating risk and developing effective help and in more serious cases of self-harm requires therapeutic as well as empathetic talking;
d) An overview of the child and their family history and their life story and updating a chronology and overview of their self-harming and other risks are critical to understanding underlying drivers and being able to identify escalation or changes in behaviour; this will require coordination between different people and places who have knowledge of different incidents;
e) The 15-19 age range is a particularly critical stage for managing transitions for all children and especially for the minority who are presenting with very complex levels of needs; frameworks and pathways for responding to children with complex needs should prevent 'fault lines' for example based on age and be promoting continuity of key relationships; the impact of transition protocols for older adolescents and deficits in transfer of knowledge at critical points of transfer disrupts the work of individual practitioners as found in this case;

f) Developmentally sensitive and risk-proportionate approaches are required with the objective of detecting difficulties and the drivers of self-harm;
g) Individual professionals need effective mechanisms to escalate their concerns about individual children when the quality of care or the significance of the child's self-harm is causing enhanced levels of concern; this requires effective joint working arrangements between mental health and social care professionals for assessment, care planning and accessing timely and appropriate services rather than parallel processes and pathways; co-located people can enhance such arrangements involving different services;
h) The strategic development of specialist services and individual case management require appropriate leadership; service leadership should be at a senior level and bring together paediatric and psychiatric services;
i) Individual case management; communication, integration and common leadership at individual case management level of assessment and care planning is particularly important when there is an interface between child and mental health law and services; nominating a lead professional who has the overview of risk assessment and the capacity to co-ordinate the activity of multi-agency interventions has merit;
j) The role of community based CAMHS is critical and comes within the scope of local commissioning arrangements; those should be guided by clear recognition of the significance of self-harm, reflect joint strategies that involve the local authority and ensure that community and multi-agency responses to self-harm are clear and supported with appropriate activity and resources;
k) Understanding of law in the use of restrictive practices to control risk is essential to prevent fundamental and important breaches and requires greater attention to collaborative practice with young people and their families; this includes recognition of family and carers needs and the use of advocacy to promote clear understanding between the child, family and people trying to help;
l) Investigation and management of adults who pose a risk to children in regard to CSE require prioritisation; processes that are delayed and do not control the behaviour and potential risk of an alleged perpetrator leave victims vulnerable and less able to engage in support and therapy.

176. The key findings are designed to offer challenge and reflection for the local safeguarding children board and partners that is informed by a systems based framework developed by the Social Care Institution for Excellence (SCIE). It is intended to consider the conditions that can help conscientious practitioners do their work effectively.

177. In providing the recommendations, reflections and challenges to the Blackburn with Darwen Safeguarding Children Board there will be an expectation that there will be a formal response to the key findings by the respective partners.

4.1 Cognitive influences and the child's voice in processing information and developing plans;

178. Young people between the ages of 16 and 18 years are going through significant change and are potentially at their most vulnerable emotionally and psychologically, exacerbated if as in this case they are dealing with additional sources of significant trauma. Local policy and practice needs to be focussed on how services can truly reflect child focussed help and support at this critical stage in human development.

179. Adolescence (and puberty) is accompanied by significant physical, psychological, and emotional changes. Its association with brain maturation and physical growth and its effects on health and wellbeing are profound and sometimes paradoxical. It has been viewed as a point of maturing out of childhood-onset conditions and in part explains the distinction made at 16 years for children to be treated more as adults in terms of their access to services (as well as acquiring important legal rights and recognition such as mental capacity and consent to treatment). Adolescence and puberty has relevance for child mental health with the rise in psychosocial disorders of young people. It marks a transition in risks from depression and other mental disorders, psychosomatic syndromes, substance misuse, and antisocial behaviours. It is a peak time when young people are at a higher risk of psychosocial problems at the point in their lives when they are also grappling with a broad range of cultural and developmental changes. For children who are finding this stage in their life difficult and disruptive, they will be particularly vulnerable and less able to engage. How they are processing and dealing with changes from within themselves alongside changes in their external world and dealing for example with sources of stress or trauma can be manifested in their behaviour.

180. Children and young people who have experienced significant adversity and damage in their childhood are likely to have ongoing needs into young adulthood. Using measures such as chronological age rather than emotional or psychological development to determine access or denial to services or to key worker support is more likely to create the latent conditions in which people are ill equipped to develop the quality of child focussed response necessary.

181. Children and young people face many barriers in being able to talk about their feelings and problems which can feel overwhelming; this reflects many

different factors including confusion and turmoil, an absence of vocabulary to give description or voice to emotions as well as feeling that nobody will understand or take it seriously. All of the people who worked with Lola Grace did see self-harm as a serious issue. Developing the opportunity for children who are evidently in great distress to express their feelings and wishes beyond the evidence for example of going missing or self-harm. Although there was evidence of conscientious practice by people wanting to encourage Lola Grace to talk, the opportunities to do this within the framework of talking therapies was limited outside of T4 provision.

182. Self-harm generates powerful feelings that can complicate how people communicate with each other and process information. It influences communication between families and professionals as well as between different practitioners. Parents, along with some professionals without specialist knowledge and training, can feel powerless and at a loss about what is best to do for a child who is self-harming at the level that Lola Grace was.

183. Many families of children who self-harm have reported feeling that they are being blamed or feel a stigma that they have a child who wants to injure them self. It creates an additional barrier that can undermine communication and engagement particularly if a family have already been dealing with other adversity and difficulties that have brought them into contact with services previously as was the case for Lola Grace and her family.

184. Young people feeling involved and consulted is particularly important in regard to areas of risk such as self-harm. Young people value collaborative working which balances power, can develop trusting relationships, and can facilitate therapeutic sharing of responsibility. These emotional aspects of self-harm management are more important than medical or physical treatment procedures and were so problematic in achieving with Lola Grace. Clear communication between professionals, children and families as well as between different professionals and organisations and a caring and sensitive approach from all professionals is essential. Feeling out of place on paediatric wards, delays or waiting times to access specialist psychiatric help and families feeling left out are issues highlighted for example by Young Minds.

185. Legislation and national guidance promotes the use of advocacy particularly when children are subject of child protection arrangements, are looked after, are subject to assessment and treatment under a section of the Mental Health Act or want to make a complaint. Advocacy is not a substitute for help such as talking therapies. An advocate works for and with a child or young person to help ensure that their views, wishes and feelings are sufficiently understood. Advocates can be drawn from a wide variety of backgrounds; an essential quality is being able to achieve the confidence and engagement of

the child or young person and to be seen to be not acting on behalf of any agency.

186. An advocate can offer advice and support to a child or young person. The main purpose of a child advocate is to enable children to express their wishes and feelings. The aim of child advocacy is to encourage empowerment of children and uphold their human rights for example when action is considered necessary to control their freedom of movement. An advocate can make sure a child or young person's wishes and feelings are known, can attend decision making meetings with the Local Authority or school on behalf of a child or young person, help to uphold a child or young person's legal rights and ensure they are fairly treated, provide impartial information to the child or young person, prepare meetings with social workers for the child or young person, assist the child or young person in making a complaint in a constructive and effective manner, negotiate with social workers and other relevant people, ask questions to relevant people and speak on the child or young person's behalf.

4.2 Responding to incidents and information about self-harm

187. Self-harm is a wide spectrum of behaviours found in children and adults. It can be one off or lower risk activity such as scratching through to some of the more lethal behaviours that Lola Grace developed to deal with very painful thoughts and feelings. The point has been made that self-harming behaviour is increasingly an aspect of child behaviour that people working in the organisations represented in this review will be dealing with on a regular basis. Professionals across the board need to be able to recognise and sensitively respond to self-harming behaviour.

188. Physical interventions are not effective beyond dealing with immediate threats to safety such as standing on motorway bridges or being on railway lines for example. Understanding the triggers and underlying reasons for the need to self-harm and being able to discern the factors that represent risk and escalation of risk as well as any protective factors and being able to develop the crucial relationships of support based on collaboration and consistency have to be the objective.

189. Clearly there is a distinction between what different professionals are expected to do. A police officer for example is not expected to deliver therapeutic counselling but is expected to ensure that self-harm is recognised, that the circumstances in which it has occurred are appropriately recorded and that effective referrals are being made with an appropriate indication of risk. Social workers will be expected to conduct assessments that are based on a competent understanding about self-harm and be in a position to work with other specialist practitioners in developing the most

effective forms of help and intervention. Hospital and community CAMHS will be expected to provide effective advice and insight and be able to coordinate activity and services that reflect formulated understanding in collaboration with people such as social workers. Schools and primary health professionals are most likely to see early signs of self-harm and will often need to be part of longer term programmes of help.

190. All of the research and guidance that has been referenced for this report emphasises the importance of any response to self-harm getting beyond treating physical symptoms and identifying and developing a response to the underlying drivers for the behaviour.

191. Training expectations as outlined in NICE guidance are that clinical and non-clinical staff who come into contact with people who self-harm have a sufficient understanding to provide compassionate and informed care (NICE, 2004, 2011). Although training was discussed at various times particularly in relation to placement arrangements, several of the carers reported that they had not had that input or felt insufficiently prepared.

192. Training should teach how to recognise and respond to self-harm, including assessment and management approaches. It should include education about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes. Training should specifically aim to improve the quality and experience of care of young people who self-harm. The people who provided family based or residential day-to-day care for Lola Grace outside of T4 units did not have specific training or dedicated support for responding to Lola Grace. Several of the carers have reported that they did not know the extent of Lola Grace's self-harm.

4.3 Tools and frameworks to support professional judgment and practice

193. The law provides important duties and responsibilities on statutory organisations to protect children under 18 from significant harm and to promote their continuing development and well-being. The law and respective standards of professional practice expect a good understanding of how for example issues of consent and mental capacity are applied as children grow into adolescence. Child safeguarding frameworks are intended to guide professional practice and decision making when children are at risk of significant harm and to prevent the impairment of children's health or of their development and to ensure that they have safe and effective care. The safeguarding framework provides the structure for the sharing and for the analysis of critical information that has an impact on the safety of a child, and for this to guide decisions in regard to how a multi-agency response is developed, and for it to be supported by a core group of people working directly with the child, and where relevant, their family.

194. These frameworks were not used to guide important decision making especially after Lola Grace became 16. For example, there was no referral from the AMHT following any self-harming incident. There was little evidence of consultation with the respective lead safeguarding professionals in organisations regarding Lola Grace's self-harm or from CSE. Critically, the developing disengagement between many services and Lola Grace was never identified as a very significant source of risk. Some of this reflects a common understanding that the safeguarding frameworks are primarily designed to protect children from abusive care giving.

195. Only one agency made reference to use of a self-harm pathway to guide their practice and decision making; this was the provider of the community CAMHS. The Pan-Lancashire LSCB procedures[22] on self-harm and suicidal ideation include reference to the local care pathway and provides summary advice on how to respond to self-harm. It also includes a matrix of related risks associated with self-harming behaviour and suggested action. The guidance acknowledges that self-harm is a coping mechanism but does not provide advice or reference to self-harm that should be indicating significant harm or is escalating. There is no reference to how multi-agency information sharing and assessment will be managed. It has to be said that national safeguarding guidance is largely silent on this as well.

196. Using a structured framework for collating information about self-harm for example into a shared chronology, understanding the child's and their family's history and story improves the overview of patterns and drivers of risk and the ability to escalate the response of respective services. This is not an argument that a child protection plan for example should be an automatic or is an effective response to self-harm, or that such a plan would in itself address the gaps that are identified. Making a clear statement that the enhanced or increasing risk of significant harm to a particular child is recognised and that it needs addressing through a multi-agency response is a starting point to developing child specific strategies and plans.

197. The T4 assessments of mental health for example identified unresolved childhood trauma, a history of sexual abuse, the significance of leaving school and the very significant relationship with the school counsellor, the wider family history of self-harm and suicide and the absence of therapeutic work outside of the T4 units.

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[22] http://panlancashirescb.proceduresonline.com/chapters/p_self_harm.html?zoom_highlight=self-harm

198. The mental health assessments and the Children Act assessments could not identify (or omitted to discuss) any strong protective factors and the feelings that Lola Grace had about hopelessness (for example in reporting further contact by males) and feeling generally let down, which were significant aggravating factors for risk. The use of parallel frameworks under children's and mental health legislation and associated guidance exacerbated the absence of overview for individual practitioners. Neither process was linked sufficiently with developing a more effective response and strategy in regard to sexual abuse and exploitation.

199. Judgments involving risk as it relates to individual children such as Lola Grace have to demonstrate reasonableness and competence about how judgments and decisions are made taking account of legal and professional standards and ensure that appropriate treatment and care is provided at all stages involving community and inpatient services.

200. The Royal College of Psychiatrists (RCP) summarise recommended practice acknowledging that it is important to identify the underlying causes or triggers for the self-harming behaviour[23]. Intervention should be tailored to the needs of the specific young person and should be a collaborative process (rather than being reliant on restrictive or controlling practice). The aim should be to reduce self-harming behaviour, reduce risk and to identify the underlying difficulties.

201. Lack of knowledge about permitted circumstances under which children can be subject to control and restrictions, even when there are legitimate concerns about the safety of the child, are highlighted by this review. In particular the implication of legislation and of case law as it applies to deprivation of liberty and the circumstances under which a court must be used to seek authority. Allied to an understanding of law is the need for practitioners to have appropriate training and support to minimise risk averse practice and decision making when working with complex needs and behaviour. Earlier sections of this report summarised how coercive or overly restrictive measures can have adverse consequences in regard to securing engagement by the child or young person.

202. The effort to prevent Lola Grace from harming herself became a cycle of increasing restrictions and supervision of Lola Grace. Some of this practice was not compliant with important legal requirements particularly after Lola Grace became 16. Although there were discussions about for example whether the deprivation of liberty processes applied to Lola Grace's circumstances these were never adequately resolved. Although the law and professional standards expect all professionals to take whatever measures

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[23] https://www.rcpsych.ac.uk/files/pdfversion/CR192.pdf

they feel are necessary to protect a child from immediate harm, the law and common professional ethics do not support or endorse practice and decision making that does not comply with the relevant law and codes of practice. Taking measures for example to prevent a dangerous and immediate act such as jumping from a height is justifiable; engaging in care practices that amount to constant supervision and restriction of movement without appropriate legal authority and in an approved care setting is oppressive and illegal. It is not clear that this was clearly enough understood by key professionals. The President of the Court of Protection makes clear in a letter published jointly in February 2014 with the National Director Social Care Ofsted to providers of children's homes that orders of the Court of Protection authorising a deprivation of liberty should not be sought or be made or be relied upon to permit children's homes to act in breach of the Regulations that apply to them[24].

203. Care placements (as distinct to hospital in-patient care) used to working with children and young people exhibiting high risk behaviour require additional training or support to assist in providing care for the child and to help understand the behaviour and how to provide a response. They also need to have full histories and information about emerging issues associated with risk.

204. Providing care and treatment to children in a specialist controlled access hospital such as a T4 CAMHS unit under any circumstances and especially as a measure of helping them to recover mentally and physically is always going to be a time limited measure and carries with it an element of risk for example from contagion of other self-harming young people.

205. The use of the controlled setting of the T4 unit can never be a long term solution. In the words of Hale LJ regarding a non-related deprivation of liberty judgment, 'a gilded cage is still a cage' (P v Cheshire West). The law requires professionals to make balanced judgments between keeping a child safe and not depriving them of their liberty indefinitely. The very process of depriving a child of their liberty in conditions where they might observe other children with levels of extreme need and distress also represents considerable risk for example from contagion with other young people who self-harm.

206. The absence of any effective talking or therapy being achieved for Lola Grace is a significant issue. This does not mean that it could have prevented the tragic circumstances of Lola Grace's death but it would have created a far

[24]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/381207/Deprivation_20of_20liberty_20_20guidance_20for_20providers_20of_20children_E2_80_99s_20homes_20and_20residential_20special_20schools.pdf

stronger opportunity for Lola Grace to have developed safer strategies for dealing with her internal stress. The fact that it did not happen is partly attributable to people waiting for Lola Grace's home circumstances to be more stable and enduring. To paraphrase Voltaire's aphorism, this could be described as perfection being the obstacle to doing the right thing. Any plan to move children from their birth families is fraught with risk and particularly for older children with established relationships and networks. Matters were exacerbated when Lola Grace had to transfer from community CAMHS to community adult mental health services that not only required yet another set of new people to become involved but represented a different ethos and models of working that arguably were incompatible with a child as vulnerable as Lola Grace.

4.4 Management and agency to agency systems

207. Corporate parenting is understood by government and by professional organisations to describe how local authorities in conjunction with partner organisations such as criminal justice, education and health approach their responsibilities to children who are looked after.

208. Local authorities are under a duty (section 10 of the Children Act 2004) to make arrangements to promote co-operation between 'relevant partners' with a view to improving the well-being of children in their area. This should include arrangements in relation to looked-after children and care leavers such as Lola Grace. Local authorities are required to consider the implications of how they take account of the corporate parenting principles, especially the need to help achieve access to services, when they make arrangements under section 10 of the 2004 Act. Section 10(5) of the 2004 Act places a duty on relevant partners to co-operate with the local authority in the making of these arrangements, thereby promoting and ensuring a joined up approach. The guidance[25] (p17) refers for example to one local authority that has worked with local mental health services in order to respond to the mental health needs of looked-after children and care leavers as they make the transition from care by extending the service to care leavers up to the age of 25 years.

209. The learning from the review in regard to accessing and co-ordinating access to specialist help and services review has implications for commissioning, procurement and organisation of care and support for children presenting with the complex level of need represented by Lola Grace's circumstances. Access to therapeutic advice, support and supervision

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[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683698/Applying_corporate_parenting_principles_to_looked_after_children_and_care_leavers.pdf

for practitioners working with children who are presenting with higher levels of risk associated with self-harm; this includes mentoring or support to a multi-agency team working with very vulnerable children.

210. NICE guidance[26] describes how transition arrangements should be developmentally appropriate, and take account of a range of factors including cognitive maturity. It should not be driven by strict chronological determinants. The guidance is explicit in stating that transfer should not be based on rigid age thresholds and should take place at a time of relative stability for the young person (para 1.2.3).

211. Although transition stress was a significant factor there are apparent gaps indicated in regard to responding to the complex needs represented by Lola Grace. At more than one point there was reference to people needing to develop bespoke packages or to identify a therapeutic family based placement for example.

212. An analysis of the gap is indicated to identify and to respond to the needs of young people who are presenting with multi-dimensional safeguarding concerns such as those associated with higher risk self-harm, suicidal ideation and sexual exploitation. The analysis should be informed by local and national professional understanding as to what type and range of resources are most beneficial; these include sessions of talking therapy with elements of cognitive–behavioural therapy (CBT), problem-solving therapy, psychodynamic treatments or family therapy (NICE, 2004, 2011). Dialectic behavioural therapy (DBT) shows promise for repeated self-harm. These were examples of therapy identified in assessments for example at the tier 4 units.

213. It is also often important to involve family members to facilitate the young person's recovery and to acknowledge the support needs that parents or carers may have since self-harm is often very stressful for the young person's family. These and others are discussed in formulations for example but were not implemented outside of a T4 hospital. Potential gaps include the capacity and timescale for offering therapeutic talking and family based interventions and support as part of the third tier of local CAMHS provision through to developing alternative options to using in-patient fourth tier hospital based care. This group of young people is a relatively small proportion of the local child population although they represent a disproportionate level of risk to themselves and in regard to the deployment of financial and professional resources. Given the numbers of young people are proportionately relatively small in individual local authority areas, there may be merit in collaborating

[26] Transition from children's to adults' services for young people using health or social care services. NICE guideline Published: 24 February 2016 www.nice.org.uk/guidance/ng43

with other local area commissioning arrangements with NHS England. Some of the people who had day-to-day care of Lola Grace reported feeling unprepared for knowing how to respond to Lola Grace. Some of the formal assessments of Lola Grace outside of the specialist T4 units suggest that further work on awareness and professional practice in response to self-harm was an area for development.

214. The NICE guidance encourages the development of a joint mission statement, transition and information protocols that include agreed approaches to practice. This should also include clear arrangements for sharing safeguarding information.

215. A key message from this review is the need for services to have the flexibility to offer continuity of assessment and care that minimises potential barriers between the young person, their family and professionals and can promote effective coordination between the different organisations and services. The NICE guidance encourages the policy and practice of helping the young person identify a single practitioner who should act as their 'named worker' to co-ordinate their transition care and support. The NICE guidance describes how the named worker can be someone who has a meaningful relationship and a professional background that reflects the primary needs of the young person; it can be an education, health, social care practitioner. This cannot be achieved by the unilateral practice of any individual professional or without clear and effective leadership of work with individual young people. In a climate where all services are facing a variety of resourcing challenges this is no easy task.

216. At the second learning event for the serious case review there was some discussion about the creation of a complex case co-ordinator able to work across different agencies, and the value of having a multi-disciplinary team drawn from education, health and social care backgrounds. In order to carry out the function of a named worker or a lead professional effectively it would require the skills and time to undertake the level of work.

217. The extent of Lola Grace's needs would have been a challenge for the most experienced of practitioners; some of the key roles fell to people at a relatively early stage in their professional career and development. Several of the professionals were dealing with very heavy workloads. An example is the deputy team manager for the adult mental health team who was supervising 20 different practitioners, and in addition to operational management responsibilities also was an approved mental health professional for the borough.

218. Good corporate parenting is achieved through effective multi-agency arrangements and practice. The extent to which individual key people are able to influence or to have oversight of arrangements, and when necessary

to escalate or to challenge have limitations. Examples include the IRO who has a role when children come within the scope of looked after arrangements or CIN but not in regard to health arrangements and the role of the care coordinator whose focus is on community mental health arrangements. The respective organisations who constitute being a corporate parent need to promote and support the effective functioning of these and other people in delivering effective mental health care and services to children and young people in the community in collaboration with the local authority and this appears to also require development.

219. The information in from this individual review indicates that the independent return from missing interviews are not being consistently completed, that incidents tended to be processed in isolation rather than assessed cumulatively, are not being used effectively enough to help develop risk strategies for individual children or being aggregated and collated to help identify potentially risk hotspots associated with self-harm (parks, railways and motorway for example).

220. Government guidance[27] requires an independent return interview to be undertaken within 72 hours of a child or young person returning as an opportunity to uncover information that can help protect the child from the risk of going missing again, the risk that they have been exposed to whilst missing or other sources of risk. This is intended to be an 'in-depth interview' and should be carried out by somebody who is independent of the child and is trained to carry out the interviews, and is able to follow up actions resulting from the interview. Guidance describes specific circumstances which includes children known to be at risk of sexual exploitation or who are frequently away from their placement. The interview is in addition to any immediate 'safe and well' check that is made for example by the police. The guidance expects children's services and the police with other relevant parties to work together to build up a comprehensive picture of why the child is going missing to understand the various 'push and pull' factors and the nature of risk. The guidance also describes expectations in regard to sharing and analysing information to identify patterns of behaviour to help for example to identify hotspots of activity in the local area. It also helps identify if there are particular homes or placements children are regularly going missing from home.

221. Information provided at the second learning event in particular suggested that there was under recording of professional decision making and practice. There was for example more work being undertaken in response to the CSE

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[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

than had been reflected in the written information from agencies. It remains the case that there were delays in the criminal investigation and decision making. In regard to improving the response to allegations and disclosure about child sexual exploitation, the CPS have implemented arrangements for early consultation between the police and CPS lawyers. Information provided at the second learning event described in the previous chapter involving CPS and the police is intended to improve the response. Monitoring the level and adequacy of improvement will determine whether further measures are needed. Based on the evidence from this review, further work on ensuring information sharing about incidents and perpetrators is sufficiently systematic should be considered.

222. Bereavement was a significant factor in Lola Grace's life. Practitioners at the second learning event spoke of the importance of bereavement support for children and for adults including professionals. Written guidance describing post incident support and help in identifying ongoing risk for children or young people effected by the bereavement would establish consistent responses and routes to service and support.

5 Implementing learning from the review

Individual agencies have identified learning for their own services as a result of participating in the serious case review. The focus of the overview report is on multi-agency learning and strategy. The BWDSCB should endorse the examples of good practice highlighted by the review in any dissemination of messages and learning from the review.

1. How effective are the **BWDSCB partner agencies'** arrangements for ensuring that they have sufficient information and understanding about the nature and extent of child self-harm in their local area? How do **BWDSCB partner agencies** satisfy themselves that the measures for evaluating the quality of commissioning and the capacity of local services to provide appropriate and effective help in response to children and adolescents who self-harm are good enough?
2. How can **the BWDSCB** partner agencies encourage improved access to advice, help and support for children who are self-harming and/or require mental health support based on cognitive and developmental need rather than chronological age? What information should the **BWDSCB partner agencies** receive about policy, commissioning or practice?
3. How can **the partner agencies of the BWDSCB** encourage improved continuity of relationships and care coordination for children and families effected by self-harm that causes, or represents a risk of, significant harm to that child?
4. How can **the BWDSCB partner agencies** ensure that there is sufficient understanding of the application of relevant law as it relates to the deprivation of liberty in the protection of children from significant harm?
5. The **BWDSCB partner agencies** should develop a local multi-agency child self-harming framework that sets out strategy and provides operational procedures to guide professional action and decision making in developing responses to significant, escalating or higher risk self-harm.
6. **The BWDSCB** should ensure that a copy of the overview report is provided to the commissioners of local CAMHS and invite a formal response to the findings.
7. **The BWDSCB** should ensure that a copy of the overview report is provided to the health and well-being board and invite a formal response to the findings, particularly in regard to the overall strategies for reducing the lethal impact of self-harm, and to consider what further measures are indicated for bereavement support.
8. **The BWDSCB** should seek further information about the effectiveness of current arrangements for the recording and collating of missing from home interviews and the extent to which the arrangements are sufficiently focused

on identifying risk to individual children and assisting in strategic mapping of need and potential sources of risk.

9. The **director of children's services** with **NHS England** should consult with their peers in Lancashire regarding the merits of developing a model of sub-regional commissioning of specialist care providers for children at risk of hospital based treatment or as part of post hospitalization care.
10. **The director of children's services** should review and report back to the BWDSCB on whether there is sufficient capacity to provide advocacy support in line with national guidance and legislation and to meet the complexity of need represented by this case.
11. **The CPS and the police** should provide information to the BWDSCB about their joint arrangements for monitoring the impact and effectiveness of revised working arrangements to avoid undue delay to the processing of decisions in regard to allegations of child sexual exploitation.

6 The methodology and terms of reference

The methodology to complete this SCR involved the following processes:

- Chronology of events from agencies;
- Agency reports to analyse practice and identify single agency learning; and
- Two learning events with involved practitioners and report authors to clarify the 'what', focus on the 'why' and 'learning' from the case. Practitioners along with commissioners of services will participate in identifying the learning for the review to create lasting improvements in services and practice.

Information from the chronologies, agency reports and learning events informed the independent author's serious case review report.

Family members were invited to contribute their perspectives of how services were delivered and possible learning for agencies through meetings with the Lead Reviewers.

The above methodology was conducted in line with requirements set out in Chapter 4 (paragraphs 9 to 11) of Working Together to Safeguard Children (2015).

Generic Terms:

- Understand precisely who did what for Lola Grace and the underlying reasons that led individuals and agencies/services to act as they did;
- Establish if there are lessons to be learnt about the way local agencies and services within these agencies worked together;
- Review of individual/agency adherence to agreed agency and multi-agency policies and procedures; and
- Inform and improve local inter-agency practice on safeguarding children so that it leads to reducing the risk of future harm to children.

Specific Terms:

- Were indicators of unmet need, risk and/or compromised parenting appropriately identified by practitioners through incidents, assessments and any disclosures? The indicators should include, but not limited to, self-harming, suicidal ideation, Child Sexual Exploitation (CSE), missing from Home (MFH) and familial mental health difficulties.
- How effective were service responses to promote the child's welfare? Were transitions (between workers, between teams, between placements, between child and adult service provision and between phases in education provision) effectively managed to ensure continuity in service provision to meet the unmet need and risk factors?
- Were risk management plans reflective of statutory responsibilities including statutory responsibilities required to authorise a deprivation of liberty?

- Identify how your agency understood the lived experience of Lola Grace and sought her wishes and feelings to inform service responses.
- How effective was the role of management oversight at all levels in agencies in enhancing the quality of practice?
- Identify any issues in regard to the capacity or availability of resources across agencies.
- Can any actions in retrospect be identified that lead to better services for families?
- Identify any examples of good practice.

Agencies who provided information to the serious case review

1. The following agencies have provided information and have participated in the learning events for the serious case review:

    a) British Transport Police (BTP); had four contacts with Lola Grace between September 2016 and November 2017 although had direct contact with Lola Grace on only three of those occasions, the fourth being dealt with by Lancashire Police who notified BTP and concerned Lola Grace assisting a friend with suicidal ideation; on two of the occasions the BTP officers used their powers under section 136 of the Mental Health Act 1983 to take her to a place of safety for a mental health assessment; the BTP implemented a suicide prevention plan (SPP) following the first incident in September 2016 that ensured contact with mental health and specialist safeguarding staff for information sharing and to guide decision making by BTP officers; BTP provided a copy of the plan which had not been shared with other services prior to the review;

    b) Children's Services (Social Work, Placement, Review & Quality and Engage Teams), BwDBC; had first contact with Lola Grace's family in 2001 in regard to older siblings; Lola Grace was subject of a child protection plan under the category of neglect from July 2010 until September 2011 when the plan was stepped down to a child in need (CIN) plan until May 2012. In September 2014 referrals were made in regard to an older sibling who was missing from home and was the victim of rape; Children's Services' involvement with Lola Grace specifically began in February 2015; by the time of this first involvement there had been two previous self-harm incidents at home; arrangements for Lola Grace to be looked after, care proceedings and leaving care support; the service also provided documentation that included copies of three assessments, notes of CIN meetings and CIN plans, copies of eight LAC reviews and copies of ten placement plans and copies of the CSE risk assessments and three CSE plans;

    c) Children's Services (Virtual Head, Education), BwDBC; statutory service for looked after children and care leavers providing oversight and referral to additional services to promote the looked after child/care leaver's

education and economic wellbeing outcomes; the service was provided from the Autumn Term of 2015 ensuring a Personal Education Plan (PEP) was in place and utilising additional pupil premium funding to provide additional education activities; the service provided copies of the personal education plans (PEP);

d) Clinical Commissioning Group (GP NHS services); provided primary care services through the GP practice; the CCG also commission services in the acute trust like CAMHS, paediatric liaison & LAC health assessments;
e) Crown Prosecution Service (CPS) provided a chronology of contact and communication with the police in regard to the referral and review of evidence and participated in the second learning event;
f) Davlin House provides semi-independent supported accommodation for young people aged 16-18; Lola Grace was living there from October 2017 until her death;
g) East Lancashire Hospitals NHS Trust (ELHT) provides emergency/urgent care centre, paediatric wards, East Lancashire Child & Adolescent Mental Health Service(ELCAS); between 2015 and her death Lola Grace presented with suicidal thoughts, self-harm and attempted suicide on 22 occasions which required 13 admissions to hospital. In February 2015 Lola Grace was referred to ELCAS following presentation at the hospital emergency service and admission to hospital. She had the support of a key worker until her transfer to adult mental health services at the age of 16; there were two referrals for in-patient mental health assessment at out of area T4 units neither of which diagnosed a mental health disorder or illness but highlighted how Lola Grace's behaviour was more about her emotional response and processing of trauma and adverse childhood experiences;
h) Fostering Solutions an independent fostering agency (IFA) initially received a referral to provide a foster care placement in April 2015 but were unable to identify a carer to match Lola Grace's needs; the agency received a second referral and provided a foster care placement in Burnley from May 2016 until August 2016; the foster carer provided additional information through a face-to-face meeting with the chair of the panel and the safeguarding development manager in July 2018;
i) Lancashire Care Foundation Trust provides services at universal, universal plus and universal plus partnership levels. Universal services and universal plus services for Lola Grace were provided through school nursing and children and young people's well-being network. More specialist support was given through T4 CAMHS. After Lola Grace became 16 and transferred from CAMHS to adult mental health services, support was through the community mental health team and mental health liaison team (hospital assessments). Lola Grace was a voluntary in patient at the first T4 unit from April 2015 to 7th July 2015 and January 2017 to February 2017 and a third voluntary in-patient admission to the second T4 unit June 2017 to July 2017. The Trust conducted a Serious Incident Review in 2018 and provided a copy of the report. The Trust also provided

other documentation including copies of minute of CPA review meetings, psychological assessment and formulation;

j) Lancashire Constabulary had little involvement with Lola Grace or her mother prior to 2015 but were parties to the child protection plan for the children between May 2010 and September 2011; they were aware of Male 2 in relation to drug offences; the police first became aware of Lola Grace in February 2015 when they responded to a report that Lola Grace had sent a picture of herself holding a knife to her body and expressing suicidal ideation; they subsequently responded to concerns about child sexual exploitation, self-harm and missing from home incidents culminating with the investigation of Lola Grace's death;
k) Legal Services, BwDBC provided legal advice and representation for the local authority in care proceedings that began in February 2016; the service also provided advice in regard to other matters including the implications and legal requirements associated with aspects of Lola Grace's care arrangements representing a deprivation of liberty;
l) NHS England (Commissioning of inpatient T4 mental health services & transitions of child mental health services);
m) Paramount Care and Safety Ltd; provided a 28 day care placement in North Wales in August 2015, a residential placement from September 2015 to May 2016, Lola Grace returning to the placement from October 2016 until October 2017;
n) Public Health; are the commissioners of the school nursing services and lead on the suicide and self-harm strategy;
o) School; Lola Grace transferred to secondary school in September 2012 and for the first two years (year 7 and 8) appeared settled with no indicators of additional needs or particular difficulty; attendance was good in Year 7 but decreased in the following year although in year 8 the majority of her attendances were authorised such as for illness; in February 2015 the school counsellor who provided a self-referring service to students in the school began having contact with Lola Grace; this was a significant and consistent relationship of individual support for Lola Grace and was only brought to an end when Lola Grace left secondary education; Lola Grace was a popular member of the school and participated in a range of extracurricular activities which included dance, gymnastics and choir; from year 9 Lola Grace was beginning to achieve less well and additional support was organised; between 2015 and 2017 Lola Grace presented with levels of distress that included instances of self-harm, running off from school, talking about ending her life, bringing tablets into school;
p) Youth Zone; provides a youth hub located at the heart of Blackburn, open to young people aged 5 to 19 years old providing after school and school holiday activities. This was a service that had some of the best levels of engagement with Lola Grace from February 2016.

2. Other services who have provided information for the review include;

a) CAFCASS;
b) Child Action North West's Care & Accommodation Services; undertook searches for placements for the local authority;
c) Greater Manchester Mental Health Trust; Male 2's involvement with the agency's substance misuse service;
d) Housing Needs, BwDBC; applications from Male 2 for housing through the homeless pathway;
e) Together Housing Group; tenancy information from the social housing provider to mother and Male 2;
f) North West Ambulance Service;
g) Primary & Junior Schools of Lola Grace;
h) Lancashire Women's Centre;
i) Young People's Services, BwDBC.

7. Summary of care placements and inpatient care provided for Lola Grace

Until March 2015 Lola Grace had lived with her mother and siblings at home. From March 2015 she lived in the following places;

a) End March 2015 to Mid-April 2015 at a local hospital;
b) Mid-April 2015 to early July 2015 at an out of area T4 Unit and subject to the Mental Health Act 1983;
c) Early July 2015 to late July 2015 at home with some respite short breaks at an adolescent support unit;
d) Late July 2015 to mid-August 2015 in patient at a local hospital;
e) Mid-August 2015 for 28 days at a care placement out of area arranged as a voluntary looked after child (LAC) arrangement under the Children Act 1989;
f) Mid-September 2015 at a three day LAC placement at a local adolescent support unit
g) Mid-September 2015 to Mid-May 2016 at a local care placement as a LAC placement; an interim care order was made in February 2016 which meant that the LAC arrangement changed from being voluntary to one of shared parental responsibility between Lola Grace's mother and the local authority;
h) Mid-May 2016 to early August 2016 at an out of area foster care placement with the adolescent support unit and residential care home respite breaks to avoid placement breakdown; the care order was made in June 2016;
i) First week August 2016 to late October 2016 at a local children's home as a LAC placement;
j) Late October 2016 to late October 2017 at a local care placement as a long term care placement;
k) Early January 2017 to early February 2017 in patient at an out of area T4 Unit detained under the Mental health Act 1983;
l) Early June 2017 to mid-July 2017 at an out of area T4 Unit under the Mental Health Act 1983;
m) Late October 2017 to December 2017 in an out of area semi-independent supported accommodation.