Child Protection Committee

South Lanarkshire

Significant Case Review Summary Report

(Ref SLC SCR- 001)

Child A

December 2015

Significant Case Review Summary Report

Introduction

This Significant Case Review was undertaken following the death of a 17 year old Child A on the 29 August 2014 whilst an inpatient in a psychiatric ward in hospital (3). Child A was, at the time, a looked after child through the Children Hearing System. Post mortem report of 9th October 2014 confirms cause of death as asphyxia caused by Child A placing a plastic bag over her head which was secured by a sock around her neck. Death occurred in a wooded area in the grounds of the hospital. There was no evidence of intoxication with alcohol or drugs.

Decision to hold a significant case review

A review group was appointed to consider whether to conduct a significant case review in relation to the death of Child A. The review group included the independent chairs of South Lanarkshire Child Protection Committee, the Adult Protection Committee and senior representatives from the different agencies who had been directly involved with Child A namely education, health, reporter and social work. On 25 February 2015 an Initial Case Review meeting took place. The decision of the review group was to carry out a Significant Case Review because the circumstances of the case met the criteria laid out in section 3.2 of the Lanarkshire Significant Case Review Protocol 2010[1] 'when a child dies and the death is by suicide or accidental death'. A case review can act as a 'window on the system' and plays an important part in efforts to achieve a safer child protection system (Vincent 2004) [2]. It was agreed that the Significant Case Review should focus on learning and reflection around day to day practices and the systems within which practice operates. This approach is in line with the National Guidance for Child Protection Committees for conducting a Significant Case Review 2015[3]. For the purposes of significant case reviews, the Scottish Government identifies a child generally as 'a person under the age of 18'.

It was acknowledged that Social Work Resources had already prepared a report for the Care Inspectorate regarding the death of a child in care and that NHS Lanarkshire had also completed a Significant Adverse Event Review (SAER) report on the incident that took place on the 29/8/14 when the child committed suicide. In view of this the review group concluded that the CPC significant case review would be proportionate and to avoid duplication of effort take into account information contained within both reports. Thereafter the role of the review group was to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development

[1] *Lanarkshire Significant Case Review Protocol* (2010); Child Protection Committee

[2] Vincent, C., (2004): '*Analysis of clinical incidents: a window on the system not a search for root causes';* Quality and Safety in Health Care, volume 13.

[3] *National Guidance for Child Protection Committees for conducting a Significant Case Review* (2015); Scottish Government

of the findings from the review.

The review group decided to appoint Margaret Campbell, South Lanarkshire's lead officer for child protection, as lead reviewer given her inter-agency role, absence of any prior involvement with this case and her experience of conducting similar complex enquiries. She had access to all case records and was able to scrutinise all relevant policies and procedures on behalf of the review group.

To ensure that the group had advice on mental health services an approach was made to the Mental Welfare Commission for Scotland who provided a consultant, Margo Fyfe, to advise the group. She has been able to meet as required with the chair and lead reviewer and provide comment from her perspective and that of the senior MWCS team on the content of the report.

Purpose of the review

- To provide a rigorous, objective analysis of what happened and why;
- To identify improvements which are needed;
- To consolidate good practice;
- To establish whether there are corporate lessons to be learned about how better to protect children and young people;
- To establish how a young person took her own life, despite the best efforts of her parents and those professionals who were closest to her to keep her safe;
- To review single agency and inter-agency decision making and involvement with the family and others relevant to the case;
- To review partnership working to protect children in complex circumstances;
- To understand practice from the viewpoint of the individuals and agencies involved at the time rather than using hindsight.

Time period covered by the review

The review covered the period from September 2009 when Child A first became known to services up until her death on the 29th August 2014.

Remit of the review

- What lessons can be drawn from reflecting on how services manage complex and risky behaviours in young people with emergent personality disorder?
- What lessons can be drawn from reflecting on how risk of self-harm was managed within a hospital setting?
- What resources are available for young people with complex mental health needs?

- What lessons can be learned from reflecting on the intervention of all the agencies involved and was the intervention appropriate?
- What lessons can be drawn from engagement with parents taking into account their perspective of the situation?
- What more can we learn about children presenting with multi-complaints about sexual abuse?

The Review was carried out during the period from June 2015 to November 2015.

Methodology

Established practices for conducting an SCR were used, including reviewing case files and records, development of a multi-agency chronology and timeline of what information was known to whom and when, and considering policies and guidance available to staff during the timescales the review covered. The approach is systems based considering learning about how local professionals and organisations work together, in order to improve inter-agency working and better safeguard and promote the welfare of children and young people. Reference was made to Scottish Government Guidance to CPCs in Conducting an SCR (March 2015) and this report follows the recommended template. Key staff were interviewed either in a group or individually as appropriate. To avoid duplication of effort the review team took into account information contained within the Social Work report to the Care Inspectorate (6/10/14) regarding the death of a child in care and the Health Significant Adverse Event Review report (15/12/14).

Child A's history is complex and it was immediately apparent to the review group that there had been extensive involvement by many professionals over the last nearly five years of her life and detailed records kept. It has, therefore, been necessary to focus attention on those aspects of her history which seemed most relevant, to rely on the written records for information about many aspects of her care and to conduct interviews only where individuals had played a significant part in Child A's life or to further elicit complex issues. This report, therefore, includes only as much detail as required to give an accurate picture of the extent of the work with Child A and to allow sufficient analysis.

Involvement of the family

The family was notified on the 2 March 2015 that an SCR was to be undertaken. On the 27/5/15 the independent chair of the CPC and the lead reviewer met with the parents. The independent role of the Child Protection Committee was explained and the couple advised of the significant case review process. They were provided with a copy of the current South Lanarkshire Child Protection Committee Significant Case Review guidance for information. Child A's parents were also given a copy of the proposed remit of the review and advised to feedback to the lead reviewer any comments or additional actions they may wish to be included during the significant case review. The parents later intimated that there was nothing more they wished to add to the remit.

The contribution of both parents was extremely helpful, both in terms of providing an understanding of what Child A was like, as well as the problems and frustrations they experienced in trying to understand her difficulties and provide her with the help that she needed. The information provided gave a useful insight into the limitations of the services provided to Child A and the differences in the perceptions between professionals and Child A's parents of the expectations and usefulness of the partnership

arrangements that were in place which it was believed would help to keep Child A safe. Child A's older siblings were interviewed on the 9/11/15 and another meeting took place with the parents on the 11/11/15. These meetings provided some insight into how the family dealt with Child A's complex and challenging behaviour and the impact on the family overall.

Acknowledgements

As lead reviewer, I would like to acknowledge the support of the review group and all of the resources and services involved in the significant case review, particularly managers, health staff and practitioners who gave of their time in order to be interviewed. Their co-operation and the information they provided through their open and transparent discussions is appreciated. Those who were involved in the review found the process challenging and they are to be commended for their commitment and fortitude throughout what has been a difficult process. I would also like to thank Margo Fyfe from the Mental Welfare Commission who acted as a critical friend throughout the review.

The facts

Family Background

Child A is the second eldest of a family of five children. There is an older half brother residing out with the family home.

Analysis

Good practice

Throughout the period under review Child A received a very high level of input from local authority social work and education resources, mental health services and funding of a number of costly residential placements. Police responded timeously to a high volume of calls in relation to Child A going missing and investigated thoroughly many allegations of abuse. Overall, the agencies involved with Child A worked extremely hard to support her and almost without exception they saw her as a likeable young person whose behaviour was both complex and challenging, sometimes in the extreme. Over the period a number of strategies had been deployed to engage and work with Child A. Apart from the resources used staff tried different approaches ranging from work sheets and Teen Talk to use of visual images and different venues in an effort to engage more meaningfully with Child A. There was good communication amongst the key agencies working with Child A and staff agreed a common approach of using positive versus negative reinforcement in their dealings with her as well as the importance of de-escalation when crisis occurred.

Early intervention

Child A's behaviour was noted to have changed significantly during her transition from primary to secondary school. This coincided with Child A's first contact with social work services in September 2009, after making an allegation of physical abuse against her father, and her first attendance at

CAMHS in December having been referred by her GP and social work services in October 2009 because of concerns about her behaviour. There was social work and CAMHS involvement to support Child A but no diagnoses made at this stage.

Assessment and child's plan

Whilst an assessment was made that Child A was in need of support and protection, it was not clear what should be in place to meet this need. Finding appropriate services to support and treat such difficulties displayed by Child A was found to be very challenging and, although a need for a consistent approach to her risky behaviours was identified, it was difficult to achieve this. A number of strategies were deployed by agencies working with Child A and various residential placements provided the benefit of 24 hour supervision, but it did not alleviate Child A's behavioural difficulties or self-harming behaviour.

Agencies worked with and involved her family to de-escalate situations. There is evidence of the family willingness to engage with staff from across agencies in an effort to effect change, Child A had access to a number of professionals to call on, however, Child A continued to engage in risk taking behaviour out with the home, which generally necessitated agency responses, be it police, social work or health. Although there was agency discussion regarding not reinforcing negative behaviour, it was not possible to ignore Child A's attempts at self-harm or placing herself at risk.

Different approaches appear to have been used in an attempt to engage with Child A either in the community or residential options when community based resources were not sufficient to meet her needs or keep her safe. The plan remained a community one until this was thought to be untenable due to the degree of risk. This ultimately resulted in secure provision for Child A's own protection.

Mental health assessments

There were a number of psychiatric assessments on Child A after she presented at hospital with self-harming behaviour. There were also several specialist assessments undertaken in relation to Child A's mental health. The diagnostic assessment report dated 15/3/12 prepared for a Children's Hearing refers to Child A as having a mixed disorder of conduct and emotions, Attention Deficit Hyperactivity Disorder (ADHD) and pathologically prolonged grief reaction. She was also found to have traits of an emerging borderline personality disorder (BPD). Child A was later noted in CAMHS reports to have a diagnosis of asperger's syndrome with periods of emotional dysregulation and to be on the autistic spectrum.

There is considerable debate about the diagnosis of personality disorder in adolescence. It is argued, because personality is still developing in teenage years, it is impossible to state with certainty that a young person's personality is disordered. Alternatively, others argue that it is possible to diagnose emerging borderline personality disorder (BPD) on the basis of trait theories of personality (Berger, Bailey 2012)[4]. Child A exhibited a number of traits associated with an emerging borderline personality disorder. Although a formal diagnosis is not usually made until a young person is 18 with BPD for fear of labelling them, formulation can take place to treat the condition until it is formally diagnosed. This might

[4] Berger, J., Bailey, S., (2012) *'Emerging Personality Disorder in Adolescence, Ways of seeing: Ways of being'.* BIGSPD 13th Annual Conference, Manchester.

have been helpful in Child A's case.

There was an attempt to address Child A's mental health issues through Dialectic Behaviour Therapy (DBT). She was placed in a hospital specialist resource (5) in England offering DBT as no suitable resource was available in Scotland. Child A was removed from the programme early on because of a difference in medical opinion about how Child A was being treated as an inpatient in the hospital in England as well as concerns expressed by her family and social work staff about aspects of her care. In response to those concerns Child A was subsequently transferred back to secure provision in Scotland that was not a specialist resource capable of providing therapeutic intervention to address Child A's mental health needs. It is not known, therefore, if DBT might have made a significant improvement in Child A's condition had these other concerns not arisen and she had been able to complete the programme. It is possible that the challenges she was presenting might have been addressed in the longer term. Research has indicated that there are potential risks associated with DBT intervention. The most common risk, which can occur both in outpatient and inpatient treatment, is the reinforcement of problematic behaviours, leading to deterioration in functioning. Young people with borderline personality disorder and a history of childhood trauma may also deteriorate if trauma therapy that involves repeated and/or in-depth exposure to the trauma is embarked upon before their more impulsive behaviours are stabilised (Bradley *et al* 2005)[5]. Child A's behaviour may have deteriorated for the reasons outlined above requiring more intensive treatment rather than the treatment being stopped. This, however, will have to remain speculative. Regrettably there was no other alternative similar resource to which Child A could have been referred.

Research has also indicated that improvements in the symptoms and functioning of young people with borderline personality disorder tends to be gradual rather than sudden and that intervention can exacerbate risk taking behaviour until emotional stability has been achieved. Child A was in the early stages of her treatment programme and there was not enough time to evaluate the effectiveness of the intervention. Some progress was noted in the DBT progress report of 8/3/12 which indicated that although Child A displayed negative behaviours with episodes of self-harm she managed to control the level of self-harming by using the skills she had acquired from DBT. It was felt that the DBT programme would increase the development of Child A's behavioural skills to help her cope more effectively with problems in life and more importantly to accept and deal with stressful situations, non-judgmentally and rationally, therefore, making good decisions during periods of distress which in turn it is considered would minimise her levels of self-harming behaviours.

It is recognised that young people with borderline personality disorder find coping with the developmental challenges of adolescence difficult and consequently struggle to function effectively at home, at school and with their peer group. Those factors were clearly evident in Child A's case. Furthermore, it is acknowledged that the risk of suicide frequently occurs in combination with external circumstances that seem to overwhelm at risk teenagers who are unable to cope with the challenges of adolescence because of predisposing vulnerabilities, such as in Child A's case, emerging borderline

[5] Bradley, R., et al (2005) *'A multi dimensional meta-analysis of psychotherapy for PTSD'*; American Journal of Psychiatry. Feb; 162(2):214-27.

Partnership working

It is noted there was considerable multi-agency liaison and joint working in the case, to share thinking and consider planning. However, Child A was noted to add to her range of risks as she learned which behaviours elicited responses. There was much debate as to whether she could have been abused within her family or even experienced abuse which she had buried and imputed to others.

It is of note that at no time during this prolonged period of intervention was there a gap in service provision. When Child A was involved with children's services there was evidence of strong, coordinated partnership working and regular multi-agency reviews including looked after and accommodated reviews, secure screenings and through the Children's Hearing system. Trying to find a suitable resource to meet Child A's needs was an ongoing challenge throughout the period of intervention.

There was evidence of attempts to deliver good practice in achieving consistency of approach through multi-agency working involving family, social work, health and at times the police and ambulance service. There were some inconsistencies, however, when Child A presented to emergency services or police services outside her local area. In order to try and achieve some consistency in approach her consultant child and adolescent psychiatrist (3) commendably tried to communicate her care plan more widely to these services nevertheless the understanding of the need for consistency in dealing with Child A's behaviour remained patchy. Responses continued to depend on the issues she presented at times of crisis.

Allegations of sexual abuse

It is known that the experience of being sexually abused in childhood is frequently profoundly psychologically and emotionally damaging with traumatic effects. (Horvath et al 2014)[6]. Child A's repeated claims of having being sexually abused were thoroughly investigated but no evidence found to support the allegations made against her father. Police at times actually found information to discredit Child A's claims of familial abuse. However, Child A's repeated allegations of sexual abuse remained an area of concern, albeit with no evidence to substantiate those concerns apart from the incident where someone was charged.

These continued allegations clearly affected work with Child A's parents. Professionals needed to keep an open mind about the possibility of abuse and investigate fully which inevitably put a strain on relationships with the family. From the parents' point of view, it was, of course, very stressful to be frequently put under suspicion and deal with the allegations.

Child protection process

Child Protection investigations were carried out in relation to the allegations of familiar abuse made by Child A. The allegations were investigated fully and no evidence found to substantiate Child A's claims and in some instances evidence was found to disprove her claims. Although there was no evidence to proceed further under child protection which is linked to familiar responsibility and significant harm there was ongoing concern about Child A's suicidal ideation and risk taking behaviour. Social work staff

[6] Horvath, Z., et al (2014), '*It is a lonely Journey'*; Middlesex University London.

continued to deal with the child care concerns highlighted and provided support to Child A and her family through the statutory supervision order in place under the Children's Hearing.

Case management

Child A seemed to respond to structure and consistency which was confirmed by her parents and staff who knew her well. There is also evidence of this from her stay in secure unit (2) and the observations of staff whilst she was resident in hospital (3). However, overall when plans were in place, it was difficult for staff to keep to a consistent plan mainly because of Child A's extreme behaviour often leading to crisis intervention requiring intensive support as well as times secure accommodation or hospital admissions ultimately involving new staff or services. Regular communication between professionals helps to ensure a consistent approach, this was evident when Child A was under children's services but less so during her transition to adult services as there was a change in key staff both in health and social work. In spite of intensive support provided it is not clear who or what service had the lead professional role overall. Although a plan was in place, was Child A's care management being led by a social worker or by a psychiatrist or by whatever institution she was currently in? At different times depending on the circumstances she seemed to be viewed as a mental health case or as a child protection case with the lead switching between psychiatry and social work. The looked after review should have made clear decisions about who should be the lead professional and who should have been responsible for the various elements of the care plan. Whilst undoubtedly a great deal of effort and thought went into managing Child A's case, overall there does not appear to be consistent approach to the management of the case for the reasons highlighted above. Part of this is unavoidable in long term cases since there will inevitably be some change of personnel. It is noted that Child A had 5 social workers, two child and adolescent psychiatrists and two adult psychiatrists over nearly a five year period, however, the impact of this can be minimised by setting out and keeping to a consistent plan.

Planning at adult support and protection case conference

Social work adult services staff were involved in Child A's discharge planning. At an adult support and protection case conference held on the 4/8/14 there was a difference of opinion noted between health and social work staff about future plans for Child A. The views of the parents and social work staff was that Child A should return to reside with her parents before being supported gradually on to independent living. Social worker (4) was of the opinion that Child A should be linked to a care provider who had a good understanding of asperger's syndrome, ensure she had structure/routine, support with her employment (training or educational) and social needs. She also advised that in her opinion Child A could make decisions but lacked any insight into the impact of her actions or the consequences. Adult psychiatrist (1) disagreed with the proposal that Child A should return home because Child A had intimated she did not want to return home. His view was that Child A should be supported directly from hospital to supported living. He also said Child A had the skills/capacity to maintain supported living (with an appropriate provider) where she would be less reliant on her parents. Adult psychiatrist (1) remained firm in that view. Child A did not return home up until the time of her death.

Areas of concern identified at the meeting included Child A's diagnosis of asperger's syndrome and borderline personality disorder, her significant history of self-harming and offending behaviours and her inability to keep herself safe in the community. It was also noted that Child A had been unable to maintain any significant periods of stability and lacked insight into the impact of her behaviour on others. It was agreed that a further multi-agency meeting should be convened on completion of the assessment by Scottish Autism to inform future planning. Given the extent of the concerns, particularly in relation to

Child A's inability to keep herself safe, one is bound to query how realistic any options for community living were and whether this option was being pursued because of the absence of any other suitable facility.

Immediate versus long term intervention

It is evident that all staff involved with Child A and her family regularly assessed and reflected on the issues presented by her including: being disruptive and at times aggressive, lack of engagement beyond a superficial level, pattern of self-harming and increasing risk taking behaviour. Their assessment led to interventions which primarily, and by necessity, were to manage her behaviour and protect her from the risk of further harm. Even when this was the intention this did not happen as she continued to self-harm in what would be considered a safe place such as in secure accommodation or in a hospital setting. Therapeutic interventions were difficult to progress because of the crisis management in order to prevent further escalation. It is known that dangerous impulsivity can be a borderline personality trait. There were brief periods of improvement which were used positively in an effort to take forward the work with Child A, however, she seemed to struggle with this and would quickly regress to the behaviours which were giving serious cause for concern. This was the pattern throughout the period of intervention. Child A appears never to have reached a stage where she was able to fully reflect on her behaviours and the impact on her wellbeing and safety.

When Child A was stable within secure accommodation she was placed back in the community as she no longer met the criteria for secure which led to a vicious circle when she became unwell again. Actions taken at a specific time were to keep Child A safe or avoid a crisis situation. Whilst secure accommodation provided a safe place at times it could not provide the specialist health intervention required to address Child A's mental health needs relating to an emerging borderline personality disorder. In the absence of an appropriate adolescent residential health resource being available, staff worked extremely hard to support Child A both at home, in the community and in other resources. In spite of best efforts, the ongoing challenging of addressing Child A's mental health needs continued to be problematic. Assessment in care planning and management in the longer term were, therefore, difficult to progress

The use of secure provision was intended to keep Child A safe given her serious risk taking behaviour and her poor level of functioning. A more suitable resource for adolescent inpatient treatment facility providing an environment conducive to recovery and stability would have been more appropriate to Child A's needs and protection.

Referrals to West of Scotland adolescent inpatient unit

It is of note that Child A was referred on four occasions to the West of Scotland adolescent inpatient unit (4) but none resulted in an admission to the unit or an assessment of her mental health needs. Communication with the adolescent unit appears to have been problematic, with the unit failing to respond to the initial referral and, when they did respond to subsequent referrals, they took the view that Child A was too high a risk to be managed within their unit. This is concerning given that this adolescent inpatient unit was the only resource available in the West of Scotland at the time that offered dedicated services for young people who have serious mental health problems like Child A. It is understood that there is a wider context to this and that there were discussions taking place between NHS Lanarkshire and Greater Glasgow and Clyde Health Board about the use of the West of Scotland adolescent inpatient unit. This may have affected why the decision to refuse Child A does not seem to have been

challenged further by professionals and a more solid explanation for refusal sought. A fuller assessment could have been completed by the West of Scotland adolescent inpatient unit as they have the expertise in this area and they could then have evidenced their decision not to admit Child A.

Legal issues

Staff need to be familiar with and clear about the legal framework which underpins their work, ensure they have the right authority to carry out any treatment and to be aware there may be alternative means available.

There were legal issues in relation to Child A's detention and treatment whilst she was resident in hospital (5) in England. It is noted that staff at this hospital wished to ascertain that all therapeutic interventions and restrictions of Child A's liberty there were being lawfully implemented. She was subject to a Scottish secure care order which would provide sufficient authority to determine her place of residence and impose restrictions on this but this would not provide authority for medical treatment and medication. Authority for this could only be obtained via a treatment order under the English Mental Health Act 1983 (as amended). It is not clear why this was unknown to staff in hospital (5) or why it apparently was not made clear by the Reporter in Scotland. There is a possibility, therefore, that Child A's treatment in this specialist resource (5) was carried out without proper legal authority. It would have been helpful to have the legal parameters for Child A's treatment clearly set out from the beginning prior to her placement in England.

Throughout most of the work with Child A, she was subject to a supervision order firstly under the Social Work (Scotland) Act 1995 and latterly under the Children's Hearing (Scotland) Act 2011. The mental health assessments which were undertaken led on occasion to emergency measures but longer term measures could have led to a different route. A compulsory treatment order either hospital or community based under the Mental Health (Care and Treatment) (Scotland) Act 2003[7], which includes personality disorder as an identified mental disorder, could have been considered to secure longer term care and treatment and might have offered an alternative route to stabilise and treat Child A in a safe environment.

In addition, Adult services could have made better use of the Adult Support and Protection (Scotland) Act 2007[8]. The assessment undertaken indicated that Child A did not meet the three point test for adult support and protection intervention. Taking into account the three point criteria relating to adult support and protection intervention, namely people being unable to safeguard their rights, well-being, property or other interest; being at risk of harm; and affected by disability, mental disorder, illness or physical or mental infirmity, Child A did meet the three point test. A judgement seems to have been made that as she was in hospital, this was a protective factor but this was clearly a temporary situation and a protective plan needed to remain in place to ensure the safety of Child A.

Information about personality disorder relating to child A

Child A was a young adolescent going through a period of major developmental transitions physically, psychologically and socially. During this period young people experience emotional distress, frequent

[7] *The Mental Health (Care and Treatment) (Scotland) Act 2003*

[8] *The Adult Support and Protection (Scotland) Act 2007*

interpersonal disruptions and challenges in establishing a sense of identity. Consequently, in the early stages Child A's difficulties were attributed to the typical stresses and strains of the adolescent transition. It was later recognised that some of Child A's behaviour could be related to early childhood trauma, resulting in issues of attachment or linked to an emerging borderline personality disorder and autism. Child A showed early manifestations of an emerging personality disorder because of her frequent suicidal/self-harming behaviours, marked emotional instability and increasing intensity of symptoms. Like many people with borderline personality disorder Child A engaged in a variety of destructive and impulsive behaviours including self-harm.

Self-harming behaviour in borderline personality disorder is associated with a variety of different meanings for the person, including relief from acute distress and feelings, such as emptiness and anger, and to reconnect with feelings after a period of dissociation. As a result of the frequency with which they self-harm, people with borderline personality disorder are at increased risk of suicide (Cheng et al 1997)[9]. Child A displayed those behaviours. Child A's also presented as someone whose responses were driven largely by an inability to cope with the developmental challenges of adolescence and consequently she struggled to function effectively at home, in school and with her peer group, an inability that was essentially a consequence of her disability. Striking the balance in managing risk in relation to someone like Child A is difficult and equally the levels of difficulty for the young person frequently have an adverse impact on the family's capacity to function effectively. Child A's behaviour undoubtedly had a significant impact on her family and her parents continued to work with professionals to try and keep their daughter safe.

Transition from children's to adult services

There were significant difficulties in the transfer of Child A from children's to adult services in relation to health and social services and in the legal framework within which she was being treated.

Health Service

The plan was to transfer Child A to adult health services as she was over sixteen years old and not in education. It would appear there was good communication between CAMHS and adult health services during the transition period; however the transition arrangements from child to adult services did not take place as originally planned. The transfer happened sooner than was anticipated because Child A was admitted on an emergency order to the adult ward because of a serious attempt at self-harm. The perception of family was the transfer was rapid and that much of the understanding built up by CAMHS services was lost and adult services had less understanding of their and Child A's needs.

It is acknowledged that the transition to adult services for young people is often marked by a series of discontinuities in terms of personnel, treatment approach and often a failure to recognise and adapt treatment to developmental stage. This can be particularly difficult for a young person like Child A with an emerging borderline personality disorder who is likely to find endings and beginnings especially challenging as noted with Child A during changes of psychiatrists and previously with social work staff. In such circumstances joint working between adult mental health and CAMHS could have facilitated the transition to ensure consistency in progressing Child A's treatment plan as well as sharing best practice to work together. This may have provided a clearer indication of the expectation of each service in

[9] Cheng, A., et al (1997). *'Personality disorder and suicide';* British Journal of Psychiatry.

supporting the transition plan.

In the absence of a specialist adolescent resource at times of crises the only option available for Child A was to become an inpatient in an adult ward. Child A had several admissions to the acute adult mental health ward at hospital (3). She was originally detained on a compulsory order but then remained as a voluntary patient. Although the acute adult mental health ward may be appropriate for short term management of crisis, it is not a specialist unit dealing with the types of problem and behaviours shown by Child A. At an Adult Support and Protection case conference held on the 4 August 2014 it was agreed that Child A could remain in hospital (3) as a voluntary patient as long as she complied with treatment, and until appropriate accommodation with supports in place was identified. The plan was that Child A would be discharged into the community with an intensive support package put in place. During her stay in hospital, Child A was also making the transition towards greater independence from her parents. Child A wanted to live independently in the community and her parents disagreed with this option. They wished to apply for guardianship but were advised this would not be supported by the consultant adult psychiatrist (1) responsible for her care as he was of the opinion that Child A had capacity to make her own decisions. The involvement of Child A's general practitioner may have been helpful regarding determination of Child A's capacity.

It might have been beneficial to Child A if CAMHS had supported her until she reached eighteen years. Current policy is that young people over 16 and not in education are referred to adult mental health services. CAMHS had provided intensive input over a number of years previously and knew her well. In the future, the mental health national strategy work being undertaken at present will change the framework to offer CAMHS services to all young people up to the age of 18 which is in line with the corporate parenting responsibilities Health Boards now have under the Children and Young Person's (Scotland) Act 2014 in respect of looked after children.

Child A's needs were particularly complex and challenging. The best and most specialist care possible may have struggled to respond to her difficulties but it is precisely because her needs were so unusual and difficult that further attempts at specialist intervention in relation to her emerging personality disorder would have been justified.

Social Work Services

There was also a gap in the transition from children to adult social work services. When social worker (4) left the authority in March 2014 the case was not allocated to another social worker in children's services. Although Child A was on a supervision order at the time the plan was that the supervision order would be terminated and the case transferred to adult services because of her complex and enduring needs. In the interim it was held in by the team leader (1) who supervised the case and knew Child A well. Whilst the team leader knew Child A and her family well this was a significant gap in the case being formally allocated to adult services. Child A was on a supervision order and should have had an allocated children's social worker to fulfil statutory duties. The explanation given by children's services for not doing so was to minimise the number of changes of social worker. The case transferred to adult services on the 9/6/14. The adult services social worker (5) was involved informally with children's services team leader (1) but it is not evident who ultimately had lead responsibility for progressing the Child A's plan at this key point of transition. It is not clear whether the case was not allocated because it was a resource issue or difficulty in transferring the case to adult services. The explanation given by adult services for the delay was that they were considering whether to allocate the case to the community mental health team or to adult services. In the end the decision was made to allocate to adult services. Whatever the reason, Child A should have had an allocated children's

services social worker during the transition period particularly as she was subject to a supervision order. It is unclear why a child who was subject to a supervision order by the Children's Hearing and a looked after child should be considered for transfer to adult services at that time. It is recognised that there is a need for co-working with colleagues in adult services and in mental health services for young people with complex and enduring needs such as Child A who will require long term intervention and access to adult resources. Continuing care and aftercare through children's services are appropriate for most young people, though this is more complicated for children with complex and enduring needs and a clear protocol is needed which will focus on what is best in each particular case.

It is concerning that a Children Hearing's review of the supervision order had to be deferred on three occasions awaiting a review report from social work. The reason given was that Child A was in transition to adult services in both social work and health and an updated assessment was being undertaken by adult services. The delay in providing this report is difficult to understand given the issues pertaining to Child A. There should have been a report available to enable the review to take place even if the assessment by adult services was incomplete. A review report dated the 26/8/14 was eventually provided for a Children's Hearing scheduled to take place on the 1/9/14 with a recommendation to terminate supervision. This Children's Hearing was cancelled on notice of Child A's death.

The importance of ensuring appropriate planning to support these transitions is vital. There is a need to consider how best to manage transition, by establishing clear planning processes, taking steps to identify the needs of individual young people and looking at the interventions they might need to support and, if necessary, protect them in adulthood. Agencies should be clear about the collective responsibility to manage this transition to ensure that mutual responsibilities are properly reflected in services provided.

Assessment of capacity

Future planning for Child A's care was influenced by a clear view from consultant adult psychiatrist (1) that she had capacity to make decisions about her life. This view was also endorsed by consultant adult psychiatrist (2). This view was not shared by social work or the parents who were of the opinion that Child A was not capable of living independently in the community even with intensive support provided. On that basis a fuller assessment of Child A's capacity to make decisions about her future might have been helpful taking into account that the test of incapacity at section 1 (6) of the Adults with Incapacity (Scotland) Act[10] could be met where a person's disability means their ability to cope with a decision making process is severely compromised. Child A's pattern of risk taking and self-harming behaviour, over a number of years suggests someone whose responses were driven by impulsivity and whose decision making process overall was severely compromised by her emerging borderline personality disorder. It was evident she was unable to understand the consequences of her behaviour and that her actions could result in death.

Both Child A's parents and social work considered applying for guardianship under the Adults with Incapacity (Scotland) Act 2000. Child A disagreed with her parents applying for guardianship. As Child A was 17 at the time her views would have to be taken into account. Staff, therefore, need to balance the developing autonomy and capacity of the young person with the responsibilities of parents or carers taking into account the individual situation. Undoubtedly there are grey areas when making judgments

[10] *Adults with Incapacity Act (Scotland) 2000, section 1(6).*

about capacity with regard to decision-making but there do seem to be clear indicators in the case of Child A that she lacked capacity in safe decision making and guardianship may have offered the opportunity for greater security in her future care. It may also have offered greater consistency during transition to adult services taking some pressure off Child A to feel solely responsible for decisions in her life.

Planning for independence

Child A wanted to live independently, her views were taken into account and the plan was to support her independence. One would have to query whether this was a realistic option given Child A's circumstances including her complex mental disorder, social needs and pattern of extremely challenging behaviour. Child A was reported to be exceptionally difficult to deal with and presented extremely challenging behaviour compared to other young people who come into contact with services and resources, including targeted services. However, despite considerable effort, structured and focused intervention both on a single agency and multi-agency basis over a prolonged period of time, no professional involved with Child A was able to break down the barriers that might have explained the extreme nature of Child A's behaviour and repeated attempts at self-harm other than it was symptomatic of her emerging personality disorder. It is therefore difficult to fathom how this pattern of behaviour might have changed when she was discharged back into the community even with intensive and specialist support provided. It is acknowledged that there is a lack of suitable resources for a young person with Child A's profile and that seems to have affected the assessment. The number of placements Child A had over the period would undoubtedly have had an impact on her given her diagnosis of ADHD, asperger's syndrome and emerging borderline personality disorder. Staff structured interventions to provide ongoing support beyond crisis periods and considered strategies to manage the risks, incorporating them into Child A's care plan as appropriate. Their focus of intervention became one of trying to minimise or control her extreme risk taking behaviour as well as trying to understand what was causing it. It was challenging for those involved to deliver a consistent approach to managing Child A's behavioural manifestations of her distress and difficulties. An awareness of borderline personality disorder and the principles underpinning its management may have helped staff to contextualise the difficulties facing Child A. In spite of their best efforts and intensive input to support and try to keep Child A safe, frontline staff did not have the training, knowledge or expertise to deal with someone with emerging personality disorder. This required health intervention in a specialist environment or from staff with the appropriate knowledge and understanding about the disorder. It is a controversial area of mental disorder and there are considerable different views in relation to treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Treatment and monitoring during final hospital admission

Child A was a voluntary inpatient in an acute adult mental health ward at the time of her death. It is not clear how effectively the inpatient treatment was tailored to meet Child A's needs as a young person with borderline personality disorder. The focus appears to have been on preparing her for independent living within the community with intensive support provided. Staff tried to promote a therapeutic environment within the restrictions of the ward and Child A is noted to have responded well to intervention although she continued to self-harm on occasions. Careful monitoring of the impact of interventions was, therefore, warranted. The management of risk within the ward and events leading up to Child A's death was reviewed. It appeared Child A was well known and liked by staff who gave her a lot of individual attention. Child A was noted to respond well to one to one attention and staff were used to her patterns of behaviour both in and out with the ward. Child A initially was on constant observation

because of her risk behaviour and previous suicide attempt which happened in the ward. Staff were alerted to this suicide attempt in the early hours of the 27/8/14 by a patient. It was a similar attempt to the one that resulted in her death on 29/8/14.

On the 27/8/14 a multi-disciplinary team of health professionals made the decision to reduce Child A's observation from constant to general observation taking account of the rapid changes in Child A's presentation and her negative response to being more restricted by constant observation. Striking the balance in managing risk can be difficult. There was a view of thought that restricting someone with Child A's difficulties can be more damaging and they react against these restrictions by leaving the ward or self-harming. However, given the seriousness of the earlier suicide attempt it would have been more appropriate to keep Child A on constant observation for a longer period given the known pattern of her behaviour where it seemed that there were "clusters" of incidents. Although staff need to be alert to the potential dangers of reinforcing behavioural escalations with increased input and involvement as described, they also need to be aware of the risk of withdrawing prematurely during periods of apparent calm.

Child A was on general observation at the time of her death. Consequently there appeared to have been a degree of complacency amongst staff about monitoring Child A's whereabouts when she absented herself from the ward. Although it was noted that Child A was going to visit a patient in the ward above there was a gap of a number of hours between Child A leaving the ward, not turning up for night medication and the missing persons policy being initiated. On realising Child A was missing staff carried out an unsuccessful search for her within the unit and grounds of the hospital before initiating the missing person's policy. Concern was escalated further after a patient advised staff that Child A had informed her that she intended to self-harm in the adjacent woods. Given the recent serious self-harm and recent reduction from constant to general observation and also taking account of Child A's known impulsiveness staff could have escalated concerns and initiated missing persons policy more quickly in this case. This was also a finding in the SAER which recommended a review of general observation policy which was implemented locally and is now being superceded by a national review.

Information sharing with Child A's parents prior to her death

There was an issue of information sharing with the parents who believed they should have been informed of Child A's previous suicide attempt on 27/8/14. Child A did not wish them to be informed and this was accepted by ward staff as Child A was considered to be an adult and had a right to confidentiality. The parents were of the view that if they had been notified they would have informed ward staff that given Child A's previous pattern of behaviour it was likely she would try again. Also, if they had been notified she was missing they could have informed staff that Child A had a tracker on her phone which might have helped to locate Child A sooner. Child A's parents also complained to social work about not being informed of Child A's suicide attempt on the 27/8/14. Child A had explicitly asked that her parents should not be informed. There is no statutory duty on the local authority which would allow the expressed wishes of the young person to be over-ruled; however there is a duty to ascertain and have regard to the views of the child and her parents as far as reasonably practicable before making any decision. Under section 17 of the Children (Scotland) Act 1995 there is a duty to promote personal relations and direct contact between the child and any person with parental rights and responsibilities but only so far as practicable and appropriate having regards to the child's welfare. The duties are subject to the paramount concern to safeguard and promote the child's welfare so if it would be harmful to the child to disclose specific information that would be good reason not to do so. In Child A's case it may have been appropriate to share some brief details given Child A's previous history and

parents firsthand knowledge about Child A's pattern of behaviour. This information was shared with social work who did not disclose to the parents either. There is perhaps a need for collective decision making about this in cases of extremely vulnerable young people. It is a big decision to override the wishes of an adult and it is recognised to do so could jeopardise the relationship between worker and young person, however, the wishes of the young person should not always be absolute. Individual circumstances need to be taken into account with the wellbeing and protection of the young person paramount. It is noted that for the purpose of this significant case review Child A is viewed as a child, however, she is considered an adult in legislation pertaining to the disclosure of information.

Management of risk of suicide

On 27/8/14 Child A made a serious attempt at self-harm on the ward using the same method that two days later resulted in her death. The decision to remove Child A from constant observation at a review held later in the day is questionable given Child A's previous pattern of self-harming and suicidal behaviour. Child A presented as a high risk of suicide, but it seems to be accepted by staff that she had no intention to kill herself and for this reason there appears to have been no risk assessment completed to guide staff regarding suicidal ideation. In view of Child A's history and clusters of self-harming behaviour, there was a known and high risk that Child A would make further attempts to harm and, whether intentionally or otherwise, end her life. The response to this should have been clearly identified and managed.

Key issues

The need for consistency in approach in responding to Child A's complex needs and extreme behaviour

Child A was offered intensive support to address issues highlighted but her ability or readiness to work productively with these supports was variable and unpredictable depending on her mental health at the time. Frequently an additional crisis led to new interventions or the involvement of new staff or services consequently providing a consistent approach to Child A was challenging as was the opportunity to set realistic goals for progress both in the short and long term. Child A needed consistency in approach but this was difficult to provide mainly because of crisis intervention due to Child A's impulsive and risk taking behaviour and agencies having to keep responding to risks as they emerged and changed. Plans changed depending on the crisis and response required, highlighting the importance of having a plan for Child A that was consistent regardless of where she was residing or in what resource. This would have resulted in a single planning process aimed at addressing the issues that were adversely affecting Child A's wellbeing as a whole namely her suicidal ideation and self-harming behaviour. It would also have ensured consistency in approach when there was a change in staff as happened over the period.

The importance of having a lead professional to ensure Child A's care plan was progressed

Child A had a number of placements during the time she was known to services. Child A was subject to statutory measures and social work had the responsibility to implement her plan. However when Child A was in hospital, clarity was required for all those working with her about who was going to retain the overview of her plan throughout to make sure that it was implemented, reviewed and achieving the

desired outcomes. Although Child A was subject to a supervision order under the Children's Hearing, she was a voluntary inpatient in an acute adult psychiatric ward at the time of her death. This resulted in the professional lead switching between social work and psychiatry.

Maintaining continuity in social work services

The move from child to adult social work services presents significant risks. Young people at this transition stage can lose the support of those services that know them well and are familiar with their needs. The risk is exacerbated by the fact that other services may also be transferring responsibility at a similar time; in this case health services were also changing.

The importance of ensuring appropriate planning to support these transitions is vital. Child A was on a compulsory supervision order under the Children's Hearings (Scotland) Act 2011, which meant that social work were responsible for supporting her and making sure she was getting the help that she needed. Intensive input was provided to Child A by social work children's services over many years and it is questionable why Child A was transferred to adult services when she was still subject to statutory measures under a supervision order.

Child A was looked after until her death, it is difficult to understand why children services did not allocate another social worker after her previous social worker left. In the interim it was held in by the team leader who supervised the case and knew Child A well. Whilst the team leader knew Child A and her family well there was a significant gap in the case being formally allocated to adult services. The formal transfer did not happen until three months later although an adult services social worker was involved informally with children's services team leader however it is not clear who had the lead responsibility for progressing Child A's plan during this key point of transition. It would have been difficult for the team leader to provide intensive input because of his other management responsibilities. In the circumstances this case should have been allocated to another children's services social worker promptly because of the complexity of Child A's situation and the fact she was on a supervision order. This consideration should have over-ridden the concerns about Child A having to form a relationship with another worker. The parameters of the new worker in children's services should have been determined by a looked after review taking this into account.

Child A was a looked after child and was entitled to aftercare under section 29 of the Children (Scotland) Act 1995 and to have a pathway plan undertaken. This does not mean adult support and protection intervention could not be used when a child reached the age of 16, if required. Part of the reasoning for the transfer appears to be that Child A would require intensive support from adult mental health services well into adulthood and it seemed appropriate for adult social work services to become involved early on. Assessment and planning processes need to be aligned and it is important to ensure that there are appropriate operational links between adult and children's services to ensure a seamless service is provided. There is a need for clarity about who is the lead professional but also shared responsibility and co-working.

Maintaining continuity in mental health services

As Child A was aged over sixteen, the plan was for Child A to be transferred to adult mental health services. In Child A's case there was good communication between CAMHS and adult mental health services but her hospital admission to an adult ward pre-empted a planned handover. Child A was in an adult ward and because of the circumstances CAMHS withdrew. It might have been more beneficial for Child A and promoted a smoother transition if there had been more flexible working arrangement

around age-limit cut-offs.

Protocols with adult mental health services need to be in place to ensure the smooth transition of young people in transition to adult services. Such protocols need to ensure that access criteria to adult services are consistent with young people who have been previously treated by CAMHS. Those who commission CAMHS and adult mental health services should collaborate to identify service gaps and explore service models, for example, jointly commissioned services across the age range, to address the needs of young people in transition from CAMHS to adult mental health services. In exceptional circumstances where no age appropriate services are available for young people, adult services need protocols in place for young people admitted to adult wards. These protocols should include liaison with and involvement of CAMHS.

Difficulties in establishing diagnosis and treatment

Services were alert to the potential influence of developmental concerns from the beginning of Child A's contact with services in 2009. It would appear there were no obvious signs of developmental difficulties when Child A was in primary school. Behavioural abnormalities became more evident at the point of transition from primary to secondary school. When she became looked after she had been a patient of the CAMHS service for two years. Overtime she had been diagnosed with ADHD, asperger's syndrome and an emerging borderline personality disorder although there was reluctance by health staff to give a definitive diagnosis of the latter in someone under 18 years of age. Those diagnoses although requiring different responses, explained some of Child A's behaviours and presentation in relation to social interaction, social communication, cognitive flexibility and risk taking behaviours.

It is acknowledged that there is a difficulty in diagnosing personality disorder in adolescents. A key debate about this is between those who argue that personality is not fully formed until early adulthood and those who argue that some personality traits are present and stable from early childhood (Adshead et al 2012)[11]. Nonetheless research would indicate that treatment strategies should be multidimensional, targeting suicidal behaviour and the underlying psychiatric disorder or other personality and environmental risk factors. Child A displayed symptoms of personality disorder such as emotional instability, disturbed patterns of thinking, impulsive behaviour, intense and unstable relationships with others. Her behaviour was reported to be unpredictable, the diagnosis and weight given to these concerns varied through the years, with adult services perhaps less inclined to focus on this aspect viewing the child as an adult with capacity. In Child A's case although suspected there appeared to be a reluctance to make a formal diagnosis on Child A having a personality disorder as she was under eighteen years of age. However, the absence of a formal diagnosis probably made no difference and we would concur with the view of the SAER that the key issue is the lack of the range and consistency of services for young people with these sorts of problems.

Judging capacity to make decisions

Another important issue which emerged in this case which might have wider implications for practice was the dilemma for professionals in balancing their duty of care with the rights of young people to be self-determining. There are multiple factors that may potentially affect and compromise people's

[11] Adshead ,G., et al (2012, '*Personality disorder in adolescence';* Advances in Psychiatric Treatment 18:109-118. APT Journal of continuing professional development.

capacity to make decisions. These include personal, physical, psychosocial and situational demands placed on the person and the resources and supports available. Future planning for Child A's care was influenced by a clear view from adult psychiatric services staff that she had capacity to make decisions about her life. This view was not shared by the CAMHS team, social work staff or her parents. Social work staff were of the view that Child A had capacity to make some decisions in her life but not all. Her parents view was Child A had the capacity to make some decisions but when she had an episode of escalated behaviour there had to be someone responsible to step in, guide her and keep her focused. Taking into account Child A's previous history, the issue of Child A having capacity should have been explored further and a fuller assessment undertaken perhaps involving a mental health officer. Capacity should not be assumed in cases of complex, self defeating and high risk taking behaviour.

Lack of a suitable mental health facility

Given Child A's complex health needs and suicidal tendencies she required ongoing monitoring and review as well as specialist care and intervention to support her both in the short and longer term. There was a lack of suitable resources to meet Child A's mental health needs as someone with an emerging personality disorder. It was difficult to source the appropriate inpatient care when that was identified as required. She was referred from one setting to another, and continuity of care was a major concern. Child A was referred to a West of Scotland specialist adolescent psychiatric unit on four occasions but was not admitted. There appears to be a lack of understanding of what specialist services would help somebody like Child A and a lack of provision within Scotland, a conclusion also reached in the SAER. It is unacceptable that young people like Child A with the highest needs are unable to access specialist Scottish Services. Child A was placed in England for treatment but access to English services raises its own issues around distance from family and home as well as interfering with other aspects of care. This case demonstrates that the alternative at present is for young people with the issues Child A presented being admitted to a general adult psychiatric ward which appears unable to manage them safely.

Learning points

The significant case review has recognised that there are important lessons that can be drawn from the review of professional involvement with Child A and her family. In the main these are complex problems that professionals working across Scotland find equally challenging. They are not necessarily amenable to easy solutions.

In the light of the above, this case was felt to be a useful window into the system providing an insight into how the agencies work together and the challenges they face in seeking to protect and promote the wellbeing of young people at risk of suicide and with complex mental health issues. The review also highlighted the need for a clear care pathway for young people with emerging borderline personality disorder as both the types of intervention and the manner of delivery are equally important regardless if the young person is under eighteen years of age.

1. ***What lessons can be drawn from reflecting on how services manage complex and risky behaviours in young people with emergent personality disorder?***

The story of Child A 's pathway through care and treatment and her untimely death illustrate the

difficulties that statutory services have when faced with a young person with complex needs and distressed behaviours like Child A. Research has found that young people with mental health problems are at a higher risk of suicidal thoughts. The reasons behind a teenager's suicide can be complex. Research has indicated that adolescents at higher risk commonly have a previous suicide attempt or psychiatric illness. Child A had made previous attempts to self-harm and was reported to have an emerging personality disorder. Even although teenage suicide is relatively low it is still the second most likely cause of death for 15-19year olds worldwide. (King, Apter 2006).[12]

Young people with borderline personality disorder find coping with the developmental challenges of adolescence difficult and consequently struggle to function effectively at home, at school and with their peer group. Frequently, their experiences in childhood, as well as causing distress and difficulty, have also failed to prepare them for adolescence. Given these difficulties and the age of the young person, service providers frequently attempt to take responsibility for the young person or strongly encourage parents or carers to do so. This presents particular challenges as the developmental task for young people is to separate and individuate from parents/carers and to develop a degree of autonomy. Young people with borderline personality disorder often attempt to become autonomous in the absence of key capacities to exercise autonomy safely, which increases anxiety in families/carers and professionals alike. This happened in Child A's case. Promoting active engagement in decision making (for example, outlining treatment options, highlighting the consequences of certain behaviours or choices and evaluating the benefits and disadvantages of behaviour change) may assist in developing and maintaining the therapeutic alliance (Skuse et al 2011)[13]. This was the approach adopted by adult health services which is understandable but which appears to have underestimated the extent of Child A's difficulties, particualty in keeping herself safe. Young people need to be able to make informed choices, however their mental health and perceived vulnerability at the time needs to be taken into account as well as their previous patterns of behaviour.

The key lesson is that young people with these issues require clear boundaries which are difficult to achieve when their behaviour is so disruptive. Providing a consistent approach is essential but services are really only provided short-term, when young people respond positively and progress is made services are withdrawn as the young person no longer meets the criteria. This can be particularly difficult for a young person with emerging personality disorder who finds endings and beginnings especially challenging.

2. What lessons can be drawn from reflecting on how risk of self-harm was managed within the hospital setting?

As with adults, young people with borderline personality disorder may experience high levels of suicidal ideation and repeated self-harm. Therefore working with young people with borderline personality disorder necessarily requires active engagement in the management of both chronic and acute exacerbations of risk. Acute and chronic risks may require different approaches. For example, a service may provide time-limited increased support during a period of heightened acute risk. Yet in response to a less severe increase in risk, the same service may promote more active engagement of the young

[12] King, R., Apter, A., (2006); '*Suicide in Children and Adolescents'*, Cambridge University Press.

[13] Skuse, D., et al (2011) '*Emerging Personality Disorder';* Child Psychology and Psychiatry: Frameworks for Practice, chapter 34.

person in problem solving rather than providing more service input. Professionals must carefully consider strategies to manage acute and chronic risks and develop these in the care plan as appropriate.

It is recognised that patients might need varied degrees of observation depending on a patient's identified need, behaviour or current clinical risk assessment. Observation of patients is an important part of the day-to-day nursing activity, which enables the multi-disciplinary team to assess patients and their progress. It is also the opportunity for the nurse to interact on a day-to-day basis. The importance of accurate observations is clearly documented and essential. Child A was not on constant observation on the night she died in spite of having made a similar suicide attempt two days previously on the 27/8/14. It was recorded by adult psychiatrist (4) that Child A's risk of suicide is a chronic one due to impulsive behaviour rather than a psychotic or affective illness. Constant observation was removed on the 27/8/14 after it was noted that Child A no longer had any suicidal thoughts. Child A died on the 29/8/14. Child A's previous pattern of self-harming should have been taken into account. She was noted to have fairly settled periods then periods of escalating harm with several attempts made closely together. In Child A's case high vigilance was required and regular checks on her whereabouts given her impulsive and unpredictable behaviour. It is important to recognise that all practitioners involved in this case were concerned about Child A and the implications of her risk taking behaviour.

3. What resources are available for young people with complex mental health needs?

It is acknowledged that there are pros and cons in relation to early diagnosis of emerging personality disorder, however early diagnosis means early intervention and improved treatment planning. Finding appropriate resources and coordinating a multi-agency response for these young people is often difficult. Child A was found to have emerging personality disorder but there appeared to be a reluctance to formally diagnose as Child A was aged under eighteen at the time. It is concerning that even with a potential diagnosis there is no specialist inpatient treatment service or resource available either locally or nationally for young adolescents with a personality disorder and who are in transition from children's services to adult services.

Many young people with borderline personality disorder have needs that span health, social care and education. Young People with a diagnosis of borderline personality disorder or symptoms and behaviour that suggest it should have access to the full range of treatments and services recommended to deal with that type of disorder.

4. What lessons can be learned from reflecting on the intervention of all the agencies involved and was the intervention appropriate?

The review team are aware of many other young people, and some older ones, with similar types of needs where there have been difficulties establishing consistent care planning and management. The decision whether to go down a route of secure residential care, secure mental health care, manage risk in an open environment or in the community, or management in adult psychiatric ward was an ongoing challenge in this case. There were a number of multi- agency meetings held but decisions seemed to depend on resources available rather the particular needs of Child A. This case illustrates that services need to review how they manage individuals with difficulties like Child A who had an emerging personality disorder and the crucial role of appointing a lead professional through whom all key

decisions are routed and who can ensure co-ordination of complex services.

There is also a need to determine whether a young person has capacity to make their own decisions about treatment and intervention. In working with adults, assuming that the person has capacity is important. With young people a key goal of treatment may be developing capacity. In working with young people with borderline personality disorder professionals must balance the developing autonomy and capacity of the young person with the responsibility of parents and carers. Professionals need to be familiar with the various legal frameworks surrounding consent in young people to manage this balance effectively.

5. What lessons can be drawn from engagement with parents taking into account their perspective of the situation?

A death through suicide delivers a double blow to families not only do they have to cope with a sudden and often unexpected death but they also have to deal with the way their relative has died. Child A's parents contributed to the review and their insights and reflections on professional practice and impact it had on themselves was helpful to the review. Both parents acknowledged the difficulties they faced in dealing with the challenges presented by Child A whilst at the same time coping with the competing demands of their other children. Child A's risk taking behaviour, repeated allegations against her father and consistently running away had a significant impact on the family. The parents wished to apply for guardianship to secure their daughter's wellbeing and safety and were unhappy that this was not supported by adult psychiatrist (1) who believed their daughter had capacity to make decisions about her future. The parents were also concerned that Child A's suicide attempt just prior to her death was not disclosed to them. Parents should be informed where appropriate of key events in their child's life if it has implications for their child's wellbeing and safety and ongoing parental support even in cases where the child is aged between sixteen and eighteen.

Child A's mother raised concerns about the way Child A's allegations against her father were responded to. She agreed that the investigations should take place but was unhappy about the repeated investigations. She believed the findings of previous investigations where Child A's allegations were not substantiated should have been taken into account in responding to any further allegations. She felt allegations made by Child A should have been seen in the context of Child A's attention seeking behaviour and the way Child A had learned to manipulate situations to her own end. Whilst acknowledging the parents' views in relation to this such an approach cannot be justified and would not comply with local child protection procedures and the national child protection guidelines. Both parents agreed Child A was like a sponge absorbing loads of information then presenting as her own script those stories alleging they happened to her. Child A's mother said she had researched this type of behaviour which was indicative of her illness. Child A's parents felt at times they were not listened to and they were the people who knew their daughter best. In their opinion they knew how to de-escalate a situation with Child A and acted on advice given by child and adolescent psychiatrist (1) whom they believe to be very experienced in dealing with someone with emerging personality disorder.
Both parents were concerned at the length of time it took for health staff to make arrangements for them to visit the site where Child A's body was found. In their view it would have been supportive if arrangements had been made quickly after Child A's death. From the perspective of health staff, however, the parents did not ask for this until sometime afterwards. Then one of the dates offered was on what would have been the Child A's eighteenth birthday which the parents felt was insensitive. Given it is common for relatives to wish to visit the site of death this could have been suggested in

earlier consultation with the parents ascertaining their wishes. The parents also felt that the way Child A's personal possessions were returned to them could have been more sensitively handled. In future it might be more appropriate to contact the family directly to ascertain how they wished personal possessions to be returned to them recognising that this is an individual decision.

6. *What more can we learn about children presenting with multi-complaints about sexual abuse?*

The relationship between disclosure, memory, truthfulness, fantastical storytelling, suggestibility, and false allegations is complex. Since young people's responses to sexual abuse are unpredictable and inconsistent, professionals face a complicated process as they evaluate allegations of abuse. Issues of truthfulness and ways of identifying truthful accounts were a key issue in dealing with Child A. Child A was consistent in her allegations of sexual abuse made against her father. The allegations were fully investigated but no evidence found to substantiate those claims. Nonetheless Child A's behaviour would indicate some traumatic experience in her life. Research has indicated that sexual abuse can be a precursor for suicidal behaviour particularly amongst women. (Bebbington et al 2009)[14]. Self-harming and parasuicidal behaviours were a feature of Child A's presentation throughout her contact with services. It is recognised that the risk of suicide frequently occurs in combination with external circumstances that seem to overwhelm at risk teenagers who are unable to cope with the challenge of adolescence because of predisposing vulnerabilities such as mental disorders or recent life stress. The death of Child A's grandmother was noted to have had a significant impact on her.

Research has also highlighted the importance of a caregiver's support and his or her response to a child's disclosure, recantation and adjustment after making allegations of being sexually abused. It has been noted that maternal reactions to abuse, including whether the mother believed the child's allegations and, whether she acted in a protective manner or supportive manner, are important not only in the aftermath of child sexual abuse discovery, but also in terms of children's willingness to disclose. (Malloy, Lyon, 2006)[15]. In Child A's case both parents denied the allegations made and considered them to be symptomatic of her illness as well as attention seeking behaviour. No one was able to establish Child A's motivation for making such claims other that it may be related to her personality disorder where such behaviour can be a common feature with attention problems and fearing abandonment.

Symptoms of borderline personality disorder also include emotional instability, disturbed patterns of thinking, impulsive behaviour and intense but unstable relationships with others. Child A displayed those traits in her presentation and behaviour. It may be that her repeated allegations of sexual abuse related to her disturbed patterns of thinking however what was evident was that Child A had significant mental disorder and developmental problems and these were a root cause of her high risk behaviours. She was noted to be sexually vulnerable and exploited by predatory males. Apart from one incident none of her claims of abuse, rape and other sexual harm were substantiated.

The case of Child A illustrates also how these allegations can confound approaches to therapeutic work

---

[14] Bebbington, PE., et al , *' Suicide Attempts, Gender and Sexual Abuse';* American Journal of Psychiatry, October 2009.

[15] Malloy, L. C., Lyon, T. D. (2006). '*Caregiver support and child sexual abuse: Why does it matter*?' Journal of Child Sexual Abuse*, 15*(4), 97-103.

with families. Professional services must take all allegations seriously and investigate thoroughly but this inevitably affects trust and co-working with parents. There is no easy answer to this dilemma, though in some circumstances it may be possible to allocate different workers to the therapeutic work with the family from those who must conduct the investigations.

Recommendations

1. **Case management**

This report illustrates the need for leadership, consistency and continuity when working with young people with complex difficulties. To achieve this:

- A lead professional must be clearly identified and his/her role respected across all professional groups ensuring that he/she is advised of all key decisions that might from time to time taken by other professionals involved in the case in line with GIRFEC principles;
- Good supervision is necessary for the lead professional to help them stand back from the case at times as they can be overwhelmed by the demands;
- A child's plan in line with GIRFEC principles should be prepared for all young people in these circumstances and easily accessible by all professionals who come into contact with him/her;
- Transition arrangements in social work and health services should be carefully managed to ensure as much consistency and continuity as possible of approach, staff and facilities with a presumption that children's services including those provided by CAMHS will continue beyond the 16th birthday if that is in the young person's best interests;
- The CPC and APC should develop a protocol for escalating concerns in relation to high risk cases. This could involve a case discussion at Chief Officer's level when there is a difficulty in accessing resources for extremely complex and challenging cases like Child A (similar to a gold meeting convened by the police).

2. **Learning**

This report provides valuable learning for professionals working with young people with complex difficulties. Though clearly some of child A's issues were individual to her it is recommended that training of all professionals who work with young people pays particular attention to:

- Understanding of adolescent mental health and high risk indicators for teenage suicide;
- Awareness about the types of intervention required in working with a young person with an emerging borderline personality disorder to promote a constructive therapeutic relationship;
- The needs of young people with autistic spectrum disorders such as asperger's syndrome;
- Risk assessment ensuring staff are competent in risk identification, assessment, analysis and management of risk. This must be founded on a sound understanding of the issues prevalent and take account of previous patterns of behaviour to inform the risk assessment particularly when the behaviour was noted to happen in clusters;
- The full legal framework that applies to young people with mental health diagnosis including the

Mental Health (Care and Treatment) (Scotland Act) 2003, Children (Scotland) Act 1995, Adults with Incapacity (Scotland) Act 2000 and Adult Support and Protection (Scotland) Act 2007;

- Reinforcing understanding of the role of the lead professional and the process for establishing this;

- The APC to reinforce staff's knowledge about the 3 point criteria for adult protection intervention through workforce development.

3. Resources

A clear feature of this report is the paucity of specialist resources to treat a young person with such complex difficulties within Scotland. To address this:

- NHS Lanarkshire should review and consider specialist adolescent resources required in Lanarkshire to support young people with this high level of need and risk taking behaviour;

- CAMHS and adult mental health services locally should collaborate to identify service gaps and explore service models, for example, jointly commissioned services across the age range, to address the needs of young people in transition from CAMHS to adult mental health services;

- Senior managers particularly in social work, education and health should also consider a wider discussion about the way services deal with young people with complex needs like Child A who had an emerging personality disorder;

- The Mental Health Division at Scottish Government should carry out an urgent review of the services available in Scotland for young people with complex needs and particularly those with an emerging personality disorder, and autistic spectrum disorder to ensure that young people with complex needs can access safe care within Scotland with appropriate specialist input or advice.

4. Observation policy within hospital

This report follows the SAER in drawing attention to issues with observation policy within mental health hospital wards. The SAER resulted in improved guidance for hospital staff on maintaining vigilance for vulnerable patients. It is also noted that the Mental Welfare Commission wrote to all health boards about carrying out a review of safety and security of acute psychiatric ward environments for individuals at risk of absconding in May 2015 and that there is also the current review being undertaken by Health improvement Scotland on observations guidance. It is recommended that:

- Health Improvement Scotland take account of the findings of this report in their review of observations guidance;

- That the national review of observations policy and local guidance gives consideration to:

    - finding different ways to monitor patients who are off the ward, whilst acknowledging there might be a challenge in getting the balance right in terms of patients who have capacity;

    - scope to trigger early use of missing person's protocol in some instances where general observation is appropriate.

5. Involvement of parents

This report highlights a number of issues about the involvement of parents and the complexity of

working with them when they are also subject to a number of child abuse allegations. The report recognises that there are no easy solutions to this central dilemma but it does also illustrate some other practice issues for social work and health services to consider:

- The need to look at the impact of transition arrangements on families and give careful consideration to the nature and type of family involvement;
- The need to balance the developing autonomy and capacity of the young person with responsibilities of parents or carers;
- The need to consider the balance of maintaining confidentiality regarding the young person while ensuring that families and carers have enough relevant information to make informed decisions about safety;
- Given that it is common for relatives to wish to visit the site of death, there should be consultation with them as early as possible to ascertain their wishes in relation to this and appropriate arrangements made.
- The family should be contacted beforehand to ascertain how they wish personal possessions to be returned to them recognising that that is an individual decision.

6. Assessment of capacity

The Mental Welfare Commission should issue clear guidance around the issue of capacity in cases of young people with borderline personality disorder and asperger's syndrome as services should not assume capacity in such cases simply because there is no learning disability or psychosis evident in the person.

Margaret Campbell, BA, PGC Education, Dip Social Work, CQSW, AASW, Dip Child Protection, MPhil.

Lead Reviewer

Date 14/12/15