Alternative Learning Review
'ANNA'

FINAL VERSION

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1.Introduction

Following the death on Anna in October 2019 a decision was made by Warwickshire Safeguarding Partnership that although the criteria for a Local Child Safeguarding Practice Review was not met the case held potentially significant learning for the agencies involved. In January 2020, the Safeguarding Review Subgroup commissioned Jan Pickles to undertake an Alternative Learning Review. Jan Pickles is independent of all services in Warwickshire. This Review was paused by the Covid-19 pandemic and restarted in August 2020.

In September 2020, the Learning Review Panel reconvened, and a Reflective Learning event was attended by 21 professionals from all the relevant agencies to review the questions posed by the Safeguarding Review Subgroup and contribute their views on the management of this case.

2.The Terms of Reference

The Safeguarding Review Subgroup identified 'Key lines of Enquiry' and posed specific questions to the relevant agencies involved in Anna 's care. Agencies were asked to reflect on their practice and address in their analysis why actions did or did not take place; and consider the events that occurred, the decisions made, and the actions taken or not and assess practice against guidance and relevant legislation.

The review focussed on the period of the 1st of April 2018 to her death in October 2019.

The questions posed were:

1. Was information sharing effective to enable partner agencies to provide appropriate support for both Anna and her daughter, if not, what were the barriers?

2. The application of 'Think Family' approach; support focused only on her child but overlooked Anna's wellbeing and safety; why were no safeguarding concerns raised or referrals made to Adult Social Care, what were the barriers?

3. Consider if partner agencies working in silo, no collective consideration of the needs of the whole family (bigger picture) and assessment of what support may be required. Were assumptions made that Children in Care Personal Advisor Role held responsibility for Anna's care and support needs as a young adult?

4. CWPT's decision to discharge Anna without exploring the cause of her regular non-attendance of appointments; was this decision undertaken in consultation with other partner agencies supporting the family?

5. Were Anna's physical needs seen as a representation of her mental health needs; were her medical assessments appropriate to her needs and managed suitably?

6. Consider if Anna was viewed as a whole person. was every issue was considered in isolation; her lived experience as a child was not factored/considered as part of her needs, and there is no evidence to suggest a trauma-based approach was considered; why?

7. Consider if assumptions were made by professionals that DWP PIP is only accessible to adults via a formal care assessment undertaken by Adult Social Care; why was there no follow-up on this to understand the process?

8. It was assumed that Jack was Anna's carer, did his leaving impact on her stability and ultimately contribute to her suicide?

9. Is the role of Corporate Parent clear in these circumstances given Anna was a former child in care and her own child was open to Children's Services?

3. Outline of events

1.Anna was a loving mum to her daughter Ella Rose, who was described by some professionals as her 'whole world'. Although her short life ended so tragically, she was described by a professional who worked closely with her as warm and 'giggly' with a strong sense of humour and was able to enjoy some parts of her life.

2. Anna was 21 years old when she took her own life on the 4th of October by 2019 by hanging. When she was aged 15 years, she had given birth to Ella Rose, the father was her then boyfriend, Owen. Ella Rose at the time of writing this Report is six years old and now lives with her father. On the 1st of October 2019, the Police attended her property due to a reported disturbance. On entry they found conditions within the home they felt to be insanitary and made a referral to Children Social Care. During the Police attendance Anna informed them that the "raised voices" the neighbour heard were due to a 'row' over the phone with her partner, who had been away for some days visiting family. Her partner Jack was later reported missing by a third party. Anna told the Police she needed him to come to help her tidy up and help her with Ella Rose. The photographs taken by the agencies at the time show that she and Ella Rose were living in filthy and unfit conditions with animal urine soaking the carpet that Ella Rose was walking on in her bare feet. Her bed lacked bedding tucked in a corner in a disorderly and packed room with animal faeces around. These unhygienic conditions were chronic in nature and could not be attributed to a few 'untidy day's due to the absence of her partner.

3. Children's Services visited and agreed with Anna that the home conditions were unsuitable for the child, and it was agreed she stay with her grandmother's Personal Assistant[1]. Anna made full disclosure to them about her mental and physical health issues. Over the next two days Children's Services visited each day to assess the cleaning of the property and spoke with Anna about them seeking legal advice. It was agreed Ella Rose remain with her grandmother's Personal Assistant and then spend the weekend with her father and his new partner as was routine for her. Anna agreed, stating she did not want her daughter living in the conditions she had experienced as a child. At the time Anna believed her current partner, Jack was staying with his family and their relationship had ended. In early June Anna told her Personal Adviser assigned to her from the Leaving Care Team[2] that she had had a miscarriage. She had a further miscarriage in late July 2019 at 6 weeks into the

[1] The Personal Assistant employed directly by the grandmother in this case to provide support with ongoing care needs.

[2] The Personal Adviser is employed by Children's Services it is a term defined in legislation Children's Act 1989 sec 23 C

pregnancy. The University Hospital Coventry and Warwickshire Information reports notes that she was seen twice during this later miscarriage and although aware of her mental health this did not prompt any safeguarding action by the Hospital despite Anna being an open case to the Community Mental Health Trust (CMHT). At the time Anna herself had shared this information and was offered support from the Children's Services team manager and duty team. Early Help were also aware Anna's brother had been stabbed in September 2019. There is no further information to confirm this or if it did occur how serious the injuries were. We do not know if or how these events connect to Anna's suicide, although clearly if confirmed they add to the background of trauma and dislocation of her situation.

4. Anna had several long term physical and emotional difficulties. Despite investigation including an MRI scan her physical health issues were not diagnosed but resulted in a high level of chronic back pain which significantly affected her mobility and her quality of life. She told the Social Worker on the 1st of October 2019 that she suffered with Fibromyalgia, Spondylosis, irritated nerves and slipped discs. She had been receiving significant pain medication and that this was regularly reviewed by her GP though in the seven months before her death had stopped collecting the prescriptions. She stated that she had been told her symptoms would deteriorate over time. Anna used a mobility scooter outdoors and a stick inside her home to help her get around. She was intermittently taking medication for depression, an antipsychotic drug, and opiates for pain. Her last prescription for these drugs from her GP was in February 2019. This review has been unable to establish if she was receiving medication from other unknown sources or if she was without medication. The Police had noted drug paraphernalia in the property that Anna explained as used to self-medicate with cannabis to ease her physical pain this had not previously been known to services.

5.Anna had been known to Children's Services throughout her life from being a year old. Her childhood had been marked by the problematic drinking of her parents, Domestic Abuse and possibly a level of threat posed by her father to her, as she was advised to 'keep her distance' from him. In addition, her mother suffered from emotional ill health and is described as having 'breakdowns.' Anna as a child was referred to at points as her 'carer'. We know that Anna aged 16 was placed in foster care with Ella Rose from her parent's care for a period of fourteen months, due to the unhygienic conditions of her mother's home. Both Anna and her daughter were considered to have been 'Children in Care'. We do know that Anna was described as 'wary' of Social Workers due to her experience as a child. This may have affected her interaction with services. Anna, moved from her foster care placement to a supported accommodation placement, where she was living with her daughter, Ella Rose, and partner, Owen. Anna told Ella Rose's school that the foster placement had been positive for them both, her Leaving Care Personal Adviser states Anna told her that "they (her foster family) were the family she should have had all along".

6. It seems that Anna's mother continued to have problems with her own mental health into Anna's adulthood and that Anna's mother attempted to take her own life on two occasions in May and December 2018. Anna's father had died in 2014 and one of her two brothers had taken his own life five years previously. Anna had a

longstanding involvement with CAMHS, and she has previously self-harmed. Anna's mental health deteriorated when she took an overdose during early 2013. Anna was diagnosed by CAMHS with an 'emerging Personality Disorder, Depression and Social Anxiety'. Her early life would have contained within it a number of what are now recognised as 'Adverse Childhood Events' (ACE's). Anna told professionals that her own emotional and behavioural difficulties were inherited from her parents.

7. Anna was diagnosed in April 2016 aged 18 years old with 'Emotionally Unstable Personality Disorder' (EUPD) more commonly known as 'borderline personality disorder' (BPD). This is a long term and chronic illness with significant effects on emotional wellbeing and behaviour. EUPD is described by the Royal college of Psychiatrists as a condition characterised by 'impulsivity, difficulty in controlling one's emotions, negative thinking about self, tendency to self-harm or to make suicide attempts, relationship difficulties- sustaining or making them quickly, feelings of paranoia and depression and hearing voices, particularly when stressed'. A systematic review of research looking at associations between child maltreatment and EUPD, found that children with borderline features were more likely to have a history of maltreatment, and that children who had been maltreated were more likely to present with borderline features; other risk factors such as cognitive and executive function deficits, parental dysfunction and genetic vulnerability were also identified[3]. It is not known to what degree her EUPD diagnosis was a factor in Anna's death. There were seven previous incidents described as either self- harming or attempts to end her life made by Anna between 6th March 2017 and her death in October 2019. These incidents all involved emergency services being called.

8. Anna was in education at college for a short time within the period in scope, and she attempted to take her own life whilst in education. Obviously, this was a traumatic event and may account for her eventual dropping out of education. She formally left the college in January 2018, stating her poor mental health as the reason, though she had begun a new relationship with Jack some months earlier in October 2017. Anna identified Jack as her carer. At this time Anna was receiving limited support as a Care Leaver by the Leaving Care Team (the Personal Adviser role is resourced to be of a practical and limited nature). Although she attempted on one occasion to return to education, she never managed a sustained return.

9. In June 2015 Anna's foster placement ended, the foster carer describes Anna's response to the placement in exceptional terms saying that the improvement she had seen with her was her proudest moment as an experienced foster carer. She described how when Anna and her daughter were both placed in their care Anna had no idea how to parent but learned and grew into a competent mother working well with Owen to care for Ella Rose. Anna continued to have regular contact with the foster family and her foster carer described Anna as 'full of life and very focussed on Ella Rose's well-being'. Anna, Owen, and Ella Rose moved into supported accommodation in July 2015, and Anna remained a child in care until her 18th

[3] Ibrahim, Jeyda, Cosgrave, Nicola and Woolgar, Matthew (2018) Childhood maltreatment and its link to borderline personality disorder features in children: a systematic review approach. Clinical Child Psychology and Psychiatry, Vol.23, No.1.

birthday. Anna and her family moved into a secure rented property allocated to her by the Local Authority in March 2016.

10. The relationship with Owen ended in August 2017 but they remained friends thereafter. Anna had by October 2017 formed a relationship with Jack. Anna and her new partner left their property in February 2018, stating they wanted to get away from the area and be nearer to Jack's family, which Anna saw as supportive. She was not to secure permanent accommodation from this point on, although she and her family were housed temporarily by the Local Authority to the time of her death.

11.Anna and Ella Rose had had several moves within Warwickshire; notes state from February 2018 onwards mostly between two towns, but she was unable to settle and establish a lasting home. There is clear evidence that she did not fit in in the neighbourhood she was last moved to, with numerous complaints made about noise, the state of the house and garden and concerns for the wellbeing of Ella Rose being made by neighbours. Although not stated it appears the housing around was mainly occupied by older people who found the family's behaviour disruptive. In April 2018 whilst staying in the living room of a relative of Jack's in Shropshire concerns were raised as the relative was a registered sex offender. An anonymous allegation was made in April 2018 of someone touching Ella Rose's hair 'inappropriately'. The Police and Social Workers attended, and Anna, Jack and Owen were informed of the risk, Anna denied the concerns describing them as 'malicious'. A Social Work assessment describes there was no concerns about the interactions, emotional warmth, or stimulation of Ella Rose. However, this led to them being asked to leave and Anna, Jack and Ella Rose were then housed temporarily a caravan by the Local Authority.

12. Prior to the scope of this review Health Visitor records state there were on-going concerns surrounding the home conditions including a 'smoky' atmosphere possibly impacting on Ella Rose's health. Ella Rose was prescribed an inhaler and Volumatic. An undated healthcare plan states Ella Rose was suffering from 'reactive arthritis' following an infection. Ella Rose was also described as 'lactose intolerant', something her ex foster carer is adamant was not the case. There was no evidence within the Health Visitor records of an assessment of need to determine whether a handover to School Nursing service was made as per standard practice in September 2018. Warwickshire School Health and Wellbeing Service were not involved with Ella Rose. Ella Rose was admitted to hospital in August 2018 aged 4 years old with leg and abdominal pains which left her 'unresponsive' for three minutes according to her mother

13. Anna shared the care of Ella Rose with Owen and his family. The exact arrangements are not clear as some records state Ella Rose stayed with Owen and his family from Friday to Sunday as he could not get Ella Rose to school, others that Owen and his parents looked after her for the bulk of the school week, keeping her school uniform and another wardrobe of clothes and that Anna looked after her from Friday night to Monday. It was clarified at the Reflective Learning Review meeting that Ella Rose spent Monday teatime to Friday morning with Owen and his parents and remained with Anna and Jack over the weekends. This confusion may well be

significant. The school report Ella Rose having to walk to and from school, approximately two miles each way and that Ella Rose was given extra portions of food at breakfast and lunch times as she was hungry. Ella Rose was found to be stealing food in September 2018, possibly due to the demands such a distance would make physically on her and possibly due to a poor diet at home. It was noted on three occasions in November and December 2018 and March 2019 that Ella Rose 'smelt'; it was found her coat, school bag and reading books smelt of animal urine, the books were so damaged they had to be thrown away.

14.Anna due to her mobility problems did not collect Ella Rose from school, either Jack or her paternal grandparents did. Therefore, teachers only met her at Parent's evenings and Early Help meetings. Her maternal grandmother's Personal Assistant also cared for Ella Rose at points being more of a family friend as well as her mother's employee, employed through her Carer Allowance Direct Payments.

15.Anna had been diagnosed with EUPD in 2016 and received support from Coventry and Warwickshire Partnership NHS Trust for two periods, the first out of scope March 2017 to February 2018 when she was assessed and accepted for a programme of treatment of Dialectical Behaviour Therapy (DBT), an intense course of 1 to 1 and group sessions to build emotional resilience and skills. Anna was unable to sustain her involvement which her Mental Health Care Co-ordinator recognised may have partly been due to her age. A second period of support was offered by the same member of staff from mid October 2018 to a final contact in February 2019 when conditions within the home were poor but clean. Her case was closed by the service in April 2019 due to lack of engagement and whilst other agencies had concerns, there is no record of a discussion around this decision. It was noted by the Mental Health Care Co-ordinator that Annas mobility had massively deteriorated; in February 2018 Anna was walking unaided and by the October 2018, she had needed a mobility scooter and was unable to walk unaided.

16.The National Institute for Health and Care Excellence and Social Care Directorate (NICE) issued[4] a quality standards document, (Personality Disorders) in which it acknowledges that "People with personality disorders may have frequently been excluded from health or social care services because of their diagnosis". Borderline personality disorder is more frequently diagnosed among women. The Guidelines further recognised the link between certain behaviour traits some of which applied to Anna and EUPD "People with borderline and antisocial disorders tend to have high prevalence of substance misuse, depression, suicide and be more likely to be unemployed and have difficulties building relationships. Criminal behaviour is central to antisocial personality disorder. These are not protected characteristics, but they can make people vulnerable to exclusion, judgmental attitude, and poor experience of care". This suggests that the Anna's poor engagement which excluded her from receiving services from Community Mental Health Services was likely to have been a feature of her disability and not simply a wilful refusal to engage. There is evidence

[4] https://www.nice.org.uk/guidance/qs88/documents/personality-disorders-borderline-and-antisocial-quality-standard-equality-analysis-12

that a bespoke approach can be more successful in engaging this difficult to reach group.

17. Children's Services state the family had been known to services "for many years." Existing ongoing support was escalated to Child in Need (CIN) status on 25th of November 2016 due to a number of social and behavioural concerns- accommodation, managing Ella Rose, hygiene and both Anna's and her then partner's mental health. This support ended in January 2018, following improvements in the conditions within the house, Anna's behaviour, and emotional stability. Ella Rose appeared to be in consistent and regular education starting at her local school in September 2018. The school reported concerns about Ella Roses' clothes smelling, home conditions, attendance, and punctuality. They also reported that she was being bullied at school. The school reported that the previous nurseries she had attended had also identified safeguarding concerns. Throughout her time in this school the staff priority was described as making sure she was not hungry and had friends. The school applied for Pupil Premium funding to ensure all clubs and trips were paid for, as they were aware of Anna and Jack being in significant rent arrears. The school had significant contact with Jack, Anna's partner and describe him as compliant and showing little emotion. They feel he did not understand how to care for Ella Rose, for instance when she fell and hurt herself on the walk to school, he just handed her over for the staff to comfort and tend to her injuries as he appeared not know what to do or how to comfort her.

18. In February 2018 Children's Services visited Anna's home following a referral from Anna's GP with concerns about cleanliness and hygiene within the home following a visit, contrary to the Mental Health Care Co-ordinator view who had visited the home five times in the January and February of 2019. A deterioration was noted in both Annas physical condition and reported pain and that she was stressed by the 'clutter' her new partner had 'brought with him'. The Social Worker provided advice; no other action was taken. The Leaving Care team remained involved in supporting Anna as she was a care leaver. It Is significant that Anna's foster carer stated Anna had deteriorated both physically and emotionally after meeting Jack in October 2017. The foster carers view was that Anna appeared to "lose her voice and all her confidence" and that soon after meeting him she needed a mobility scooter whereas previously had not. The foster carer who saw the family frequently every few weeks at family events describes Jack as a "controlling and undermining person". This information was not shared.

19. From March 2018 records indicate a deterioration in Anna. The Leaving Care Team identified concerns about cleanliness in the home. A complaint was received by the Police concerning Anna refusing to return two cats to their owners who had been staying at the property, and an allegation of Ella Rose being 'touched inappropriately to her hair' to which the Police responded and notified Children's Services but that no further action was felt to be needed. The Police Officers attending noted the house was 'in a state' but were satisfied by Anna's explanation that she had only just returned home after two months. Anna's mother Louise made two attempts to take her own life in May and December 2018, and Anna moved to

Telford with her new partner Jack, to be near his family. Although housed on a temporary basis by Local Authorities from this time until her death she never acquired again a secure tenancy and what she felt to be a suitable home. Anna made a further attempt to take her own life in September 2018, stating on the 16th of September according to the West Midland Ambulance Services that "she had gypsy blood and because of this she was able to "speak to the dead" and had been having conversations with her fiancé's Mother. She also stated she had "passed the gift to her Daughter". A safeguarding referral was made on Ella Rose following this incident.

20. Anna was registered during the period under review with three GP practices. All were aware of her EUPD diagnosis, overdose history and suicide concerns but only GP Surgery 1 knew of her Child in Care status, the other two were unaware of her involvement with the Leaving Care Team. However, her contact with the GP's was limited. During 2017 and 2018 she was regularly prescribed medication for depression and anti-psychotic and morphine-based pain medication, her last prescription was in February 2019. The GP Surgery 2 stated that because of her history and EUPD she was discussed at their safeguarding MDT in October and November 2018 when they noted she was engaging with the Mental Health Team. In July 2019 she left the GP Surgery 2 Practice for the GP Surgery 3 where she was not seen as she did not request an appointment.

21. In December 2018 Ella Rose was identified as a Child in Need. This was 'stepped down' in May 2019 to 'Early Help'. The Deputy Head, also the Designated Safeguarding Lead (DSL) at Ella Rose's school state they were not in agreement with this decision and that their concerns were 'dismissed' by the Social Worker, although the records indicate the meeting was unanimous in the decision to step down. Although not recorded in any documents seen it should be acknowledged that the effect on Ella Rose of these experiences in early life, even before the death of her mother would have been significant and difficult, with emotional and practical impact. Living with an unhygienic mess, stress, and arguments in the home, cared by three different people in different places every week and being bullied at school would have made it unlikely that she was able to feel secure or safe. It is the Panels view that the ongoing consistent care by Owen and his parents did provide her with some routine and stability. Owen, since Anna's suicide has arranged a 'child friendly farewell' to Anna for Ella Rose and he should be recognised for that. These factors will likely have an impact on her development, emotional stability, and resilience into the long term.

4.The Family views

The Panel discussed at length the safest and most responsible way to communicate with those close to Anna during the period under review that is her mother Louise, Ella Rose's father Owen and her ex-partner Jack. Checks were made to establish the current addresses and if there was any agency contact and potential ongoing support available to those involved prior to letters being sent in November 2020. These letters yielded no response, and a further reminder letter was sent in January 2021. It must be noted that the country was in lockdown during the review period and all families had many other issues to contend with. Following the second letter the

Panels view was that further contact may be unhelpful. Without doubt this review is poorer as did not benefit from the views of those close to Anna on the events that led to her untimely death.

5. Key Decisions

1. On the available evidence it is impossible to say if different decisions had been made whether the outcome for Anna would have been any different. However, if we consider what the impact may have been of certain decisions made that seem to us to be key in the management of this case, we can ask the question; why was this decision made and what may have been the impact of it? Consideration can then be made as to whether the decision was a good one, an unavoidable one or something to consider.

2. In the Panel's view one of the key decisions was that made by Children's Services to end the involvement of Children in Need support and replace it with 'Early Help'. Both periods of CIN support were stepped down to Early Help; on the 29th of January 2018 based on the progress made by Anna, that the risks were reduced and that there were 'no safeguarding concerns' in relation to Ella Rose. Despite her being in a very new relationship with an unknown man and having given up her College course. The second decision to end Children's Services involvement was on the 14th of May 2019 with a transfer to Early Help on the 11th of June 2019 due to progress made. However, in July 2019 a MARF (Multi Agency Risk Form) was submitted to the MASH due to concerns similar to previous ones, Anna's mental health issues, her ongoing struggle to provide a suitable home and care for Ella Rose and her further pregnancy. The MARF did not generate an escalation to CIN or a longer-term plan, such as a referral to the Reablement Service or to Adult Social Care. The reason for this should be explored, as it seems that there were indicators that suggested she was vulnerable as an adult and needed additional support. Was a referral considered and discounted? Was it not considered at all? And if not why was this?

3. The problem of hygiene and pets; we learned at points that there was a dog, a snake and four cats in the house throughout the period her daughter was a CIN. Problems created by these were the reason that the Police made a referral to Children's Services when they attended her home in October 2019. Were these problems known to exist before the Police call out? If they were known were, they investigated? Given the history and background to the case it would be of value to know if this type of information if gathered was able to contribute to an understanding of the potential risks faced by Ella Rose in the home environment by the pets, and the capacity of her parents to manage her, the home, and the pets.

4. Although the report provided by Children's Service state there is evidence of a 'Think Family' approach, The Panel's view is that the 'stepping down 'of both periods from CIN to Early Help suggest an over optimism and a lack of scrutiny of the risks presented by Anna and partner to her child, and an overconfidence in the level of improvement of both the care of Ella Rose and the environment she lived in being sustained. Jack moving in with Anna in October 2017 was seen as a positive thing, he was described by Anna and accepted by the agencies working with her as her carer. There is no evidence of any checks being made on him. The ex-foster carer

who saw Anna, Jack and Ella Rose regularly felt he was a controlling man who had silenced Anna and believe he was a factor in her decreasing mobility, this view was not shared with other agencies. The lack of a prescription being dispensed for her usual pain controlling medication from February 2019 may be linked to her decreasing mobility. Although described as a carer he was seen by the school and Leaving Care Team Personal Adviser as compliant but needing to be told what to do, so although an extra pair of hands he needed Anna to manage and direct him.

5.The decisions made to step down to Early Help appears based on evidence that was given more significance than it merited. The first step down decision was made in January 2018 just after Jack joined the family. He was an unknown quantity, and assumptions were made about the positives he brought that were not evidence based. The family decided to move home to be nearer his family. From the point of Anna moving out of her house in March 2018, she never regained a secure tenancy nor a home she was happy with according to records. Although she described Jack's family as supportive, in reality, she Jack and Ella Rose were in April 2018 staying in the living room of a relative who was a registered sex offender. From here we see the local Borough Housing team providing temporary accommodation from her move and accepting a duty to house her in March 2019 and her later being placed on the priority housing list. The Leaving Care Team felt that Anna moving made the task of information sharing outside of the CIN framework more difficult. The Panel is aware these opinions are made with the benefit of hindsight not available to workers at the time. They do however highlight the importance of assessing current circumstances such as the background of a new partner, circumstances and resilience of the person receiving services using more than one source of information if possible. Anna's foster carer did not believe Jack to be good for Anna and suggested in interview with me that although he appeared 'passive' Anna always deferred to him, did not challenge him as she had her previous partner Owen and was suspicious of her 'needing' a wheelchair shortly after meeting him. These views were not shared with Children's Services as he was not perceived by them to be a threat to or negative influence on Anna or Ella Rose. Why was an assessment not undertaken regarding Jack and his suitability to be a carer for Anna and by default Ella Rose? In addition, why were the frequent moves and lack of secure housing not seen as indicators of increased risk in a household already beset by a number of significant difficulties, all with the capability to increase Anna and Ella Rose's vulnerability?

6. There was evidence of recent improvement at the time of both decisions to step down support to Early Help from CIN in January 2018 and April 2019. Report of positive relationship with Jack, return to College and working with CPN, in both instances seemed to support the decision to be made to 'step down.' It seems that the improvements made which had only been in place a short time outweighed both the chronic and recent risk indicators such as attempts to end her life, Anna's lived experience as a child and the resulting number of Adverse Childhood Experiences, EUPD, deteriorating mobility and health. It should be remembered that decision to step down in April 2019 was made just 6 months after three successive attempts by Anna to end her life. Risk of relapse into previous behaviour and her EUPD

diagnosis does not appear to figure in the decision to step down support. If this is the case what are the reasons for this?

8. Anna had been diagnosed with EUPD in March 2016, which is a serious and chronic condition which requires long term behavioural therapy and is not responsive to drug therapy. Improvement therefore is dependent on patient cooperation and engagement which Anna had already demonstrated she did not have the capacity to sustain. The nature of EUPD as described by the Royal College above brings with it conditions which can make long term work and the person receiving services buy-in problematic. This recurring feature of Anna's behaviour, probably linked to her EUPD was not in the Panel's view factored in by Children's Services when considering the sustainability of change and the risk of relapse into problematic behaviour and distorted thinking. The professionals close to her described a pattern in Anna's life of a cycle of her starting not to cope- professional help increases ability to cope- step down from help- not coping. Was this long term and difficult to treat mental Health condition factored into the assessment around the decision to step down support? If not, why was this?

9.The review was informed that an Early Help Headteacher Coach has been in post since September 2020 and that Early Help Social Workers were recruited in October 2020 to support schools and professionals to appropriately support high level and complex Early Help cases. This more robust professional response was to be reinforced by the adoption of the 'Solihull Model' in which more stable young parents who were themselves Children in Care offer peer mentoring. Parent mentor training was due to start but has been delayed due to Covid-19. Clearly these resources were not available to Anna and the Services working with her at the time. It is a moot point as to whether a different outcome would have been achieved had they been

10.It is the Panel's view that the decision to reduce support from CIN to Early Help on both dates was taken on unreliable information and an over reliance on information from one source, Anna, who the Leaving Care Team knew was 'wary' of Social Workers. In July 2019 at an Early Help pre-school holiday meeting Anna described a packed schedule of exciting activities that Ella Rose would be enjoying over the summer. This schedule may have been partly due to her paternal grandparents' input, but for the time in Anna's and Jack's care was undoubtedly either over optimistic or untrue and should have triggered concerns of Disguised Compliance. It showed a lack of understanding of the impact of Anna's EUPD on her attitudes, capacity, and behaviour, particularly when one considers she was in chronic pain most of the time and the impact that is known to have on mood and emotions by itself.

11. Another key element in this case was the approach taken by mental health services to Anna who was not compliant but capable of inflicting serious harm on herself and on others, primarily her daughter. The NICE guidelines[5] Borderline

[5] https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#assessment-and-management-by-community-mental-health-services

personality disorder: recognition and management published in January 2009 describe in section 1.3.2 Care planning:

Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user. The care plan should identify clearly the roles and responsibilities of all health and social care professionals involved.

The review was unable to evidence this had happened apart from a briefing given to Children Services when she was first diagnosed (not examined as out of scope). Anna was unable to sustain the DBT and so opted out but was not referred to a second line of less demanding treatment aimed at helping the person receiving services to manage their emotions. Anna disclosed hearing voices these were helpfully described by her Care Co-ordinator as 'pseudo voices' in that they are negative self-talk based on childhood trauma as opposed to voices telling her to act in a certain way. These undermining thoughts coupled with her multiple bereavements and loss and her belief she could 'talk to the dead' indicate that she needed more than mental health first aid from the professionals working with her. There is a significant drop out rate from the DBT significantly her age appeared to be a known a factor impacting on the persons receiving services completing the programme. The Mental Health Care Co-ordinator informed the review that Children's Services were fully briefed on Anna's diagnosis, but it appears that the skills to manage common presenting issues in those with a EUPD diagnosis were if shared with Children's Services not integrated into the work supporting Anna. The decision by Mental Health Services to end treatment does not seem to have been made after any consultation with Children's Services or the Leaving Care Team. The criteria used appears to have been her non-compliance with treatment offered. If the persons receiving services are known to be difficult to engage it makes the case more strongly for a different approach. They may appear reluctant and suspicious, and we have to accept our approach may not work and therefore be as flexible as we can. There is evidence to suggest an individualised approach can work. Otherwise, the implication is this group (PD) cannot be worked with. Therefore, our offer may need to be if possible individual work not groupwork, home visits to explain things not letters, co working with other professionals, consistency in their key worker will make engagement more likely with this group.

12.There are many instances within the chronology of this case in which Anna was referred to Community Mental Health Services following one of her seven attempts to end her life or self-harming episodes, for her care to be ended due to her non-attendance. There was also a lack of flexibility in terms of how they worked with Anna, mental health services making it clear that one to one contact was not available, and she would be discharged from the service if she did not attend what was on offer. The one exception to this approach was between 4th January 2018 and the 4th of March 2018 when eight home visits were made and in which Anna appeared to engage and cooperate with the Care Co-ordinator visiting after an attempt to take her own life and follow-on referral to the Community Mental Health Team. There is no evidence other than this period of Community Mental Health Services adapting what they offered to take account of Anna's poor compliance.

13. This approach does not seem to be cost effective across the wider provision of services given the number of 999 calls and emergency hospital admissions, five in all within two and a half years involving Anna in terms of time and resources, as well as better outcomes for Anna and Ella Rose. In the Panels view it would have been more cost effective to have made her cooperation a priority, recognising the potential harm to herself and her daughter and resource it appropriately and flexibly. There is no evidence either of Community Mental Health Services consulting with other agencies that worked with Anna in terms of their decisions to end contact. There is no evidence of Community Mental Health Services working in collaboration with Anna or other services to seek a way to improve her engagement with them. That improvement was possible is evidenced by the maintenance of contact with Anna between January and March 2019 using home visits and a CPN she knew and trusted.

14.That the school did not escalate their concerns in the stepping down of Ella Rose's supervision from CIN to Early Help is also pivotal despite the school having frequent concerns about the combination of the smell of animal urine to the point it ruined books, her exhausting walks to school[6], bullying and her hunger. It is evident they had the most day to contact with Ella Rose and were aware of a number of risk factors; she was stealing food from another child's plate, poor attendance, lateness, being bullied in school and her clothes, coat, school bag and books smelling of animal urine. Despite this the school did not feel able to escalate their concerns about the step-down decision. The reason for this need examining as the staff in the school were clearly concerned about Ella Rose's welfare. Were the school not aware of the escalation process? Did they not feel it their responsibility? Or did they feel professionally unable to challenge the decision, or the Social Worker?

15. No agency working with Anna made a referral to the Reablement Service despite her increasing mobility issues, the service offers up to 6 weeks of support to improve areas such as personal care and running the household, which related to a skills deficit, lack of confidence, and/or Anna adapting to her physical disability. No agency considered or had a discussion with Adult Social Care (ASC) about a referral to assess her care and support needs in the short or longer term. It appears from the records that, because of her mental and physical health problems some which were deteriorating, she might have had care and support needs which meant that she was entitled to an assessment from Adult Social Care The outcome was that apart from the limited support that the Leaving Care Team could offer, particularly after Anna became 21, there was no agency providing long term support to Anna in her own right, despite her ongoing mental health issues and what was probably clear to the professionals involved her deteriorating mobility.

16. The MASH sought information from her GP in November 2018 following Anna's overdose and received information via the MARF in July 2019 from the Early Help meeting due to concerns about the home, hygiene, Ella Roses' schooling and her

[6] ttps://www.nhs.uk/live-well/exercise/physical-activity-guidelines-children-and-young-people/ Children and young people aged 5 to 18 should aim for an average of at least 60 minutes of moderate intensity physical activity a day across the week

recent miscarriage. ASC are part of the MASH, a member of the Safeguarding Adult Team is co-located but they are not routinely involved in discussions regarding children, although they should be included where they can advise or contribute to a case. A referral to the Reablement Service was not considered. Following the Police attending on the 1st of October 2019 a strategy meeting within the Initial Response Service was held and again ASC did not attend, nor the MASH make a referral to them. The MASH appears not to have access to Anna's full history of repeated attempts from 2013 onwards to self -harm and to take her own life by overdose or hanging. However, the triage completed by the Police Harm Assessment Unit included some details of Anna's mental health, attempts to self-harm and medical history providing significant information to indicate Anna's vulnerabilities. Following the Reflective Learning event, it was suggested that "some kind of bullet point document with risk indicators might have been useful for the social work staff who attended later on the 1st of October 2019". The view at the Reflective Learning event was that ASC would not have accepted a referral as Children's Services were involved as they would expect them to assess the whole family. This gap in information sharing within the MASH in terms of the Harm Assessment Unit and ASC was discussed at the Reflective Learning event and raised by the Police response after the Learning event is a cause for concern. At the time of writing this review we are aware a review of the MASH was due to report in January 2021.

17. On the Home Visit by Children's Services Team 1st of October Anna was not seen by the Social Workers involved as a person with care and support needs despite her obvious mobility issues and the appalling state of the home which demonstrated a long-term failure to cope. The focus was on Ella Rose. Agencies visited the home in sequence and the Strategy meeting at the MASH which we have learned had only limited information did not identify an approach that reflected a 'Think Family' approach. The risks identified by the Harm Assessment Unit were not shared with the Social Workers who attended and agreed the improvements required with Anna. Their approach to their task indicates they had no knowledge of Anna's needs as well as Ella Rose is and shaped a response which balanced support and scrutiny to what they knew of the family. The Social Workers attending did not have access to significant information on Anna's mental and physical health, nor information from Strengthening Families or from the Police assessment made by the Harm Assessment Unit on 1st October. They adopted a "hard-line" as they understood from Anna that she had the capacity to make the property habitable with the support of a friend who they met at the property. Anna told the Social Workers attending that her relationship with Jack had ended and she was preoccupied by that. They found her to be motivated to clean up to provide a decent home for Ella Rose and confident she could do this. The Social work team that visited had the opportunity before their visit to access information held on their own system which identified Anna as a Care Leaver with other support needs and receiving support from the Leaving Care Team. They encouraged her to take a break and look after herself and as Ella Rose was in the care of her grandparents, she had time to make the property fit for Ella Rose to live in.

18. In the weeks running up to her mother's death School records indicate that Ella Rose was 'clean and happy' in school, her reading books no longer smelled of animal urine, her homework was being checked and signed, all signs of a settled home. This picture of the child is at odds with the home conditions seen by agencies on the 1st of October 2019 and suggests she may have been with her father and his family.

6. Analysis of events

In seeking to understand and evaluate the impact of the key events and decisions made there appear several key issues:

1.That the decisions to remove Ella Rose from CIN plan left services with limited oversight of mother and daughter and no Social Work support, apart from limited support from the Leaving Care Team. The school expressed concern that they were not resourced to provide the Early Help intervention that replaced the Child in Need support. The decision to withdraw was made on the evidence of progress made by Anna in her home and in cooperating and engaging with Community Mental Health Services. In addition, the presence of Jack as her new partner and 'carer' and his family were accepted as positive, increasing the sense that it was safe to withdraw services. Such a view ignored the evidence available; that Anna historically was non-compliant with Community Mental Health Services, that Jack and his family was an unknown factor recently introduced and crucially not checked out as to the net value they introduced into the family dynamic, and on Anna's resilience and ability to sustain change and meet challenges constructively. In addition, it took no account of the chronic impact of Anna's EUPD on her ability to manage stress, new relationships and destructive thoughts and feelings for which she was receiving intermittent treatment within the community due to her difficulties in engaging but also in part because of the inability of Community Mental health Services to adapt the services it provided to her.

2. We have learned that other family members had a history of overdoses and one of her brothers had killed himself in 2015. This information was not known to all agencies. It is recognised that both Anna and her family had a history of suicide and psychiatric illnesses. There is no evidence that Anna's repeat attempts to take her own life was seen as a pattern suggesting future risk of suicide or self-harm by services working with her.

3. The introduction of Jack into the family appears of significance. He was seen by those working with Anna as a positive influence helping her in the home and collecting Ella Rose with Anna seen as the 'dominant' person in the relationship. A contrary view has been expressed by Anna's ex-foster carer describing him as "a controlling individual who silenced Anna". Jack, in terms of this review remains an unknown quantity. It was only four months from his arrival in October 2017 that Anna and her family moved from their secure tenancy in Warwickshire, and she left her college course, to be nearer Jack's family. Anna moved home five times from February 2018 to her death. Although the local Borough Council appeared to work closely with the family, providing temporary accommodation and accepting their duty to house her, Anna never again achieved a secure tenancy. There was some

indication of tension that Jack's presence had brought to the home with the Children's Service's Social Worker noting that Anna was "struggling" with the "clutter" he had brought to the home in a visit made on the 3rd of February 2018. The family GP had earlier referred the family to Children's Services due the condition of the home. This was not seen as a possible relapse into earlier behaviours, and she was only given advice to contact Occupational Therapy. Potential warning signs were not picked up indicating the fragility of progress made by Anna, suggesting the impact of Jack may not have been altogether positive. This referral and follow up investigation did not appear to lead Children's Services to reconsider its step-down decision. It is also noted by the Leaving Care Team that information sharing reduced when Anna left to be near Jack's family, that communication outside of the CIN framework did not occur regularly. Again, making it difficult for agencies to maintain oversight of the case.

4. Good information exchange sharing between the services working with Anna was not always achieved. The CIN framework appeared positive in achieving this, and the MASH Team contacted other services appropriately but outside of that there were clear gaps. ASC are co-located within the MASH but was not involved in the Anna case discussions. The Community Mental Health Service did not regularly liaise with Children's Services in relation to Anna, thus reducing effective working. The local Borough Council Housing Team state they were not invited to CIN meetings after 2016, despite the very real risks stemming from the family leaving their property in February 2018 and often being provided with unsuitable accommodation. Housing reported that Anna and the family were moved five times and sometimes into hotels and a caravan after they left their home. There were exceptions which are detailed below, but overall key decisions were made by agencies without consultation with others. The Leaving Care Team state they were not invited to a Strategy Meeting involving Anna on the 1st of October2019 despite having the most consistent and recent contact with her.

5. A more effective approach to Anna's mental health care and her difficulties in engaging on a non-acute basis was never discussed with the other services. There seemed to be a culture within that service as described by the report of the Leaving Care Team for this enquiry; "the approach of the Community Mental Health Team service is that the person needs to want to engage for their work to be effective" which whilst accurate for all cases appears to be a barrier to working together on a planned approach to those with lesser motivation to engage. A view could be that it seems such an approach discriminates against patients such as Anna who have low motivation because of capacity or mistrust or other barriers to attendance but present a high risk of harm to self and others. The Panel were informed at the Learning Event that Anna was motivated to ensure Ella Rose had a better childhood than she had, a good place for all agencies to plan from. It assumed that Anna had capacity to make decisions, which was not questioned or tested despite the repeated attempts to take her life and the extremely poor standard of hygiene. This lack of cooperation, coordination and information exchange reduced the effectiveness of both oversight and ensuring the safety of Anna and her child.

6. Six state services worked with Anna at various times of the period in scope. There appeared to be few examples of coordination and collaboration, including information sharing. The only agency that offered consistent support to Anna was the Leaving Care Team who due to their resources (the Personal Adviser role is resourced to be of a practical and limited nature)were limited in what they could do but despite this, attempts were made to link Anna with Adult Education through English and Maths sessions, a referral was made to the Citizens Advice Bureau and invitations to several Leaving Care events one of which Anna attended. The Leaving Care Team were seen by the GP Surgery 1 as holding a case manager role. They amongst the agencies appeared the most successful in securing Anna's cooperation.

7. Finally, the capacity of Anna to make decisions on her and her child's behalf does not seem to have been questioned despite the poor hygiene and repeated attempts to take her life. Her decisions particularly around leaving a secure tenancy, leaving college, and making Jack, whom she had not known for very long, her carer was never it seems questioned, all significant decisions for a young adult to make but especially one with such a troubled and insecure background and no close family member to discuss this with. At no point was advice sought from ASC about whether she had care and support needs.

8.From the chronology we see a pattern of Anna struggling to cope, receiving support from agencies, making short term improvements in her standard of care of herself and Ella Rose then once support is withdrawn a return to not coping. This pattern has been recognised by the school and the Leaving Care Team. Given her level of vulnerability, pain management and mobility issues there appear no consideration of a longer-term plan to support her. ASC it seems were never consulted or involved in assessment of Anna and whether she required support to keep herself safe in the longer term. This may have been due to several factors; normalisation to her behaviour and/or the impact of vicarious trauma on professionals working with her and a lack of understanding of the role of ASC. This assumption of capacity meant that the possibility of her access to other sources of support and treatment was never explored. As a person receiving services regardless of the issue of capacity but in terms of the family's future her options should have been discussed with her. There was nobody else in her life that could have taken the role of a 'supportive' parent figure.

9. This case highlights a number of training needs. At no point were the social work concepts of the 'Rule of Optimism' or 'Disguised Compliance' referred to or implicit within the evidence that has been available. The use of trauma informed approaches appeared likewise absent in all agencies contact with Anna. This despite it being known she had experienced significant Adverse Childhood Experiences and was replicating some of this in her care of Ella Rose, and her own self harm and suicide attempts. The lack of inquisitive enquiry as to the nature of Anna 's relationship with Jack and the reasons behind their move from their home, suggests a lack of understanding of the incidence and indicators of coercive and controlling behaviours. The lack of reference to her EUPD diagnosis and emotional management issues demonstrated in her pattern of suicide attempts suggests a need for training on this issue and a multi-disciplinary care pathway to manage the risks and aid recovery.

The inability of Ella Roses school to escalate their concerns about the decision made in Ella Rose's Safeguarding Review to step down indicates a training need for the school.

7. Wider significance

1.The issues that are likely to be relevant in terms of management of future cases are firstly the lack of a holistic view of Anna's life. She was demanding in terms of resources such as 999 calls, emergency hospital admissions and yet no service was able to establish effective control and management of her to ensure the cycle of decline in mood and coping, emergency admission, referral to community resources and failure to attend follow up was addressed. There are potentially other people receiving services in the area with similar characteristics that is low motivation due to mental health issues and beyond the control of the individual but high needs and high risk of harm to self and others within the area. There is an example out of scope of this review when in June 2017 Anna was discussed at the Leaving Care Panel who recognised that the group work intervention offered by Mental Health Services did not work for Anna. They had concerns that her lack of willingness to engage may be related to her EUPD, and which the CPN with her professional knowledge was able to confirm. This demonstrates the need for a multi-agency approach across the disciplines, involving health, adult and children's social care, mental health, acute medical care, and the emergency services. There were at least five agencies with regular contact with Anna in the period in scope. Despite her behaviour having an impact on all of them there was little liaison and no coordination of approach to Anna. Such cases can only be managed when agencies working with the person pool information, sequence and coordinate responses and approaches.

2. This case illustrates that the method of assessing risk by Children's Services needs to be improved. The significance of Anna's previous behaviour and relapses do not seem to have been considered in the decisions to end the CIN status of her child. The impact of her EUPD and implications of this for the care of her child also does not seem to have been understood and decision making about the progress she was making was largely dependent on one source, Anna herself and not verified. This could be improved by the adoption of a more inquisitive and risk led approach.

3. Ella Rose attended a local primary school, representatives from the school attended the meeting at which the decision to reduce supervision from Child in Need status to 'Early Help' was made despite the concern expressed by the school about this. Possibly they had more contact with Ella Rose and her mother and family than any other agency. That they felt unable to escalate their concerns formally is a concern and a potential opportunity missed to achieve a better outcome. There will clearly be similar situations likely to occur in the future. This issue of reluctance to challenge the decision of Children's Services at or after the meeting should be explored and addressed in the Designated Safeguarding Lead training. All agencies attending such key meetings need to be confident in challenging the way meetings are run, challenging the consensus, ensuring that their dissent is recorded in the minutes. managing conflict and how to escalate concerns in line with the agreed Policy. The Chairing of such meetings in an inclusive way is also necessary to

establish an agreed plan. This learning potentially by the role playing of practice based scenarios could be used to benefit all non-social work agencies involved in such meetings where a power differential between agencies is perceived.

4. The Panel's view is that there was within those working with Anna a lack of recognition of the impact and characteristics on behaviour and emotions of EUPD. Anna was assumed to have capacity by all agencies in responding to her behaviour. This assumption may have been correct, but the issue was never questioned. A better understanding of the impact of EUPD and what works in terms of this group of people receiving services is something that should be considered. It is a relatively common condition but can be difficult to identify as it can mistakenly be seen as difficult and resistant behaviour inherent in the person, rather than a condition which is treatable with the right resources and approach.

5. It seems that much of the work with Anna herself in terms of supervision, oversight and practical help was done by the Leaving Care Team and the Personal Adviser of Anna. The Leaving Care Team continued their involvement after Anna's 21st birthday, in line with her wishes and their concerns about her welfare and that of her child. Reliance on this level of support for care leavers is not sustainable as the Personal Adviser role is resourced to be of a practical and limited nature. A longer-term plan is required for those who at the end of their eligibility for this service still face difficulties as young adults. Services cannot depend in similar cases that adults will have such a resource behind them. Another way must be found to manage this high need/ high risk client group.

6. The University Hospital Coventry and Warwickshire team who dealt with Annas miscarriage on the 22nd and 29th July 2019 were on both occasions aware of her mental health history according to the chronology took no safeguarding action. At the time Anna was an open case at the CMHT. This is practice that needs to be improved.

8. Response to the questions posed

1. Information sharing.

Although after her death the foster carers learnt of her death on 'Face book' and contacted Children's Services. This news was deeply distressing for the foster carers who appreciate the speed with which social media disseminates news but would have benefited from an offer of support. The "Suicide, self-harm and accidental death amongst children in care/care leaver" guidance refers to contacting former foster carers and other service providers, and what appropriate services and support may be offered. This was at that time implemented by the Leaving Care Team in respect of the Children's Team and is being reviewed in light of the learning from this review to include the fostering service.

The MASH referral and response did not deliver as the model of multi- agency hubs intended a multi -agency approach to the referral made by the Police following their visit to Anna. This appears a systemic fault specific to the MASH in question and is not a generic issue relating to the model. It lies with the Local Authority to address this in the current review which reports in January 2021. Following discussions of the

findings from the MASH review with its author there appears recognition of the issues raised by this report in its conclusions. This MASH must find a structure which enables it to collate and evaluate information, access records, secure advice, and opinion from all sources rapidly, and agree a coordinated approach.

2. A Think Family approach.

There is no evidence of a Think Family approach in the case recording Annas needs as an adult were not referred to ASC or to the Reablement Service.

The strategy meeting on the 1st of October 2019 at the MASH was not attended by ASC and the Leaving Care team the service with the close working relationship with Anna (though it did had access to their recording) it appears a strategic Think Family approach was not agreed which reflected Annas need for support.

3. Silo working and the role of the Leaving Care team Personal Adviser.

Anna ‘s case demonstrates that Children and Adult services appear to operate in silo’s That the MASH referral although it generated a MARF did not lead to a referral to Adult Services in terms of Anna and her capacity and ability to protect herself and Ella Rose The MASH may be a vehicle for this.

4. CWPT decision making.

Anna case demonstrates that decisions to close her case were made without recourse to other agencies views or intentions. Anna when not coping with the offer of DBT work was not offered a less demanding structured programme. To address the issues she faced from her EUPD.

5. Anna’s physical needs.

It has not been possible to identify if Annas had a definitive diagnosis. At no point despite her declining mobility noticed by professionals was a referral made to the Reablement team. Though it appears some adaptions to her home was made at some point.

6. A trauma informed approach.

There is evidence the foster carers and Personal Adviser worked instinctively in a trauma-informed way that is listening to young people carefully, helping them recognise how past experiences influence their ways of relating to the world today and offering a trustworthy relationship where they can try to build a safer life for themselves and avoid the replication of traumatic experiences. However, there was no evidence of an agreed multi-agency strategic approach to Anna who had experienced many ACEs herself. Much of the focus of the contact with Anna was on the outcomes of her care of Ella Rose rather than her own experiences and the impact on her as an individual and as a mother.

7.Understanding of DWP PIP.

This review was asked to consider if assumptions were made by professionals that DWP PIP is only accessible to adults via a formal care assessment undertaken by

Adult Social Care, and why was there no follow-up on this to understand the process. The records reviewed have not highlighted an understanding of the DWP PIP process.

8.The impact of Jack's leaving Anna's suicide.

The Social Worker attending on the 1st of October 2019 were clearly of the opinion that Anna believed Jack had ended the relationship and that she was preoccupied by this. As the review has had no contact with family members or Jack the review cannot comment on whether this ultimately contributed to her taking her life.

9.Role of the Corporate Parent.

The role of the Corporate Parent was not referred to in the Individual Management reviews provided to the review. Corporate Parenting is the "collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are looked after by us". This needs to be translated in to clear actions for Children in Care when they become young adults. As point 8 in the Analysis section of this report states 'As a person receiving services regardless of the issue of capacity but in terms of the family's future her options should have been discussed with her. There was nobody else in her life that could have taken the role of a 'supportive' parent figure.' In this review we have seen Anna did not have an independent adult or advocate to discuss the significant life decisions she was making such as leaving a secure tenancy to be nearer to the family of a new partner.

9. Good Practice

1. The approach, application, and resilience of the Personal Adviser in the Leaving Care Team involved in this case is a shining example of good practice. Anna had the same worker through most of the period in scope ensuring consistency. Communication was maintained by home visit and telephone and there is evidence of regular information exchange with others. The Personal Adviser and her manager visited Anna in hospital after an attempt to take her life, a powerful message of concern and care expressed to Anna by that gesture. The Personal Adviser also communicated regularly with other agencies involved in her care. The Personal Adviser emailed Community Mental Health Services to express her concern after Anna's discharge from hospital. She with the support of her manager also initiated a multi-agency forum on receiving a psychological diagnosis, possibly of Anna's EUPD status in June 2017 to secure better inter-agency work and communication. The Leaving Care Team were the team that were constant in their supervision of Anna. The Panel's view is that they exceeded their limited brief in doing this

2. Another example of good practice was that demonstrated by the Community Mental Health Team which between January and April 2019 after becoming involved following another attempt to end her life managed to maintain contact and continued to work with Anna for the longest period at any time within scope. They did this by making home visits, an adaption that was enough to secure compliance for a significant period and the CPN was a professional that Anna knew and trusted.

3. The local Borough Housing Team also demonstrated a positive approach to Anna. Accepting responsibility to find her temporary accommodation, and accepting their duty to house, despite Anna leaving a secure tenancy in Warwickshire voluntarily. They demonstrated by this a flexibility and sense of responsibility to help, much of which was at their discretion to do so.

4.The Children's Services Team Manager enabled Anna to share her possible miscarriage with her and alongside the Duty team present offered her support. That Anna felt able to disclose something of significance and personal to the agency suggests that a degree of empathy and compassion was shown by those involved to have enabled this disclosure of vulnerability from Anna.

5. Although out of scope of this Learning Review, the support and care given to Anna by her foster carers and their wider family was impressive. They continued to include Anna and her family in all family gatherings after leaving the placement. Her foster carer was reportedly described by Anna as "the family she should have had all along".

6. The Reflective Learning event identified that the Police Critical Incident debriefing process offered significant support to the professionals involved many of whom were deeply shocked by this tragedy. This policy and guidance were immediately shared with other agencies attending the event.

10. Conclusion

1. It is important when considering service improvement not to fall back onto recommendations based on training staff. This can often be a panacea that masks the real issue which can be a combination of culture, resources, the quality of supervision and even inertia, in that this is how things have always been done.

2. In this case it seems that the issue of professional optimism which may be organisational as well as worker located along with resource scarcity led to a failure by a number of agencies to recognise warning signs and to grasp 'improvements' which turned out to be temporary as signs of established recovery. We hope that this case will show that such an approach is not realistic and too costly in the longer term to be maintained.

3. Improvements will only be made in the management of cases such as this when there is a multi-disciplinary body that can collate information and interventions from all statutory and non-statutory services, including mental health services and direct a unified response based on known and evaluated principles. Along with a willingness to share information with other agencies consistent with GDPR. This was not reflected in the practice of the MASH at that time.

4. Anna is a tragic case that is emblematic of how our services respond on an incident basis and how workers within those services can become isolated and desensitised to the risky behaviours and levels of abuse, neglect, and chaos that we know we would not accept for ourselves or our children. In making this statement it is of concern that the CMHT were not represented on the Panel. Their involvement in working with this group of people receiving services alongside the other agencies will be critical if it is to be successful.

5. The Panel were informed in the significant investment into Early Help to ensure schools are resourced to fulfil their responsibilities and be part of a wider system to support families in a holistic way. The Adverse Childhood Experiences (ACE) training planned for 2020 delayed by the pandemic will support trauma informed practice and enhance the restorative offer to children and families In Warwickshire. This planned training is and to be delivered by Dr Karen Treisman to the Senior Leadership Team, Operations Managers, Team Leaders and nominated staff to embed cultural change. Anna, we know was replicating the care she received as a child and by understanding her ACEs the offer to her could have been different.

6. Specifically, the following areas need to be addressed:

- That events that become historic such as suicide attempts, overdoses, trauma are recognised as current risk factors in all assessments involving adults and children irrespective of the type of assessment and are evaluated for their impact and likelihood to affect present day functioning.
- That knowledge and awareness of Personality Disorder, a significant unaddressed feature in this case be spread and shared through critical person facing bodies- Children and Adult Services, Education, Pre, and Post Natal care
- That change in families, situations, or people within them are seen as a potential risk factor as well as potential protective factors for example a new adult entering the family, planned relocation to another area, etc and are accurately assessed by means which does not rely on one source of information.

11.Recommendations

1. Warwickshire Safeguarding to seek assurance that the Community Mental Health Services deliver its approach to treatment for people with a Personality Disorder (PD) in line with NICE Guidance to promote improved access to treatment for this group.

2. That Children's Services consider how they have the skills, knowledge, and case support to understand and work with people who use services with PD.

   In addition, a review of online training that all front-facing staff (including Reception, Ambulance Trust etc) are required to access to improve knowledge, understanding and where appropriate skill in working with people with mental health issues including PD.

3. In order to effectively assess and manage risk, those who have direct contact with the person receiving support need to have access to all relevant and current information about the person to properly support them.
4. That a multi-agency task and finish group be established to address the gap in information sharing that this case has highlighted to better embed the Think Family approach. Those relevant agencies, including the Police consider the

impact of their actions related to the protection of children have on vulnerable adult family members.

5. That those working with children are aware of the role that Social Care and Support can play in supporting adults with care and support needs and how referrals are made and that identifying and addressing care and support needs of adults is part of the 'Think Family' Approach.

6. The forthcoming review of the Children and Families Front Door ensure that the failings in information sharing identified by this review are addressed. In particular the need for a single point of contact to enable the pooling of all known information from all relevant agencies leading to a coordinated response is made on behalf of all agencies.

7. Warwickshire Safeguarding to seek assurance that the Escalation Protocol is fully embedded and being used effectively across all agencies.

   In addition, the Resolving Professional Differences/Escalation Policy be reissued to all staff attending decision making meetings. That Chairs of these meetings remind those attending of their duty to speak up should they disagree with the decisions taken and any dissent is recorded in the minutes.

8. Given the features of this case and the light it has shone on practice the Panel would suggest the following:

   i. That Warwickshire Safeguarding Partnership consider the review of existing supervision methods and frequency by sampling and evaluating a proportion of supervision sessions across the agencies that have had involvement in this case from a safeguarding perspective. This review to have a focus in particular on the use of Reflective Practice and the use of evidence-based processes.

   ii. That Warwickshire Safeguarding Partnership conduct a multi-disciplinary representative sample of cases to quality assure their case management processes and procedures for suitability in working with this group of people receiving services. Risks are diverse and include physical, sexual, and emotional risk to others and self and can literally escalate overnight. The brief would be to establish whether existing systems are resilient enough to cope with this group of people receiving services, and to identify strengths and weaknesses, and consider given the learning from this case what changes could be made, what help would be needed to achieve this change.

9. Warwickshire Safeguarding Partnership to develop a ‘Lessons Learned’ Briefing summarising this case and the learning arising from it (including Pupil Premium) and produce accompanying 7 Minute Briefings on the issues of Disguised Compliance, the Rule of Optimism (particularly around ‘new partners’ joining vulnerable families) and Poor care/ abuse of pets and safeguarding children, for dissemination to all staff within Warwickshire agencies. The 7-minute briefing on Suicide Prevention is to incorporate learning from this review.

10. Warwickshire Safeguarding gain assurance that the newly adopted Head Teacher coach is embedded in the MASH and the refreshed DSL Training includes information on the Escalation Process.

11. The added resources of an Early Help Headteacher Coach and Early Help Social workers and managers introduced in September and October 2020 should now ensure step up/down processes are effective. This case should be used to stress test and provide assurance to the Warwickshire Safeguarding Partnership that these new resources and arrangements are effective in cases that relate in particular to families in which mental health concerns have been identified.