Serious Case Review

SASHA

Published 7th May 2020

At the family's request the HSCB has named this SCR 'Sasha'.

Contents

Where technical terms are used (in bold) they can be understood further by reference to the London Child Protection Procedures, using the search facility http://www.londoncp.co.uk/search/search.html. When evaluating actions in this case reference should be made to the 2016 edition of the London Child Protection procedures.

The SCR was endorsed by the Hounslow Safeguarding Children Board (HSCB) in September 2018 but could not be published before the Inquest into Sasha's death, which was not held until May 2019.

In June 2019 the HSCB was replaced by the Hounslow Safeguarding Children Partnership.

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1. Introduction

1.1 The Chair of the HSCB decided that Sasha's death met the criteria for a Serious Case Review under: **Working Together to Safeguard Children, 2015**, chapter 4[1]. The primary purposes of a SCR are to identify key lessons and any improvements which are required in the context of local agency and multi-agency safeguarding systems.

1.2 Sasha was a vulnerable child and young person over a number of years. From late 2015 there was increasing concern about her. Sasha became looked after in March 2017 (aged 17) and died in August 2017. The Inquest in May 2019 decided that Sasha sadly died as a result of suicide.

1.3 In the period covered by this review, late 2015 to August 2017, Sasha received services from Children's Social Care, CAMHS, other local health services, Police, Youth Offending Services, Connexions, commissioned independent living services for looked after children, and services in relation to possible Child Sexual Exploitation. In the early part of the period under review (to summer 2016) she had been at school, in year 11; after that she should have been at college or have been in employment.

1.4 The Review Panel found no indication that Sasha's tragic death could have been anticipated. Although she had expressed acute anxiety and suicidal ideation earlier in the year in the weeks up to her death she did not speak of or show current suicidal thoughts or behaviour with any professional staff or with her family. When asked she said that she had not felt suicidal for some time.

1.5 The Review looked systemically at Sasha's life and the services she and her family were offered. It sought to learn from her difficulties as an adolescent and how she was adversely affected by her previous and current experiences and the negative social context of exploitation into which she was drawn, where others could take advantage of her vulnerabilities.

1.6 The HSCB thanks Sasha's family for their assistance in the Review and notes their love for her. Their perspective showed the challenges of supporting a young person in adolescence and how it is important to find ways to engage the whole family.

1.7 The HSCB also thanks the Practitioners and Managers who worked with Sasha for their openness to this learning process, and it notes their commitment to her and their own sense of grief at her tragic death. We saw some very good work and attempts to engage with a young woman who was independently minded but who was perhaps not as strong or resilient as she seemed.

[1] **Working Together to Safeguard Children**, 2015

1.8 Systems issues which may have been important in this case and more widely included workloads, understanding of and working with emotional attachment and ACE, a "start again culture", use of cannabis by young people, momentum and co-ordination in multi-agency work, IT systems and information sharing, recognising when young people are carers, NEET (Not in Education, Employment or Training) and the use of thresholds and step-down to Early Help services from in care or child in need.

1.9 Section 6 of this review analyses and evaluates the single agency and the multi-agency work and its co-ordination in detail.

1.10 The Review Panel identified four main lessons and some additional learning points. These are:

- Assessing anxiety, low or variable mood and suicidal ideation in adolescents.
- Assessing competence, resilience and emotional attachment disorder in adolescents and considering the impact of ACE and impact of cannabis use.
- Contextual Safeguarding (the need for a wider understanding across the workforce).
- Using a holistic family approach to assessing children and young people where their parents have difficulties.

1.11 Other lessons confirmed the need to consider the impact of a young person's full life history in assessments, the need to consider the impact of drug use, the importance of reflective supervision and the importance of management support to guide coordination and prioritisation when there are many tasks and several agencies supporting a young person.

1.12 The Hounslow Safeguarding Children Board (HSCB) endorsed the Review in September 2018 but it could not be published until after the Inquest which was not completed until May 2019.

1.13 The HSCB agreed the four recommendations from the Review Panel, namely:

- To work with the Safeguarding Adults Board to develop a "Think Family Approach"
- To review how practitioners are supported and trained in in assessing adolescents who have complex and unresolved emotional issues, possibly coupled with drug use and impulsivity
- To promote awareness of and response to Contextual Safeguarding
- To ensure that individual service user focussed risk assessments are undertaken in arranging placements in adolescent independence units.

These recommendations are set out in more detail in Section 8.

2. Summary of key events in Sasha's life

2.1 Sasha was the third of three children in her family. As a young child she had been made subject of a child protection plan and later care proceedings. Between 2006 and 2007 she was in foster care. She was returned to her mother's care and in 2009 the case was closed to Children's Services. Intermittently, concerns were raised about the quality of her care from 2009. In 2013 there was concern that her mother was again unwell, and Sasha moved to live with her older half-sister *(referred to in this report as sister)*. It was assessed that Sasha was resilient and that no additional action was required as her sister was able to care for her well. However, Sasha later returned to live with her mother whose health again deteriorated.

2.2 From late 2015 (approaching 16 years old) Sasha began acting out of character. She was absent from school and missed some exams. Up to that point she had been doing well academically and in sports. There was a question whether she was being exploited. Children's Social Care re-assessed the case. Sasha was thought to be being adversely affected by a peer. She did not want ongoing support from children's services and although it was agreed that referrals to other services were appropriate, they were not done. The school was to monitor her progress.

2.3 In April 2016, Sasha and her friend were charged for carrying an offensive weapon and being carried in a stolen car. This led to the involvement of the Youth Offending Service (YOS) and a Referral Order. There were increasing concerns about Sasha being involved on the edges of criminal activity, and possibly drugs. She missed some of her GCSE exams and went missing at times. Children's Social Care re-assessed her case. It was understood that Sasha had ended her friendship with the young person with whom she had been getting into trouble. Sasha was advised of services for drug use, given the concern about her use of cannabis, and advised about counselling; but she declined both referrals. It was noted that she may be at risk of sexual exploitation, but this was not followed up as planned.

2.4 From July 2016, YOS worked with Sasha under the Referral Order. There were continued concerns about her emotional stability and about drug use. She was later cautioned for possession of cannabis – which she was using regularly – although the extent of her use could not be fully established. She did not go to college as planned in the autumn and this was not picked up. By the December of 2016, she was no longer co-operating with the terms of the Referral Order and was not in education, employment or training.

2.5 In January 2017, police officers attended Sasha's home as she had reported that she believed there was someone in the house with a gun. Sasha told the officers that she was fearful of retribution as she had tried to withdraw from a gang of older men for whom she had carried drugs. She said that she had taken a small number of tablets but was assessed not to need emergency treatment.

2.6 Sasha was assessed by her GP the following day and was referred to CAMHS. Suicidal ideation was noted but she was not thought to be actively suicidal. Sasha did not respond to initial

contacts by CAMHS over several weeks. Later she was offered the services of the CAMHS Adolescent Team but did not engage well, often "forgetting appointments".

2.7 When she did talk with the CAMHS worker on the phone she spoke of anxiety and panic attacks, but she did not show current signs of risk of suicide.

2.8 YOS continued to work with her but were not initially aware of the increasing concerns about her mental health. Sasha was not co-operating with the Referral Order. CAMHS was having continued difficulty in engaging her.

2.9 Children's Social Care had been informed of the concern in January but there was a delay in allocating her case for re-assessment, pending the arrival of a practitioner who had worked previously with Sasha. By the end of March, Children's Social Care had completed the re-assessment and agreed that Sasha should be accommodated in care and placed in a small unit for preparation for independence, given her age (now 17) and the situation at home.

2.10 From the first Looked After Children Review, at the end of April, there was good multi-agency planning for Sasha. It was noted that she was at increasing risk of exploitation, including from a new boyfriend who was in his 20s and who appeared to be controlling her. She was given advice about this but would not accept that he may be controlling her or may be being abusive.

2.11 The Care Plan ensured that her health needs and that her education and training needs were assessed. This resulted in her being referred to more services for follow up of counselling and education. She was also referred to the Multi-Agency Sexual Exploitation Panel and to the Independent Domestic Violence Advisor for young people.

2.12 Sasha was confused about whether she was still a CAMHS patient as she had not kept appointments and thought they had closed her case. When she did have contact with CAMHS, at times by phone, she was not found to have suicidal ideation. She described regular panic attacks. Strategies for dealing with these were suggested but Sasha did not keep follow-up appointments and said that her boyfriend was discouraging her from doing so.

2.13 In mid-June, a Multi-Agency Strategy Meeting was held to consider risks to Sasha from her older boyfriend and concerns about her vulnerability in the Independence Unit where she was based, as there was no 24-hour staff presence. It was suggested that she should move.

2.14 Sasha was upset about the proposed move. She continued to miss her appointments with CAMHS and was disengaging with practitioners who were seeking to support her. Her Referral Order came to an end. This disengagement was seen to be because of the boyfriend's influence. It was thought that Sasha was smoking cannabis more.

2.15 At the second Looked After Children Review, in July, it was noted that Sasha was not safe in her current placement and that she would have to move. Sasha did not feel that she was being listened to and it was agreed that she would be consulted further and be able to visit the proposed new placement. She did not accept the risks of alleged sexual exploitation and was finding the thought of moving away to a different area very unsettling. Sasha agreed to meet with the CAMHS worker as she had found their session together very helpful; but she did not keep that appointment. There were no known concerns about risk of self-harm.

2.16 There was increasing evidence about risk to Sasha, but she wanted the proposed move to a different unit to be delayed until the Independent Reviewing Officer (IRO) returned from leave, believing that the IRO had told her that she would stay in the first unit until she was 21.

2.17 Sasha withdrew more from staff and there was concern that she was smoking cannabis more. The decision was made to go ahead with the proposed move as she was seen to be at risk, although she did not agree.

2.18 Sasha moved to the second Independent Unit at the beginning of August and quickly went on a few days planned trip with a volunteer scheme; but she returned early. The Independent Domestic Violence Advisor completed a risk assessment with Sasha and noted that she showed no signs of self-harm or suicidal ideation. In conversation with her social worker in the second week of August Sasha agreed to see the CAMHS worker, again. She told a member of staff in the new unit that she had not felt suicidal and had not self-harmed for a long time.

2.19 In mid-August Sasha spent most of a Sunday with her stepfather, as usual. They did their routine Sunday things together and he had no concern about her mood or behaviour. In the evening Sasha was visited by a friend who found her to be upset but the friend was not permitted to stay beyond visiting time. Sasha's boyfriend later attended the unit worried about a text he had received from her. Sasha was found hanging in her room. She died in hospital three days later.

3. Pen Picture and the Family's View of Sasha

3.1 Sasha had a lot of strengths. She was seen as a bright and able student, at school. She was ambitious for herself and hoped to become a lawyer. In later adolescence there were times when she had to meet her own care needs when her mother was unwell; and was probably, at times, her mother's carer, although this was not identified at the time. Sasha managed this period well with the support of the school. She was described as "friendly" with professionals and "willing to engage".

3.2 Professionals who worked with her described her as, highly intelligent, articulate, respectful of authority, mature for her age, proud, self-assured, determined, confident, engaging and

friendly. Many of the practitioners who met or worked with her said she seemed to be 'resilient', given her life experiences. She also showed signs of vulnerability, sometimes shy and sometimes sad; and lonely. She could also be feisty and mistrustful of workers (because of previous experience). She was seen as easily led and, at times, acutely anxious.

3.3 In her final year, and particularly after leaving school, Sasha found it difficult to structure her day and motivate herself. Her behaviour changed; she became increasing anxious, had panic attacks, some with paranoid thoughts, and used cannabis, which she thought calmed her. She became involved in criminal activities – possibly through involvement with troubled peers. She was also thought to have been exploited by an older boyfriend and was thought to become emotionally attached to people who then influenced her in negative ways.

3.4 Sasha's mother had poor health. They loved each other but Sasha's mother was unable to care for her as she became an older adolescent and she became more independent and out of control. As a result of this review it is has been noted that she should probably have had an assessment as a young carer, to be considered for support and services from the Young Carers Project as she was caring for herself and probably taking some responsibility for her mother. No agency working with her recognised the need for this or made such a referral.

3.5 Sasha had positive relationships with her older sister (and at times lived with her) and with her stepfather. He did not live in the family home. They both thought that Sasha changed as a result of the relationship with the second boyfriend. She was less open with them. Sometimes Sasha would ring her stepfather when she had panic attacks and he would calm her down. Both the stepfather and sister thought that the first Independent Unit was good for Sasha and she made good friends there; they were unhappy that Sasha had to move.

4. Practitioners' and Managers' Views, including Systemic Contexts and Issues

4.1 Practitioners' reflections were sought through the agency internal management reviews submitted to the SCR. They were also asked to comment on any possible wider systems issues which may have impacted on the work, at the time. Effort was made to avoid hindsight in judging the work done but some of the retrospective reflections assisted with developing further learning.

4.2 A key theme was Sasha's contradictions - her clear strengths and seeming resilience and whether her vulnerabilities were masked, preventing a full understanding of her needs. A key question was: ***Did her resilience or perceived resilience prevent agencies seeing how needy she was?***

Possible systemic influences at the time of the work suggested by the practitioners and managers.

4.3 **High workloads for Children's Social Care and CAMHS at the time**. Practitioners believed that the high numbers of young people referred to CAMHS with self-harm or suicidal ideation could mean that it was hard to have the capacity for different approaches with harder to engage young people. There was an impact on thresholds and how young people were prioritised, suicidal ideation alone might not have been seen as high risk.

(CAMHS subsequently commented that an increasing number of referrals did not impact on decisions about priority and access to services. A young person with mental illness or suicidal behaviour would always be prioritised within the different tiers at which CAMHS operated. It is to be noted that since Sasha's death a new Crisis Intervention Service has been introduced – young people with suicidal ideation are assessed through this service.) With such busy workloads there was a question if there was time for in-depth assessments and in-depth direct relationship work with young people, especially with regard to emotional attachment and possible attachment disorder. Social workers felt that there was not enough time to do this and so there was a need to refer on to specialists. At the time work was impacted by high staff turnover. Workers' outside CAMHS questioned awareness of and confidence in working with panic, anxiety, self-harm and suicidal ideation in young people and noted the need for more reflective supervision.

4.4 **Considering the impact of Adverse Childhood Experiences (ACEs).** There were system challenges in accessing relevant historic records to inform assessments, impacting on understanding Sasha's history of ACEs and there was low awareness of research into ACEs to inform the assessments and the impact on her of multiple adversities over time.

4.5 **Start again culture.** Practitioners questioned whether there was a culture of "start again" - where new assessments did not sufficiently take into consideration the previous assessments and attempts to work with families.

4.6 **Impact of cannabis use by young people.** Workers who were not drug specialists did not feel confident in knowledge and skills to work with young people on the impact of cannabis use on thinking, cognition, feelings, mood and paranoia in a crucial stage of the young person's adolescent brain development.

4.7 **Loss of momentum and the need for multi-agency co-ordination.** The loss of momentum at changes of workers (resulting in drift and non-completion of tasks) was perceived to be an issue wider than this case. Where there are several practitioners it was noted that there can be a risk of workers working too independently. In this case there was an increasing network of practitioners seeking to work with Sasha in parallel (when she was disengaging) and there was no common prioritisation of tasks – resulting in her being asked to attend different places at the same time. A systems issue was: ***how do practitioners know who else is involved and keep each other informed – especially at significant points such as change of address or placement or status (e.g. care)?***

4.8 **IT systems issues and information sharing.** Different data storage systems, including access to old stored paper records, hampered work. This was a systems issue. It was important for full background information to be shared when asking partners to undertake specialist assessment or intervention – such as Looked After Medicals, Domestic Violence Assessment or CAMHS assessments; a wider view was that this did not routinely happen in a number of cases.

4.9 **Recognising young carers.** Practitioners noted that the possibility of being a young carer and the emotional impact of caring for vulnerable parents was not routinely considered. This was across services.

4.10 **NEET - Not in education, training or employment.** Recognising and responding to (vulnerable) older young people who are NEET was not always integrated into mainstream work.

4.11 **Use of thresholds and "step-down".** Practitioners questioned the application of thresholds over time and whether there was a need to have intervened earlier, Sasha's family thought this too. Practitioners asked, ***"What is the role of Early Help Services when a child is stepped-down from child in need or from care?"*** It was not clear that this was routinely thought about.

5. Analysis and Evaluation of the Multi-Agency Response

Review of Sasha's journey through the multi-agency safeguarding system

Children's Social Care (CSC)

5.1 In the period under review concern was appropriately raised by the school and Sasha was referred to CSC in the December of 2015 since her behaviour was changing. She was being negatively influenced by peers and was possibly at risk of sexual exploitation. School was very supportive to Sasha and had previously assisted her with counselling and emotional support. In the period January 2016 to March 2017, there were three Child and Family Assessments.

5.2 The first **Child and Family Assessment December 2015 – March 2016**. The assessment covered the key concerns, including the risk of child sexual exploitation (CSE), and the analysis was clear. The recommendations to provide support were appropriate, however they were not sufficiently followed through; particularly given the history and the prominence given by both Sasha and the school to her negative relationship with a peer.

5.3 A referral was made to an under-18s substance misuse service, but Sasha did not engage with this. The social worker asked the school to complete the sexual exploitation work, and to continue to offer pastoral support. The case was closed in April 2016 based on the

assessment of lower risk and the belief that support could be offered through referrals to other agencies, however the school appear not to have been informed of the case closure. A 'step-down' to the Family First and Intensive Support Service was not considered, nor was a referral to the Young Carers' Coordinator, either of which could have provided ongoing support.

5.4 The second **Child and Family Assessment Late April - July 2016** was started as a result of intelligence that Sasha may be at risk of being used to carry drugs. Both Sasha and her mother stated that Sasha's friendship with her disruptive friend had ended. Sasha's recent court appearance, for possession of a knife and being carried in a stolen car, was seen by both as a wake-up call. The assessment noted that Sasha had finished her exams, left school and planned to go to college. Neither Sasha nor her mother felt there was a need for additional support. It was reasonable to conclude that Sasha was vulnerable but was not at increased risk, given the separation from the allegedly disruptive peer, mother's accepting parenting responsibility and the work being done by YOS. At that time many cases were not being considered for 'step-down' to other services, resulting in a rise in re-referrals.

CSC has noted that subsequent practice is better and use of an Access to Intervention Panel, a gateway for stepdown to targeted early help and step-down, is now embedded and re-referral rates have reduced.

5.5 In both the first and second Child and Family Assessments Sasha was involved. The social workers appropriately discussed the potential risk of CSE with her, but she consistently denied being a victim of CSE. The social worker rightly discussed safety planning with her, however, the use of the CSE screening tool would have been beneficial. The social worker's conclusion that Sasha was not at significant risk of CSE and the decision to close the case was commensurate with the decision not to refer to the Multi-Agency Sexual Exploitation (MASE) Panel. The MASE Panel would have required a higher level of CSE concern and necessitate the case remaining open.

It is possible therefore that the understanding of MASE and its thresholds was less well developed than now since training has subsequently been provided for all staff, CSE workflows have been implemented, and regular CSE audits take place.

5.6 The third **Child and Family Assessment January – March 2017.** A multi-agency strategy meeting should have been held in January given the risks identified. The third assessment was delayed awaiting a worker who knew Sasha. When it was completed it was of a good standard, recognising the risks and taking account of the history and of Sasha's mother's inability to parent her. It recognised her vulnerabilities and the risks posed to her, including sexual exploitation and the possibility of "county lines". The recommendations were clear, and the decision to accommodate Sasha in care in March 2017 was correct and based on well-reasoned analysis. This was then progressed with minimal delay.

5.7 A significant factor in this period was the start of the involvement of CAMHS and the reports of Sasha being anxious and experiencing panic attacks. This represented a significant change in her presentation to that in 2016, and it is possible that this was linked to, or exacerbated by, her cannabis use.

5.8 **Care Plan and Reviews and change of social worker.** Sasha was accommodated at the end of March and placed in an Independent Unit, with five hours staff support per week; this being the type of service thought to be appropriate for a young person of her capabilities.

5.9 Sasha's change to being looked after meant that her case would be managed in a different part of the service which required a further change of social worker. This transition was managed well with both social workers meeting for handover with Sasha and attending the first Looked After Children (LAC) Review.

5.10 The Care Plan was appropriate given Sasha's identified capabilities and needs and the understanding that she was accessing support from CAMHS and had an Independent Unit keyworker as well as social work support. Both LAC Reviews were held within timescales and were well-managed. Sasha attended them both and fully participated.

5.11 From May there were concerns about possible risk to Sasha in the Independent Unit This led to consideration of the need to move her to a Unit where there was more staff supervision. She did not accept that there was any risk and was reluctant to move. A multi-agency strategy meeting was held in mid-June to consider the risks. There is inevitably a delicate balance between adhering to the wishes and feelings of a 17-year-old and taking appropriate measures to mitigate known risks in order to safeguard the young person. The social worker worked hard with Sasha to help her understand why a move was needed while seeking to understand Sasha's reluctance. The CSC plan to move Sasha was appropriate in the circumstances, given the level of risk.

5.12 The second LAC Review was held in mid-July. It was dominated by discussions about the proposed placement move. It would have been helpful if there had been prior discussions about this plan between the social worker, the IRO and the Team Manager. A confusion resulted leaving Sasha to believe that the placement move had been put on hold, pending her going to visit the proposed new unit, which was not the case.

5.13 It was the unanimous view of the SCR Review Panel that it was right to move Sasha, given the risks she was facing. However, there is a question about the timing of the move in relation to obtaining the IRO's final view, subject to ensuring sufficient safeguards in the original Independence Unit, in the meantime.

Youth Offending Service (YOS) – support for managing Sasha's developing criminal behaviour

5.14 Sasha became known to the YOS when she was sentenced to a 10-month Referral Order (for carrying an offensive weapon and travelling in a stolen car) in June 2016. YOS's first assessment identified Sasha to be at medium risk of further offending, medium risk of serious harm, and low on safety and well-being. The YOS appropriately sought information about Sasha's background from CSC in completing the assessment. Further assessments were done in October 2016 and June 2017; they met national standards.

5.15 A programme was devised to work with her on Victim Awareness, Engagement in Education (she had just left school when the work started), reduction in cannabis use, a prison visit as part of the 'Keep Out' programme, a knife awareness programme, 20 hours of Community Reparation, and membership of a girls' group to work on understanding the consequences of offending.

5.16 Initially, Sasha engaged well but later she did not cooperate. At the final assessment in June 2017 she was assessed as at high risk of re-offending based on her continued use of cannabis; and at high risk for safety and well-being as a result of her emotional health and an assessment that she was probably in an abusive relationship and at risk of exploitation.

5.17 A breach of the Referral Order for non-compliance was considered twice. On the first occasion YOS met with Sasha and her stepfather to warn her and there was slight improvement. Sasha was referred back to court for non-compliance in early 2017; the Court decided that the Order should be continued.

5.18 The YOS work was of a good standard, but its success was dependent on Sasha's intermittent co-operation and whether she gave workers reliable information. There was a gap in not following up Sasha's education or training from September 2016 as she was not in college. She should have been referred to the YOS Education Liaison Officer.

5.19 YOS was not initially aware of the deterioration in Sasha's emotional health from January 2017 and staff did not see any concerns of anxiety. Sasha did not disclose what had happened or that she had been referred to CAMHS. In April YOS became more fully aware of the concerns. The YOS worker attended the first LAC Review. The Order had come to an end by the time of the second LAC Review.

The placing of a CAMHS worker within the YOS since this time is facilitating the sharing of information between the two services.

5.20 A question raised by this Review is whether more work could have been done to work on Sasha's relationship with her friend, who was younger, with whom she had been arrested and with whom she came to the attention of the Police with on a number of occasions. The friend was seen to be a negative influence on Sasha. Sasha told her family and workers several times that she had already separated or wished to separate from this peer, however, this was not the case and it was not until she met her second boyfriend that this separation appears to have happened. ***Where two or more young people regularly associate together***

in anti-social or criminal activities should there be work with them to seek to disrupt their relationships? Sasha claimed to professionals working with her and her family that she was influenced by the friend and was also worried about her friend's welfare in very risky and potentially exploitative situations with older men. The friend, also on a Referral Order for the same offence as Sasha, was worked with by a different YOS in south-east London until she came to live in Hounslow in Spring 2017. The friend said in the work that was done subsequently with her that it was Sasha who "led her astray".

In November 2017, the YOS introduced formal measures to monitor and manage the negative relationships between young people accessing the service, where known. A "Keep Apart" List is monitored and updated weekly to include the names of young people who should not attend the YOS at the same time either because there are issues between two or more parties or their influence ever each other is deemed to be negative and YOS would not want to encourage association. Since June 2018 the YOS has been exploring restorative approaches to resolving conflict between parties to enable their safe removal from the list.

Child and Adolescent Mental Health Service (CAMHS)

5.21 Sasha was first and briefly known to referred to CAMHS when she was seen by a Police Psychiatric Liaison Nurse in March 2016 at a police station in relation to a suspected burglary. No mental health issues were identified in that assessment.

5.22 In January 2017, following the episode when she thought she had heard someone in the house with a gun, Sasha was referred to CAMHS by her GP, via Adult Services. The referral suggested paranoid ideation, potential auditory hallucinations and suicidal ideation, with no immediate thoughts of suicide and a history of smoking cannabis 3 – 4 times per week.

5.23 Appropriate priority was given in the initial Duty Assessment and attempts were made to contact Sasha and messages were left over a number of days, with contact back to the GP to check contact details. Eventually a remote risk assessment was completed by phone. Sasha reported hearing voices and experiencing panic attacks on a frequent basis, impacting on sleep, concentration, mood and appetite. She reported using cannabis regularly for a year, three to four times per week but stated that she had ceased smoking "a week ago". Although Sasha disclosed thoughts of self-harm, she denied feeling actively suicidal. She also had thoughts of harming others when she felt angry but did not think that she would act upon these. A Safety Plan, with contingencies, was agreed with Sasha over the phone.

5.24 At the end of January 2017, the Adolescent Mental Health Team allocated a CAMHS worker for assessment in the second week of March. *This was well within the eleven-week guideline and would have been made earlier if Sasha had been assessed to have been at higher risk.* A letter confirming the appointment was sent to the sister's address.

5.25 Sasha did not attend the appointment. She later said that she had forgotten and that she had moved back home as her sister was too strict. Sasha reported that her symptoms had

not improved – she was still hearing voices and having panic attacks. She said that she would like help from CAMHS. The worker agreed to call Sasha the following day to do a risk assessment. The CAMHS worker followed this up with a call to CSC and was told that the case was open but awaiting allocation, and that there was no recent information. The CAMHS worker was asked to send in a referral and advised that CSC would get back if they had further information.

5.26 Sasha did not respond to the CAMHS worker's call or messages. The worker rang Sasha's sister who confirmed that Sasha had moved back to her mother's home and was hard to get hold of sometimes. The sister said that Sasha had been improving but she was worried that now Sasha had moved home that Sasha's well-being may deteriorate again. The CAMHS worker wrote to Sasha at her mother's address offering a further appointment and also sent a referral to CSC, informing the sister that this had been done.

5.27 In early April the CAMHS worker phoned Sasha and left a voicemail; she also rang CSC and asked for the new social worker to ring her, for an update on the case. *(In this period Sasha had been meeting with the social worker, had come into care, and moved to the Independence Unit – these events may have been an influence on Sasha not taking up CAMHS as she was meeting with and talking with the social worker.)*

5.28 A further CAMHS appointment was offered for the end of April. The CAMHS worker rang the social worker at the end of April to say that there had been no success in contacting Sasha. *At this point Sasha had still not had a face to face assessment with the Mental Health Service.* The CAMHS worker learned for the first time that Sasha was now in care and that the planned CAMHS appointment was the same day as the first LAC Review and so Sasha might be late. The CAMHS meeting was re-arranged for the following week.

5.29 In May, Sasha had her first face to face meeting with CAMHS. She stated that she was feeling better since her move to the Independent Unit. Sasha said that she had had no suicidal thoughts since she had moved to the unit. There was a history of anxiety and panic. She was not feeling suicidal currently, she was feeling better and she said that she was at less risk from others now that she had stopped her association with "bad people", since her move. Sasha agreed to return to CAMHS a week later and complete the assessment with a view to having four to six sessions about managing anxiety and panic through psychoeducation and management.

5.30 Sasha did not attend that appointment. The worker contacted her, and she came that afternoon. She described an ongoing low level of anxiety, including chest pains and shortage of breath. Sometimes there were triggers that could be identified and sometimes not. There had been no intense panic attacks since their last meeting. However, in describing a recent incident that had made her angry Sasha said that she was shaking. Sasha also shared information about her new, older, boyfriend who was discouraging her from attending CAMHS, but she wanted to attend. Sasha also shared her family history and the impact on her of her mother's long-term ill-health. It was agreed that she would have six fortnightly

sessions to monitor her mental state, and to work on anxiety management, sleep-hygiene and diet.

5.31 Two days later Sasha tried to contact the CAMHS worker during a panic attack when she had locked herself in a clinic toilet, being worried about the result of a health assessment. The CAMHS worker rang back later and coping strategies were discussed on the phone. The CAMHS worker and Sasha agreed a session earlier than the one already booked, which was appropriate. This also suggests some confidence in the CAMHS worker by Sasha.

5.32 Sasha later re-arranged that appointment as she had a housing appointment which clashed. Sasha did not attend the re-arranged appointment and did not respond to messages. The following week the CAMHS worker left messages for Sasha about the agreed series of two weekly sessions, with no response. She telephoned Sasha's Keyworker who shared concerns about Sasha's boyfriend possibly being controlling. A meeting with an Independent Domestic Violence Advisor for young people with Sasha was being arranged. A new CAMHS appointment was offered.

5.33 Sasha attended the appointment but did not stay long as she had friends waiting for her in the waiting area. A strong small of cannabis was noted. Sasha talked about having had a strong emotional and stress reaction to her boyfriend saying he was breaking up with her as a result of a report that she had been seen smoking in the street. He did not break up with her and his behaviour could be interpreted as exercising greater control through emotional manipulation. The strength of the panic attack had left her feeling "alone" and she had tried to call the CAMHS worker. It also became clear that she believed her boyfriend when he said that he had people "watching her". Sasha understood on one level that this may not be a healthy relationship but said that she needed someone strong and male to make her feel safe and emotionally contained. Sasha also talked about possible auditory hallucinations and being watched by cameras in her room. She said that she was not using cannabis. A further session was planned for the following week.

5.34 Sasha did not attend the following appointment, having "forgotten" as she was now on a new work/training placement, but she did want to talk about "some things that were happening" and the CAMHS worker agreed to contact Sasha the following week. The worker tried to contact her several times leaving messages or sending texts, to no response. Sasha did not attend the planned face to face session at the end of June. *(This was at the time when Sasha was very unhappy about the plans to move her from the Independent Unit for her own safety.)*

5.35 The CAMHS practitioner tried to contact Sasha several times and learned from the Keyworker that Sasha was disengaging from all workers and was spending the majority of time with her boyfriend. It was also noted that she had been "high" on cannabis on a number of occasions. At the LAC Review Sasha said that she would re-engage with the CAMHS worker, a session was booked but she did not attend. The worker was then on annual leave and a new appointment had not been offered before the fatal incident.

5.36 CAMHS prioritised Sasha's case appropriately, but there is a question about an 8-week delay in allocation within the Child and Adolescent Team, which may be a systems issue. They were persistent in their attempts to engage and work with her. Assessments of her mental health and risks of self-harm or suicidal ideation were undertaken in the contacts that there were. Anxiety, panic attacks, auditory hallucinations and possible contra-implications on these of cannabis use were considered and appropriate treatment was offered. Safety Plans were put in place. These assessments were made in a historic context of Sasha's experience of growing up with the challenges of her mother's intermittent ill-health. The working diagnosis for Sasha was anxiety disorder. Safeguarding issues were noted and acted upon. The service sought to maintain telephone contact with Sasha appropriately to monitor her state of mind and would have prioritised face to face meetings with her, if required. However, she repeatedly did not respond. In contacts Sasha was asked about her suicidal ideation and maintained that she was "better"; although she was having regular panic attacks, she said that was not thinking about taking her life.

5.37 The CAMHS service worked appropriately with other agencies, making a referral, seeking information, engaging in a LAC Review and Strategy Meeting and liaising with the social worker and Independent Unit Keyworker. They also had contact with Sasha's sister with Sasha's consent but not with her mother; however, Sasha was competent and had capacity to make her own decisions about parental responsibility and had also expressed anger with her mother.

Metropolitan Police Service

5.38 In March 2016, Police investigated a suspected theft by Sasha and her first 19-year-old boyfriend, Sasha was eliminated from the enquiry but concern about possible CSE was noted and a police notification was shared with YOS and CSC.

5.39 In May 2016, Sasha and her younger friend were arrested for carrying the offensive weapon and travelling in a stolen car. That night Police had attended previously the family home after midnight following a call from Sasha, who claimed that she had been "thrown out". Sasha's mother said that she had had tried to stop Sasha and her friend leaving, but they had pushed past her and threatened to call the Police. The mother said the friend was a bad influence on Sasha. A police notification about this was shared with the Hounslow YOS but not with CSC.

This review has noted that a non-crime domestic incident report should have been created which may have resulted in a follow up by officers from the Community Safety Unit.

5.40 Later in May 2016, Sasha arrived at school with a suitcase saying that she had been thrown out of home. The Police Schools Officer and the School liaised with Sasha's stepfather who agreed to fund a local hotel for the night so that Sasha could attend an exam the next day. CSC was sent a police notification for follow up.

5.41 A few days later there was concern that Sasha was 'missing'. She had not attended the exam and her mother stated that she was with friends but did not know where they were. Later, Sasha assured the Police that she was at an address in south east London with a friend. The following week Sasha and her mother attended a Police-led Missing Persons Safe and Well Check. The Police response was appropriate, and a notification was shared with CSC.

5.42 In September, Sasha was arrested at her friend's house. The two girls were accused of stealing a mobile phone. Sasha was found with and arrested for possession of cannabis. She later received a caution and the matter was referred to YOS. CSC was informed.

5.43 Police were called to the incident in January 2017 when Sasha thought someone was in the house with a gun. Sasha was safe but shared with the Police that she had been involved with a bad crowd of men in their 20s and that she and her friend had been involved in taking drugs to the south coast. Risk of CSE was noted and a report was shared with CSC.

5.44 South London Police attended an incident in a hotel in south east London in March 2017 where Sasha and her friend were suspected of theft, they had paid for the room in advance and it was alleged that there had been male visitors; although this was not substantiated. Both girls were asked to leave the hotel. CSC were not informed.

5.45 Police officers appropriately attended multi-agency meetings in June to consider the threats of CSE to Sasha. One action was to place a marker on the police computer so that Sasha's vulnerability to CSE would be quickly identified if she came to police attention. It was also agreed that an Investigating Officer would look into the boyfriend's background and possible risks to Sasha. There was liaison with CSC, but the investigation had not proceeded far before Sasha died. As she was not deemed to be at high risk it was possible that the investigation did not have high priority, given the workload.

5.46 The overall review of the Police involvement notes that the case shows good work. It is noted that despite measures in the borough to improve understanding of officers about CSE that there were a few times when front line staff did not recognise the risk of CSE or document their concerns effectively.

Independent Living Accommodation

5.47 Sasha was placed in a local newly established private Independent Unit for young women in care. There was no 24-hour supervision. Sasha said that it gave her a sense of stability as she could not stay with her mother and she had an element of freedom. She was allocated 5 hours per week support from a Keyworker from the unit and used this well to help her sort out attendance at meetings and interviews. Sometimes the Keyworker accompanied her, which gave Sasha more confidence. Sasha and her Keyworker appeared to develop a good relationship. Sasha also made friends with the other residents and enjoyed this.

5.48 However, as a result of concerns about risk to Sasha and the other young women she was moved and was unhappy about this. She withdrew from contacts with workers and spent more time with her boyfriend. It was agreed that Sasha would be offered some transition meetings with the Keyworker from the first Unit, but it is not clear that this happened.

5.49 Sasha had only been at the second unit for a week before the fatal incident. The second unit has subsequently changed staff and there has been a problem accessing its records to analyse what work was done with Sasha. We know that she felt more restricted there and more isolated. One member of staff noted that she had said she did not feel suicidal and did not self-harm anymore.

5.50 Sasha's family raised a question with this Review about this move as Sasha was so unhappy about it. They wondered if it was in any way responsible for her taking her own life. This review has found no evidence that this was the case. There is no doubt that she was unhappy about the move. We have noted elsewhere that the Review Panel's unanimous view was that the move was necessary; but there may be a question about how it was managed and its timing, in order to bring Sasha into accepting the reasons. She was consulted and the rationale for the move was clearly discussed with her several times, but she did not like it.

5.51 A systems question arises about the use and safety of private and voluntary accommodation for older young people in care moving on to independence where a foster home would not be suitable, given their age. In London, such units are commissioned under block regional commissioning arrangements. This review explored this and found that the commissioning process was followed properly. There is a question, however, about the risk assessments for individual young people being placed in units where staff are not on site 24-hours. In agreeing such placements consideration should be given to how the young person will be kept safe and to any likely risks, including possible exploitation. A house of vulnerable young women may become a target for those who seek to exploit them.

Child Sexual Exploitation and referral to the Independent Domestic Violence Advisor (IDVA)

5.52 On several occasions workers appropriately recognised that Sasha may be at risk of differing forms of exploitation, primarily sexual exploitation, given the situations in which she found herself and, in her attempting, to "protect" her younger friend. Initial decisions to refer her to the MASE Panel were not completed as they should have been; probably as a result of case closure and actions not being followed through. There were, however, conversations with her by several workers about possible risks which at times she seemed to acknowledge and then later did not accept.

5.53 After she became looked after Sasha was referred to the IDVA service. The IDVA worked well with her in several meetings to raise awareness of the risk of exploitation in domestically abusive relationships but Sasha would not accept that her second boyfriend might be acting exploitatively, arguing that he was being treated unfairly and perhaps in discriminatory way. There may have been no physical violence but there were clear reports

by Sasha herself which suggested that he was emotionally controlling of her, and there were also suggestions that he may have been involving her in criminal activities – or that he was associated with others who were. There is also a question about how much her own drug use (cannabis) may have been a dynamic in this. In an assessment using the DASH assessment[2] tool a few days before she took her life it was noted, by the IDVA, that Sasha reported no signs of depression or suicidal thinking.

Other Local Health Agencies

5.54 Occasionally Sasha sought to consult her GP Practice about a range of issues but did not follow these through, even when the Practice tried to follow up. A key issue here is that, given her age and mental capacity, and her seeming presentation and resilience, she appeared able to make informed decisions and there were no grounds to identify her as so vulnerable as to not be able to make such decisions in her own right.

5.55 When Sasha attended the Medical Practice with her sister following the incident in January 2017 - when she thought she had heard a person with a gun and was anxious and "suicidal" - a mental health risk assessment was done. She was not deemed to be at immediate risk of self-harm or suicide. An urgent referral was made to the Mental Health Trust. This was appropriate, albeit being sent to Adult Services rather than to CAMHS.

5.56 The same Medical Practice provided primary health care to Sasha's mother over this period. The review shows that there were very few contacts with Sasha's mother in this period and those that there were not significant and were not immediately suggestive of risk to Sasha. This Review has considered whether, given the ongoing concerns about Sasha's mother's emotional health whether there was sufficient holistic join up and consideration of the fact that she had a vulnerable daughter (albeit of 16 – 17 years of age) who might have been acting as a young carer. There is no evidence that the Practice missed opportunities to share concerns about Sasha, but it is acknowledged that a holistic Think Family approach was not used.

5.57 An issue noted by the GP Practice was that they were not informed in a timely way when Sasha became a looked after a child.

5.58 Sasha attended the local Hospital in the early hours after she had reportedly hurt herself 'jumping off a wall'. Later information from Sasha herself – not known to the hospital at the time – has raised a question about whether this may have been as the result of domestic abuse by her first boyfriend (or someone else). There is a question about whether there was sufficient curiosity about a 16-year-old and younger friend attending A&E on their own in the early hours. A systems theory approach to understanding responses in a busy A&E department would probably note an acceptance of how apparently competent young people with capacity and of an age to give consent are assessed. The school nurse valiantly attempted to follow this up on reviewing a notification of a young person attending A&E.

[2] DASH Domestic Abuse, Stalking and Harassment Checklist
http://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

5.59 As a looked after child Sasha was entitled to additional support for health needs. She had a Looked After Medical shortly after coming in to care. She gave consent for the medical assessment in her own right and cooperated with it. She told the specialist Paediatrician about her panic attacks and about her general physical health and relationships. Sasha said that she had not been able to "get emotional support" and that she "had been discharged from CAMHS as she had not attended". *(She was in fact still a patient of the CAMHS service but was not attending appointments)*. It was in this medical that Sasha disclosed that an injury for which she had previously gone to A&E had been caused by a previous partner (see 6.58). She raised no concerns about physical abuse by her current, older partner but described him as controlling. She was open about concerns about her mental health, not being in education or employment, having a history of substance misuse (said not to be current by Sasha - *although other information suggests that it was*), being in a relationship with an older man and having contact with other older men and being involved in crime. Sasha reported feeling "safer and better" since coming in to care and moving to the Independence Unit and she talked of having positive thoughts for the future. Physically she was healthy. The main concern was panic attacks which Sasha said she had been having throughout her time at secondary school, from year 7. The Paediatrician agreed to refer Sasha to the LAC Education Psychologist, unaware that she was still a patient of CAMHS. Other follow up for more general health matters was to be put in place, including a dental check-up and sexual health advice.

5.60 The LAC Health assessment was thorough and picked up that Sasha was occasionally affected by panic attacks. Sasha did not talk of feeling suicidal and the Paediatrician was unaware of the reason for the referral to CAMHS in January or that CAMHS was still seeking to support Sasha. There were no concerns in Sasha's presentation that she may have current self-harming behaviour or suicidal ideation. *It is to be noted that Sasha appeared open and capable in her responses and to have mental capacity.* There was no reason to doubt her account.

5.61 A question has been raised about whether the doctor had been given sufficient background health information prior to the assessment and how this can be ensured and whether this is a more common systemic issue.

5.62 Sasha attended a separate Health Clinic for advice on two occasions, in November 2016 and May 2017. On both occasions she was appropriately screened for risks, including risk of sexual exploitation, and she was given advice about relationships. On the second occasion Sasha denied depression but said that she was "anxious"' and receiving support from CAMHS for this. It is not clear that Sasha was asked about self-harm or suicidal thinking, although this would be usual practice. There were no concerns about her mental health. Sasha was open with the Clinic practitioner about being in care in an Independent Unit, her involvement with YOS, CSC and CAMHS and that she was receiving regular support from all of these. Her general vulnerability was noted, and appropriate safeguarding screenings were undertaken. In May 2017, as Sasha was known to be a looked after young person, the

practitioner additionally discussed the assessment with the Safeguarding Lead in the service, as is agency policy. It was noted that Sasha was well supported and that her Unit keyworker was aware of her attendance at the Clinic. She was encouraged to attend for further support; but she did not do so.

Not in Employment or Education (NEET)

5.63 Sasha's increasing involvement in anti-social behaviour and crime meant that she did not complete all her GCSEs. She did well in those that she did complete. She did not register for the Sixth Form at her school which knew her well and had supported her well throughout years 7 – 11. Sasha said that she had enrolled for college and attended for a few days, but this review has learned that, in fact, she did not register or attend. This coincided with her increasing anti-social behaviour and possible contacts with older men involved with criminal activities and drugs.

5.64 It has been acknowledged as part of this Review that the issue of NEET should have been picked up sooner. When Sasha was asked about her work or training she would say what she hoped or planned to do but would not follow through. YOS should have followed this up more rigorously and CSC should have referred her to Connexions for follow up in the earlier assessments before January 2017.

5.65 When she came into care, NEET became an important part of the care plan and she was referred to Connexions. After an initial assessment Sasha was referred within Connexions to a different worker but this transition was not successfully completed and so there was a gap with no involvement. When this was realised there was intensive activity to seek a training placement for her. She cooperated briefly while still under the Referral Order but dropped out of a programme when this ceased. She did talk in late July of "looking forward" to going to college in the autumn.

Coordination and multi-agency work

5.66 A number of agencies worked with Sasha and her family. In the earlier period some of the work was in parallel rather than well-coordinated. From March 2017, after Sasha came into care, the social workers ensured more effective co-ordination. However, there was an initial period when some key partners, especially CAMHS, were not aware that she had come into care.

5.67 In the final stages there was good social work and attempts to build a relationship with Sasha and support her into adulthood. There is a systemic issue in relation to all the separate strands of specialist assessments, planning and actions required by statutory guidance when a young person becomes looked after. For Sasha this meant that at a time when she was disengaging and possibly under the influence of her older boyfriend more and more meetings with professionals and expectations were being made of her. At times she seemed to have several different appointments a week, sometimes on one day. There is a question

about whether more could have been done to prioritise what was important and manageable for a fragile and vulnerable young woman. Perhaps more effort was required to assist her in making a good connection to the CAMHS service.

5.68 As a young person Sasha was seen as able, intelligent and competent. She was on the edge of adulthood but fragile, despite her apparent resilience. She made decisions for herself; not always the best decisions. There is no doubt that she was given lots of good advice and that a range of agencies sought to work with her to help her manage her situation and to deal with the, at times, overwhelming emotional panic that she sometimes felt. She co-operated in sessions for the most part (until the proposed move of Units) and showed seeming insight. She agreed to actions and help but then did not follow through on these agreements, possibly because of influence of others who had a hold over her.

5.69 This Review has noted that Sasha was appropriately consulted, and her views were taken into consideration, even when she did not like a particular course of action. It was commendable that, aged 17, she was accommodated by CSC. There had been a longstanding problem of trying to work with Sasha's mother in Sasha's interests because of her mother's own health and needs. At times she was avoidant and at times she co-operated. There was creative use and good use of other adults in the family – Sasha's sister and stepfather, to support Sasha but this was not consistent across agencies. Different agencies worked with different adults. There may have been value in considering a wider Family" Approach at an earlier stage in this period. A family meeting may have been helpful. The importance of Sasha's emotional and stabilising relationship with her stepfather was not explored as fully as it might have been.

6. Significant and Priority Lessons

Assessing anxiety, low or variable mood and suicidal ideation in adolescents

6.1 The Review Panel has formed a view that at the point of Sasha's death this tragedy could not have been anticipated. There was no indication to professionals (or family) that she was thinking about taking her life and her behaviour was not showing increased vulnerability to risk of self-harm. The single-agency and multi-agency work with Sasha from January 2017 regularly took good account of her mental and emotional state and any risk of self-harm or suicide. She was offered help with her feelings of panic but did not, or was not able to, take up this therapeutic work fully for a variety of reasons and distractions. She was seen to be responding positively to being in care and despite her unhappiness about the change of her placement, she was planning and looking forward to her future optimistically.

6.2 The review of the work done by all agencies from late in 2015, and particularly those working closely with Sasha towards the end of her life, shows that good work was done to identify her vulnerabilities and to support her. Sasha was a complex young person. She was intelligent and at times engaged well with the various professional staff who sought to help

her. In hindsight it may be seen that this engagement was superficial, but it appeared genuine at the time. On occasions she showed good insight into herself, her history and what was happening to her. She listened to the advice that she was given but did not always agree with it. She made promises to continue to with work with YOS and CAMHS but did not follow these through. She was at a critical time in her life, later adolescence, involved in adolescent behaviour, acting out, sexual activity and risk taking. She became involved with anti-social and criminal behaviour. It is thought this was through association with and influence by other young people, and later men in their 20s, rather than by her own initiative. Cannabis use appears to have been associated with this and a clear picture of the extent of her use was never established. It is not uncommon for young people or users to minimise this. She was not seen as an alcohol user or to use other drugs. She was suspected of being involved in serious activities of drug supply, county lines[3], allegedly carrying drugs for older men, but this was never established despite possible intelligence and Sasha's own report. It was thought that at a minimum her older boyfriend was controlling her – a form of domestic abuse - or that she was at risk of sexual exploitation, which she would not accept.

6.3 Sasha had mental capacity to make her own decisions. No grounds were identified to suggest that she could or should be sectioned under the Mental Health Act at any point when she was in crisis as a result of her mental health. She did not meet the criteria for secure accommodation for her own protection. Practitioners could only advise and negotiate with her, seeking to help her consider her actions or offering therapeutic treatment voluntarily.

6.4 Practitioners sought to engage with Sasha as her increasing vulnerability became clearer and to make relationships through trust to help her make decisions and manage her life. She was given good advice. However, she had difficulty following this through despite saying that she would, possibly because of the negative influences on her and because of her own inner emotional world. Her previous experiences suggest that despite appearances she was not well integrated emotionally or psychologically. Although she was an adult she was functioning more as a child and was at times impulsive in her actions – not thinking through possible consequences. Such impulsivity may also play into adverse influence from peers or others.

6.5 From January 2017, good attempts were made to assess and work with her stated and evidenced anxiety. It was known that she had reported that she had taken tablets and had suicidal ideation when she was fearful about a gun *(a possible hallucination based on fear)*. This was taken seriously and the following day the GP assessed her to have no acute risk of suicide. She was referred to CAMHS, assessed by clinicians by phone and later in face to face meetings. She was offered therapeutic treatment but did not or could not follow this through. From that point her mental state, including suicidal ideation was monitored as

[3] County Lines – the supply of drugs from urban centres to other regions, often involving exploitation of the people used to carry the drugs. http://www.nationalcrimeagency.gov.uk/publications/620-NCA-Intelligence-Assessment-County-Lines-Gangs-and-Safeguarding/file

often as Sasha would allow but she often missed or avoided appointments. Staff in YOS and CSC also monitored her mental well-being. Her anxiety and panic attacks – including a good assessment when Sasha talked about her panic when her second boyfriend told her he was ending their relationship - were assessed to be of more concern than the risk of suicide, although that risk was not forgotten. There were attempts to understand how much cannabis use might be affecting her mental state, mood and anxiety, but there were differing responses from her as to how much cannabis Sasha was using.

6.6 Sasha's social and emotional situation influenced her mood. Her relationship with her mother came to a head, partly as a result of Sasha's own anti-social behaviour and her mother's ill-health. They argued more about Sasha's behaviour and the involvement of her younger friend. It was appropriate for Sasha to be accommodated even though she was 17. Her life became slightly more settled in care and she was not missing after this, but she was influenced by her older boyfriend who was thought, by her own report, to be controlling her in an abusive way.

6.7 The decision to move her to the second Independence Unit was the right decision. The Panel found no evidence that this was a direct trigger to her later fatal action. However, it resulted in increased upset and anxiety for Sasha and appears to have increased her reluctance to work with CAMHS and her social worker, even though she promised that she would. There were no signs, however, that there was any current suicidal ideation or increased risk of self-harm as a result of being moved to the new Unit. There was, however, an increase in Sasha avoiding those who were trying to help her.

Assessing competence, resilience and emotional attachment disorder in adolescents and considering the impact of Adverse Childhood Experiences and cannabis use

6.8 Sasha was bright and able, she did well at school, although she was socially isolated and alleged being bullied when she was younger. She appeared to be an insightful and resilient person, despite her experiences. She seemed able to make helping relationships with staff in school and with practitioners in YOS and CSC and to relate well and maturely to health professionals and others. A question from this review, however, is whether this help was well internalised by Sasha and could be realistically sustained. Young people who work with counsellors and social workers can develop a learned vocabulary of what to say and how to behave, which can be meant at the time but is superficial with neither the inner strength nor psychological integration to see it through. There is also a suggestion of disguised compliance at times. Sasha's resilience appeared genuine but given her experiences and actual behaviour her seeming maturity and competence was perhaps a 'pseudo- maturity'.

6.9 Research shows us that children who grow up in ACEs may develop attachment disorders. They can learn to cope and even to care for themselves and possibly also a parent and this may appear to be resilient. They can appear to make effective relationships, but these are not mature and may not be sustainable. There may be an underlying, possibly subconscious, fear of rejection if they allow themselves to get too close. Sasha found it easier to make

friendships with other young people who were isolated or had their own relationship and emotional security difficulties. She gave an impression to the practitioners - who worked hard with her in one to one sessions - that she trusted them, was mature enough to make relationships and decisions and wanted to follow their advice and was open to change, but there was perhaps not enough inner resilience to allow this. Her intermittent history of adverse childhood experiences balanced at other times by some good care and positive loving family relationships may not have been enough to sustain her through her turbulent adolescent experiences and the unhelpful (exploitative) social and sexual relationships that she entered into. Increased risk taking, impulsive actions, drug and alcohol use, anti-social behaviour, domestic abuse and self-harm are correlated in the research with unresolved adverse childhood experiences. Such lack of inner security and age-appropriate maturity can be a contributor to impulsive actions. It can also be a factor in vulnerability to CSE.

6.10 A question arising from this review is ***How well are practitioners in frontline services, and their supervisors, outside mental health services trained in understanding and working with emotional attachment disorders and understanding the impact in adolescence of previous adverse childhood experiences?*** Newer research into understanding previous trauma and its impact in therapeutic relationships needs to be more widely understood by frontline practitioners[4]. Practitioners working with Sasha who attended the Focus Group for this review did not feel confident in this area. Some thought that Sasha was genuinely resilient, but others acknowledged that this area of research was not familiar to them, especially those in universal services. It has implications for the way in which services assess and work with children and young people who have had adverse childhood experiences as a result of gaps in parental care or because of parental ill health and absence, including previous episodes of care away from family. With Sasha, her assessment in this area would have been more complex as she had had some good experiences of emotional bonding with her sister and stepfather who were consistent, and also with her mother, when her mother was well.

6.11 It is not surprising that the use of cannabis may have made her feel “better”, but pharmacologically it may also have increased her anxiety and paranoia.

Contextual Safeguarding

6.12 There has been increasing recognition of the risks to adolescents posed by their connections or associations outside the family. Such analysis was not yet common across children’s agencies generally and was not formally in use in Hounslow at the time that Sasha was being supported.

[4] **Trauma-informed responses in relationship-based practice**; Danny Taggart, 2018
https://www.rip.org.uk/news-and-views/blog/trauma-informed-responses-in-relationship-based-practice/

"Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. Therefore, children's social care practitioners need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts."[5]

6.13 It was acknowledged in the work that Sasha was probably influenced adversely by peer relationships, possibly by older men involved with drugs, and later the alleged controlling and exploitative relationship with her older boyfriend. These were discussed with her in face to face sessions and, on occasions, she promised to end her associations. She was unable to do so, because of her underlying inner vulnerability and immaturity. The review has questioned whether enough consideration was given to considering how to work with the wider contextual system including the system around the other young person who was thought to be a negative influence on Sasha. In later stages, when she was at the first Independent Unit, there was a wider multi-agency approach to look at the whole context in which she was situated; this was positive.

6.14 The HSCB recognised during this review that it needed to raise the understanding of contextual safeguarding and of different ways to approach it. It was noted as part of this Review that the YOS has initiated work to identify young people who may have adverse influence, or impact on each other in a way, to seek to disrupt this. More could perhaps have been attempted to disrupt the negative dynamic between Sasha and her younger friend whom she was seeking to protect. Understanding young people's more hedonistic, in the moment and risk-taking behaviour and impulsivity will play a part here too.

Using a holistic family approach to assessing children and young people where their parents have difficulties

6.15 Sasha and her mother were both vulnerable and had been so for some time. Historically, information had been passed appropriately between agencies when there were concerns but the review has found that there was not a holistic approach to working with the whole family. At times it was hard to engage Sasha's mother but at other times, when she was better, she co-operated. The HSCB and its partners have acknowledged that a 'Think Family'[6] Approach had not been formally introduced in a multi-disciplinary systematic and strategic

[5] See the Contextual Safeguarding website https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding
See also Contextual Safeguarding in the new version of Working Together 2018 published 4 July 2018: page 23 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf

[6] Social Care Institute for Excellence: **Think child, think parent, think family**
https://www.scie.org.uk/publications/ataglance/ataglance09.asp

way across local services. Such an approach may have brought more consistency with regard to how the family as a whole was supported and involved in Sasha's interests as well as her mother's. Within this a family meeting of key individuals to think and plan for Sasha would have been helpful rather than different family members being involved in different ways. This may also have shown how significant, stable and influential a figure such as her stepfather was in her life and in her vulnerable mother's life. Like Sasha's sister he had a great deal to offer, was trusted and valued by her, and could have been involved more formally than he was, even though he did not have parental responsibility. Such an approach would also have raised the issue of how much she was a carer for her mother at times.

Other learning points

6.16 There is a need to consider the impact of a young person's full longitudinal history on their emotional development and its impact on any current behaviour difficulties. More attention could have been given to Sasha's longer-term psycho-social history and the adverse experiences that she had in assessing her ability to manage her situation. This may have enabled more questioning of her apparent resilience and whether, in fact, it was genuine or was a facet of a pseudo-maturity.

6.17 The impact of drug use by Sasha was considered and she was referred to support for this within YOS and also given advice by other practitioners. She declined referral to the Visions Drug Service for young people. It was understood that she experienced the use of cannabis as relieving her anxiety. It is not clear that she was helped to understand that it could also be increasing the intensity of her emotional reactions and panic at times or be contributing to irrational thoughts or hallucinations. She was open about cannabis use. It is not thought that she used alcohol or other drugs, but it has become known in hindsight that she experimented adversely with laughing gas. She was also suspected of and spoke of carrying drugs for others (county-lines). However, there is a question (a common question) about how honest she was about the extent of her own drug use and thus its impact. Her reports of ceasing using were taken at face value – although occasionally doubted. This raises the question of how knowledgeable and confident front-line practitioners, who are not drugs specialists, feel in raising and advising young people on these matters. Such dynamics can also be considered within contextual safeguarding as part of peer culture or pressures, as well as in their own right.

6.18 Reflective supervision and complex young people**.** Sasha was unusual in that she had particular vulnerability given her more fragile upbringing and adverse experiences when she was younger as well as in adolescence, including a period of separation from her mother in foster care. Her seeming adolescent resilience, confidence and capability, accompanied by her being bright, showed that she had had some good care and relationships which gave her strength. The review has questioned whether a busy social work Intake Team undertaking Child and Family Assessments can have the depth of reflective supervision to help social workers think more deeply about young people's affect, emotional capacity and resilience

beyond initial impressions to question how genuine they can be and whether there is a psychological mask or persona in place as an expression of learned, but not authentic, maturity.

6.19 While adolescents must be assessed and taken at face value there also needs to be questioning of whether their responses are realistic and genuine. Reflective supervision or consultancy will help front line practitioners caught up with acting out teenagers to question and think through whether there is the evidence of the apparent maturity. With Sasha it was not consistent as her behaviour and, at times paralysing anxiety showed. For workers in universal services rather than in social work, CAMHS or YOS this raises the question about where they get advice and support in thinking about the needs of such emotionally vulnerable young people and recognising that they may not, in fact, be coping as well as they appear to be. They may need to be referred for help earlier. The Government's proposal to have a designated mental health lead in every school, may meet some of this need, in time.

6.20 Another supervisory and case management issue learned from this case was the need to co-ordinate and prioritise tasks when there are an increasing number of them for a young person. Supervision can help with thinking this through, especially when a young person is not good at managing and is receiving services from several agencies at the same time which make competing demands for meetings or attention and deadlines. A systems issue is that Key Performance Indicators may increase the pressure in prioritising and will lead to criticism of an agency if these are not met. As Sasha came into care she met a whole set of expectations and requirements of meetings and processes that had to be achieved and juggled alongside YOS and CAMHS; and more workers were being brought in to meet with her - Connexions, Work Placement, IDVA, possible referrals for drugs advice, or for exploitation advice. This was also in the context of emotional pressure from her controlling boyfriend not to meet with these people as they were not genuine and did not have her true interest at heart. It is not surprising, therefore, that she did not attend her CAMHS appointments, which were perhaps among the most important to help her with her anxiety, and how to manage her panic attacks which it was known could be extreme and debilitating. On some days she had several appointments, at times conflicting. While some of the standards and expectations have good underlying reason and, like the Care Plan and LAC expectations cannot be avoided, it is important for consideration to be given in the overall multi-agency case management to coordinate what is manageable/realistic for a an emotionally vulnerable young person and what is most important and in what order. Examples are the increased activity from Connexions at a critical time when Sasha had been out of education for so long and a trip out of London as part of a citizenship scheme just as she was moving reluctantly to a new placement with which she needed to engage. It could be argued that assertively supporting her in getting to CAMHS was more important, given that she was angry and was still having days when she was panicking because of the strength of her emotions. She had not yet learned coping strategies for when her emotions were overwhelming her.

7. Recommendations

The recommendations below were agreed by the HSCB in September 2018 and actions were agreed to address them. The HSCB has since become the Hounslow Safeguarding Children Partnership (HSCP) under the new arrangements in Working Together, 2018.

Recommendation 1

The HSCB should work with the Hounslow Safeguarding Adults Board and the Hounslow Health and Well-Being Board to review approaches to the assessment of and interventions with whole families where parents are vulnerable. The Boards may wish to promote the principles of the Think Family Approach: **Think Child, think parent, think Family**[7] through a programme to raise awareness and joint working across the adults' and children's workforce. This should include consideration of joint guidance on assessments and intervention, the possible use of family group conferencing approaches and recognition of young carers; and a review of the HSCB and Hounslow Adult Safeguarding Board Training programmes to ensure that knowledge and skills are promoted in this area.

Such an approach will ensure that the assessment of children and child development over time, including emotional development, will consider the psychological impact of any adverse childhood experiences, including parental behaviour caused by mental ill health or substance misuse.

Recommendation 2

The HSCB Training Sub Committee should review how to support practitioners' skills in assessing adolescents with challenging, complex relationship issues and unresolved care and control conflicts when assessing behaviour and development in young people who may have had insecure attachments or who may have had adverse childhood experiences, including trauma.

The Training Sub Committee should consider whether practitioners who are not in specialist mental health services should be provided with training or guidance in recognising and working with young people with regard to emotional development and relationships in order to have a greater understanding of adolescent emotions, and their possible impact on behaviour and choices, including the use and possible adverse impact of drugs such as cannabis and the importance of considering the dynamic of adolescent impulsivity in risk taking.

The outcome of this review will be to ensure that the annual training package is able to offer knowledge and skills-based training for key agencies in considering and assessing young people's emotional health, apparent resilience in young people who may, in fact, be fragile

[7] Social Care Institute for Excellence: **Think child, think parent, think family**
https://www.scie.org.uk/publications/ataglance/ataglance09.asp

and that adolescent risk-taking behaviour is often impulsive rather than planned. The review should consider whether any cohort of practitioners would benefit from more in-depth training and whether a summary briefing may be provided for others.

Recommendation 3

The HSCB and its partners should promote awareness of developing approaches to understanding and working with '**Contextual Safeguarding**' for adolescents. The HSCB may wish to consider a multi-disciplinary workshop on this issue to increase awareness beyond sexual exploitation into other forms of non-familial exploitation such as group association, anti-social behaviour and 'county lines'.

This would enable Partner Agencies to be confident that practitioners and their managers are considering the wider context beyond families where young people can be adversely influenced by peers and anti-social community-based groups into dangerous and risk-taking activities.

Recommendation 4

When agreeing placements of young people in **private and voluntary Independence Units** risk assessments should be undertaken for each young person where there is no 24-hour supervision. CSC may wish to issue specific guidance to staff on this.

Experience has shown that young people moving through independence provision can be subject to a number of social risks which may appear attractive and hence they may consider themselves to be safe while in fact they are at risk of being exploited or harmed. Such risk assessments will ensure that young people moving into community-based independence are as safe as possible and that Care Plans and Placement Plans for young people consider any wider risks from the community and the young person's capacity to manage these.

Recommendation 5

The HSCB should commission a case audit of a small sample of cases of adolescents with mental health problems and anti-social behaviour to ascertain how case co-ordination is used across services to ensure a team approach to information sharing, assessments and case coordination at Levels 2 and 3.

This will give the HSCB a view of how such cases are being managed and whether any additional guidance or policy is required.

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Malcolm Ward

Independent Reviewer

September 2018 & July 2019