# LSCPR "Ruby and Daisy" for KSCMP


**LSCPR regarding Ruby and Daisy for KSCMP** **1**

**A letter to Ruby's siblings and peers from the independent reviewer** **2**

**Terms of Reference: Methodology, Agency and Family Participation in this review** **3**

**The Children: Ruby and Daisy** **5**

**Background and Summary of Interventions** **6**

**The Learning Themes** **9**

**Theme One: How were Ruby and Daisy's lived experiences sought out, understood and responded to by professionals and agencies?** **9**

The children's lived experiences 9
Think family. The importance of a whole family approach to risk 12
Making referrals or Requests for Support and decision-making. 14
Making sense of the child's lived experience: triangulating information. 15
Challenging parents and carers around inconsistency and non-acceptance of help. 16
The importance of the multi-agency assessment of risk 22
Considering a family's culture 24
Referrals and Thresholds, decision making, disagreements and escalation in safeguarding practice. 25

**Theme Two: What does this case tell us about the effectiveness of the multi-agency safeguarding response to poor mental health or mental illness?** **25**

How does the system respond to mental illness and suicidal ideation? 26
Safety Planning with children at risk of self-harm or suicide 29
Families and safety planning 31
Noticing a child in decline. 32

**Theme Three: How does the multi-agency safeguarding system respond to the impact of other children's suicides upon their friends, peers and the wider community?** **33**

**Theme Four: What does the period from the final 48 hours of Ruby's life to the immediate response by agencies after her death tell us about the effectiveness of multi-agency safeguarding processes and practices?** **36**

**Summary of learning points** **41**

**Conclusions and recommendations** **43**

## A letter to Ruby’s siblings and peers from the independent reviewer.

*The organisations that make up Kent Safeguarding Children Multi-agency Partnership (KSCMP) have worked together to complete this report which is called a Local Child Safeguarding Practice Review. This review is ‘statutory,’ which means it is written in the law that a review like this must happen because of the circumstances of Ruby’s death. The KSCMP decided that the review would also consider Daisy's (Ruby’s sister) experiences, because at times Daisy had mental health difficulties and at times tried suicide. There were lots of similarities in what the two girls experienced. The independent reviewer and KSCMP would like to offer their condolences to any child who has found Ruby’s death has affected them, as well as to the family.*

*The review found that Daisy and Ruby had difficult experiences at home and both had developed mental health problems at around the same age, when in their early teens. Daisy and Ruby sometimes harmed themselves, had suicidal thoughts and took overdoses. Their lives at home were not always happy for them, and the relationships each girl had with their mother and step father was sometimes difficult. Each girl also had a close relationship with their grandparents.*

*Daisy and Ruby talked to professionals working in different places about their lives, for example, to the GP, counsellors, schools, Early Help Workers and people in charities and a sports club. Some adults were kind and helpful, however, they did not always work together to really understand what was going on for Daisy and Ruby and for the whole family. Sometimes the professionals listened more to Daisy and Ruby’s parents who didn’t seem to understand the difficulties the girls were experiencing. One of the most important lessons from this review is for professionals to see children over a period of time and notice any changes in them, for example if the child seems to be getting less happy or more unwell.*

*This review has lots of learning points to help professionals listen to and help children like Daisy and Ruby better, and to help them work with each other more effectively. These are listed at the end of the report. There are also some recommendations for the KSCMP to consider to try to help make children safer.*

## Introduction

1. This Local Child Safeguarding Practice Review (LCSPR) was commissioned by the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) after the tragic death of Ruby. Ruby took her life in her bedroom at home on a weekday afternoon during a school week. She was 13 years old. Her older sister Daisy has also experienced poor mental health and had previously attempted suicide. A Rapid Review was held after the Child Safeguarding Practice Review Panel was notified of the incident and local learning was identified.

2. It was decided that further learning should be explored. This LSCPR considers both girls' journeys through intervention – Daisy's experience of suicide attempts are regarded as '*near misses*', and there is learning arising for the safeguarding system in Kent.

3. Alongside this review, there are other Kent LSCPRs currently underway. Where there is learning shared across them, this will be identified. The independent reviewer has also identified other local learning that is still highly relevant for the safeguarding system in Kent: the report entitled "Suicide in Children and Young People 2018 – a thematic review"[1], and I would suggest that the KSCMP revisit this report as referenced below.

4. The Rapid Review identified learning regarding
   - Intrafamilial Child Sexual Abuse
   - Think family – considering all of the needs of each family member and how each need may compound the family's difficulties
   - Lived Experience – listened to children and recorded their experiences but did not seem to be heard or analysed for what it meant for the child's development and wellbeing.
   - Peer relationships - perhaps a need to map these better
   - Gillick competence
   - Parental refusal of services/non-acceptance of offers of help
   - Chronologies
   - Intra- and extra-familial harm
   - Domestic abuse in the family
   - Risk-taking behaviours of children
   - Privately commissioned healthcare providers
   - Escalation and Professional Challenge policy
   - Information checks for strategy discussions

## Terms of Reference: Methodology, Agency and Family Participation in this review.

5. The Terms of Reference, co-produced with the family, detailed the approach to be taken in conducting the review. The review became more complex than initially anticipated as during the course of the review process, additional information indicated that both girls had had more contact with practitioners and agencies offering help than understood at the point of the Rapid Review. The following table details the involvement of practitioners and their agencies in the review:

| | **Agency / Service** | **IMR /adapted** | **Learning Event** | **Individual discussion** |
|---|---|---|---|---|
| 1 | Kent's Integrated Children's Services (CSWS and EH) | Y | Y | |
| 2 | Kent Community Health NHS Foundation Trust | Y | Y | |
| 3 | Kent Education Safeguarding Services for 3 x schools. | Y | Y | Y (1) school |

[1] Summary of Suicide in Children and Young People - A Thematic Analysis 2014 – 2018; (KSCMP 2020)

| | | | | |
|---|---|---|---|---|
| 4 | Kent Police | Y | Y | |
| 5 | North-East London Foundation Trust | Y | Y | |
| 6 | Integrated Care Board for Primary Care | Y | Y | |
| 7 | Medway NHS Foundation Trust (Acute Trust) | Y | Y | |
| 8 | Private counsellor 1 (Daisy) | Y | N | Y |
| 9 | Private counsellor 2 (Daisy) | Y | N | Y |
| 10 | Jewish organisation wellbeing support (Mother) | Y | N/A | Y |
| 11 | Kent sports club | Y | Y | Y |
| 12 | Domestic Abuse organisation (support for Daisy) | Y | N/A | |
| 13 | Psychologist (diagnosis of Daisy 2022) | N | N/A | |
| 14 | Place 2 Be counselling | N | N/A | |
| 15 | We Are With You: Kent Mind and Body | Y | N/A | |
| 16 | Queen Victoria Hospital (QVH) NHS Foundation Trust, Burns Unit, East Grinsted | Y | N/A | |

6. It is useful to describe the help offered to meet the needs of children such as Ruby and Daisy. Within Kent there are different counselling service provisions, with organisations providing tiered approaches that both Ruby and Daisy accessed. Some Kent schools provide in-school counselling services and commission private organisations for this provision. In this case, the following services provided counselling services in school: Place 2 Be, and Kent Counselling in Schools. Additional support was accessed by Daisy in school from a Domestic Abuse organisation. Other private services were accessed by the family for the purposes of counselling, mainly for Daisy. There was also an additional service that Ruby was referred to by a KCHFT counsellor: Mind and Body – Ruby was on the waiting list for this at the time she died.

7. Kent Community Health NHS Foundation Trust (KCHFT) provide Tiers 1 and 2 support for children with emotional health and well-being needs. KCHFT Tier 1 service is provided by school health practitioners within the school health service, whilst Tier 2 is provided by Trained Counsellors. North East London NHS Foundation Trust, Children and Young People's Mental Health Service (CYPMHS – previously known as CAMHS) are currently commissioned in Kent to provide Tier 3 services. Both Daisy and Ruby saw the CAMHS Crisis team during attendances at the Emergency Department as well as being referred for intervention, which would have been offered by the CYPMHS locality teams.

8. The impact of the loss of Ruby on the family and practitioners has been very palpable throughout the review process. Despite this, the family have shown great strength and has participated constructively within this review, motivated by a hope that the learning for those in practice with children and families will lead to positive outcomes for other children who may experience poor mental health, including suicidal ideation. Ruby's mother, maternal grandfather, and step-nan were consulted regarding the areas to include in the Terms of Reference before these were approved by the KSCMP panel.

9. The ideas and messages from the following family members for those in practice are referenced throughout this analysis. These were gathered through face-to-face meetings, MS Teams calls, and telephone calls with the independent reviewer and the KSCMP Practice Review Manager, with:

   - Daisy herself.
   - Ruby and Daisy's mother and the girls' stepfather.
   - Ruby and Daisy's maternal grandfather and step-nan (current carers for Daisy)

   A sibling of Ruby and Daisy (between them in age) declined to participate, although they said hello during the visit to the family home. Ruby's biological father was offered the opportunity to engage, however, has not responded.

   Many agencies that work with children in Kent have learned much from Daisy and Ruby's experiences, and changes have already been made to support practice improvement and enhancement within individual agencies.

10. Although many questions remain unanswered for practitioners and the family regarding the circumstances around Ruby's decline and death, it is not for this review to prioritise seeking those answers. The family are still subject to court proceedings, and the Coroner's Inquest has concluded. This LSCPR focuses on multi-agency safeguarding practice and the factors that support good practice, as well as identifying what areas of safeguarding practice might have been different to enhance future practice; however, due to some anomalies in the information and evidence provided in the review, it has been necessary to establish some of the factual details within the body of this report to inform the learning.

## The Children: Daisy and Ruby.

11. Daisy is the oldest child in the family; at the time of writing she is 17 years old and started Year 13 in school this year. Ruby was her mother's third child of six. There is a sibling between Daisy and Ruby in age, who started Year 12 this academic year. These three children are siblings from their mother's earlier relationship and had no contact with their father for several years. The three younger siblings are all from the current relationship between the mother and Daisy and Ruby's stepfather. These children are all still under 11 years of age.

12. Daisy and one of her half-siblings currently reside with the paternal grandparents. After the end of her relationship with her first partner, when the three older children were young, the mother moved to a house next door to the maternal grandfather (her father) and step-nan. These grandparents owned this house. The mother started a relationship with the stepfather and had three more children (at that house). Grandparents report relational difficulties emerged between them and the mother and stepfather, caused by the concerns they had for the children's wellbeing. Mother reports relational difficulties were far longer standing, dating back to her own childhood. Grandparents were also concerned regarding the physical conditions in the house where the mother and stepfather lived with the children. The maternal grandparents evicted the family who applied for social housing. The

family moved to a different house 4/5 miles from the grandparents during the second term of Ruby's Year 8 at school, aged 12.

13. Daisy and maternal grandparents report Daisy has resided with them since Year 10, aged 15. Mother says Daisy was in Year 11 at the time she moved in with them. She is currently studying four A-level subjects. In meeting the independent reviewer, Daisy demonstrated she is very bright, articulate, and reflective. Daisy was able to draw from her experience and make suggestions for a more comprehensive safeguarding professional network. Daisy enjoys travel and study. More recently, she has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and is autistic.

14. The tragic outcome for Ruby is difficult to fathom when hearing the family and professional accounts of an energetic, clever, funny girl. Through primary school and into Year 7, Ruby achieved well academically. Family members recall her in a way that suggests Ruby was the child in the family with fewer challenges and a personality that could overcome adversity. Ruby was engaged with a local sports club and is remembered as talented and a great team player.

15. All the children are currently the subject of statutory intervention by Kent Integrated Children's Services (ICS). It is reported that the younger half-sibling had moved to the maternal grandparents prior to Ruby's death in order to support her school attendance although Mother disputes this. The outcome of the family court regarding the Child Arrangement Order is now awaited. This proposed arrangement is supported by the Local Authority.

## Background and Summary of Interventions.

16. Some of the agency information in the family history appears relevant to the period under review: the mother separated from her first partner, the father to Ruby and Daisy and their sibling when Ruby was still in preschool. There is information which suggests there had been domestic abuse in the adults' relationship. Until recently, there had not been contact between their father and the three older siblings. There is also information which suggests that there has been domestic abuse in the relationship between the mother and stepfather, although there have been no recent reports. There is also information which suggests some substance use on the part of the stepfather, though there is no known addiction for either adult. There is also information which suggests that, at times, Daisy and Ruby have experienced physical abuse, physical and emotional neglect, and inconsistent parenting by their mother and stepfather. One of the schools described their parenting style as 'low-warmth, high-criticism'.

17. The period under review commenced in 2019 when additional intervention was first offered to the family to meet Daisy's needs regarding her emotional health and wellbeing. The period ends after the immediate response to the death of Ruby by suicide. As per the Terms of Reference – this period under review is intended to focus this analysis on the girls' journey through intervention and the effectiveness of the multiagency response; to capture the learning from the critical period of 48 hours leading up to Ruby's death; and to identify

good practice that took place after Ruby's death in responding particularly to other children who may have known Ruby. Both girls attended a local, selective academy for girls, Daisy from 2018 and Ruby from 2021. The four eldest children all attended the same primary school; indeed, the same school the mother attended. Daisy and Ruby have been registered at a local GP practice since 2018. Daisy's mental health difficulties were first seen by practitioners from universal services, school, and the GP in 2019 and Ruby's in 2021.

18. The first additional service offered was when Daisy was in school Year 8, aged 12. She was referred to the Children and Young People's Mental Health Service (CYPMHS) by Insight Healthcare, which delivered Improving Access to Psychological Therapies (IAPT) to adults for some NHS trusts. The mother had referred Daisy directly to Insight, saying she couldn't get an appointment for Daisy at her GP practice. This is the first known incident of the family using services outside the universal and targeted pathways for children. Daisy was self-harming, which may have been linked to an incident involving some of her peers, who were alleged to have assaulted her. The family did not respond to CYPMHS contacts. Later on in Year 8, there was an anonymous referral made to the NSPCC which came as a Request for Support to the ICS Front Door Service (FDS), alleging that Daisy may have been sexually abused by her stepfather. This did not result in any further intervention. Records suggest Early Help was offered at this time and the family declined it, although Mother does not recall being offered Early Help.

19. In September 2022, school Year 10, Daisy's school referred her to Kent Community Health NHS Foundation Trust (KCHFT) School Health Children and Young Persons Counselling Service. The referral was declined due to Daisy already seeing a private counsellor. Within this referral it documented that the mother had concerns about the counsellor who had made suggestions about various diagnoses that Daisy had – the mother believed that Daisy suffered with anxiety and wanted the school to support this. Within this referral it also documented that Daisy had reported to Mother that she had an eating disorder. Subsequent to this, Daisy had two accident and emergency attendances due to taking an overdose and self-harming behaviours. Another referral was made in October 2022 into KCHFT School Health Children and Young Persons Counselling Service. The referral stated that a referral had been made recently that was declined due to Daisy seeing a private counsellor, however, Daisy had not seen the counsellor for three weeks and there were no planned appointments. This referral was discussed at the KCHFT School Health single point of access health conference screening and was accepted by NELFT Tier 3 CYPMHS.

20. During the period under review, there was one five-month period when the family were open to Early Help and four briefer episodes when one of the children was open to Children's Social Work. During this time, there was an Early Help assessment, and an internal Early Help review, which included the views of some of the agencies working with the family. A Child and Family assessment was not completed at any time, although on at least two occasions, Kent ICS decided that Requests for Support about the family had met the threshold for a Child and Family assessment. On one occasion, the mother declined the assessment and Ruby was not seen. On the second, Daisy herself did not want to speak to a practitioner. The reasons for this are discussed below. There were no multi-agency meetings with the family organised by ICS. There were interactions, e.g., communication between the school and Early Help or CYPMHS, but multi-agency preventative intervention was not

offered within the framework of a clear multi-agency plan. Individual working relationships between practitioners are evident, but this was not supported by any formalised opportunities to promote better working together.

21. There were five episodes where the CYPMHS service ‘knew’ of Daisy and 5 when they ‘knew’ Ruby. This included receiving referrals from other agencies for Tier 3 intervention or intervening during a crisis (linked to presentations by each girl at the Emergency Department). However, there were no successful longer-term periods of intervention by CYPMHS despite the children’s needs being identified as requiring Tier 3 intervention by practitioners who knew the girls. The reasons for this are discussed below.

22. This review has identified that Daisy also received intervention from two private psychotherapists/counsellors during year 10, when aged 14 and 15. These took place before and after a privately commissioned psychological assessment. Maternal grandparents arranged all of these interventions with Mother’s knowledge. These took place around the time of Daisy’s move to the maternal grandparents. Records suggest Daisy had received support in school in Year 11, aged 14/15, from a charity offering support to women and children affected by domestic abuse.

23. During school Year 8, aged 12, Ruby took an overdose and was seen by the CYPMHS crisis service, but several offers made by the CYPMHS community team were not taken up according to records. Mother says Ruby was not offered support by the CYPMHS community team after attending hospital for an overdose. Ruby also sought medical attention for a burn sustained to her thigh after spraying an aerosol spray onto it, Ruby then needed to seek further medical attention for a skin graft.

24. Ruby was referred in January 2023 to KCHFT School Health for emotional health and wellbeing support, and counselling sessions started in April 2023 with KCHFT Children and Young People’s Counselling service, when she was aged 13. 12 sessions took place in total which were a mixture of face to face and online sessions. Following completion of these counselling sessions, KCHFT Tier 2 counselling service thought that Ruby would benefit from engaging with further support, therefore, a referral was made to Mind and Body. Ruby was also signposted to North East London NHS Foundation Trust (NELFT) to see if any additional support could be offered. Mother also made two further referrals to KCHFT School health for emotional health and wellbeing support for Ruby at the end of the summer term. The referral stated that Ruby was receiving counselling until July and felt this has made a real difference to her. Mother was very upset and worried now this had come to an end. This referral was declined and parents were informed that Ruby should access support from Mind and Body (We Are With You service) prior to re-referring for further counselling. The second referral was also declined to ‘allow time for strategies worked on to become embedded.’ Ruby’s GP was copied into these letters to parents. The GP had seen Ruby over a period of 5 months during this same year and had sought to refer Ruby to CYPMHS during that time.

25. During the summer holidays, at the end of school Year 8, aged 13, Ruby had an initial assessment by Mind and Body, a local charity offering support with self-harm, and was

waiting for the group programme to start. In the first half term of Year 9, Ruby accepted some help from a small private organisation commissioned by some schools to offer counselling to pupils. Ruby's mother also recalls that Ruby had help from a pastoral care worker in school during that term.

## The Learning Themes.

26. This analysis draws upon the information submitted by agency Independent Management Report (IMR) writers, the practitioner learning event, additional conversations with practitioners including those from the voluntary and private sectors, and family members who have participated. It is an analysis of multi-agency safeguarding practice, however, throughout the review activities, the sense is that the experience of intervention for these two girls and their family has been one of intervention offered to them as individual children by individual agencies responding to individual incidents. The four themes below were identified in the Terms of Reference and there is some overlap as some of the features of practice outlined in Theme One are repeated, as seen in practice with children with mental health difficulties and in the last critical period before Ruby died.

## Theme One: How were Ruby and Daisy's lived experiences sought out, understood and responded to by professionals and agencies?

### The children's lived experiences.

27. The Rapid Review found that: "*In this case it appears 'voice of the child' was taken too literally. What the children were saying was recorded well but not 'heard' or acted upon, and therefore lived experience was not properly considered or appreciated. Although school included in their Requests for Support what the children 'said,' there was a lack of multi-agency analysis about 'why' the children would be sharing this information with professionals."* To an extent this is accurate, however, this section seeks to expand on this further with the benefit of reflection from the family and practitioners who worked with Daisy and Ruby. Some key agencies had not recorded previous judgements and decisions effectively, thus rendering the information that was available less useful for those making the next decision in practice.

28. Daisy and Ruby received some good help from some individual practitioners who understood their lived experience well and sought out the details from them of their home and school lives and of their experiences of the family. The narratives about which practitioner and which agency were helpful sometimes varied within the family and across the professional network. What appears as a constant is that both girls were always willing to meet with and talk to practitioners about their difficulties, including about complex and difficult family dynamics, often on the first occasion that either child met a practitioner.

Ruby was consistent in the messages that her home life was difficult for her and that this was a stressor for her, exacerbating her poor mental health. School practitioners sought help for the children; several health practitioners saw each child alone and worked directly with them to help them manage adverse experiences, including their mental health challenges. Some practitioners took the time to ensure that the child had something in place whilst awaiting the preferred intervention, as well as building good professional relationships with them, e.g., the GP saw Ruby regularly whilst awaiting the CYPMHS service. However, whilst the pathways to help were sometimes followed appropriately, the mother did not accept the offers of help.

29. A recurrent theme in several of the agencies' analyses provided to the review is that practitioners demonstrated an over-reliance upon the parents' narrative about the child rather than having the child's lived experience informing practice and decisions. Given the girls' age and capabilities, this appears as unusual and attributable to the mother's presentation as articulate and clear about what she wanted for her children. Being child-centred and believing that the child's welfare is paramount is a fundamental principle in safeguarding practice. The girls' age and understanding suggests they were Gillick competent – another principle in action which should underpin practice with adolescents and drive any challenge made to parents in order to assert the child's right to access intervention.

**Learning: That practitioners should be clear as to their role in assuring that the child's legal rights inform practice decisions and actions.**

30. The mother's narrative often differed from the child's account in several episodes where the child had told a practitioner about their unhappiness or even about possible abuse or neglect, and at times for both Daisy and Ruby, refuted that they were mentally ill. Some of these frontline practitioners in different agencies were reassured by and accepted the parent's account and then did not speak to the child, even when the child had been clear that they wanted to talk to a practitioner.

**Learning: Being 'reassured' about a child's lived experience can stifle the professional curiosity of any practitioner. Practitioners should seek out the child's lived experience when making key decisions about the child's case.**

31. The openness of both children to adults is notable, although there was also evidence to suggest they were more guarded about certain experiences. On separate occasions, both girls told a practitioner that they did not want to go home and that they did not feel listened to by their parents and at times did not feel safe to go home. Daisy located her need to self-harm to manage her anger and rage as arising from the challenges she faced at home and spoke to practitioners at the acute trust about "*wanting to end it all.*" Ruby was happy to sit and talk one-on-one, but it was felt she didn't want everyone to know her business. Like Daisy, Ruby told several practitioners that she did not see a future for herself and could not see the point in life. The school recalled their sense that Ruby was distracted by life at home whilst in school and identified that the pressures of home impacted her academic performance. She had gone from achieving well in school Year 7, aged 11, to not being able

to access the curriculum or manage school life in Year 9, aged 13, despite the school seeking internal and external counselling for Ruby and referring her to CYPMHS.

32. When Daisy met with the independent reviewer, she described details of her lived experience whilst she was still living in the family home. She recalled the symptoms of physical neglect in her presentation at school. The school also recalled her presentation and behaviours as different from those of her peers in Years 7 and 8. Interestingly, these behaviours were not observed by her primary school, and there is some learning within education as to how key information, especially descriptions about the child, travels from primary to secondary school where there have been no reported safeguarding concerns. It may also have been the case that when the secondary school observed Daisy as different, she may well have been experiencing a decline, much like her sister did in school Year 8 (see paragraphs 92-3, regarding 'decline'). Daisy also recalled that her mother refused services for her such as CYPMHS, when Daisy felt she needed help. Daisy felt this should not be possible: if a child needs help, their access to CYPMHS should be mandatory and not optional. She felt that her mother's position as "*anti-CYPMHS*" was fed somewhat by information that she saw online (see paragraphs 65-66 below).

    **Learning: Considering a longer-term view of the child's journey will support practitioners in identifying any patterns or differences in the presentation of a child and potentially, any decline in their development trajectory.**

33. Daisy also recalled her sister's experience in the family as different from hers. Whereas Daisy recalls being very controlled, Ruby was allowed more freedom and fewer rules in the home, for example, she had two or three mobile phones. It is not clear why this was – it could be a cause for concern in terms of exploitation for a child aged 12/13 to have different phones, however, this does not feature as a consideration in any agency's practice, although Ruby's phones have been mentioned to the independent reviewer by practitioners and family members. When Daisy moved, she only really saw Ruby at school, where they chatted. Daisy expressed her regret that "maybe I could have done more to help her."

34. Daisy suggested ideas to the independent reviewer to enhance practice in identifying what might be going on for a child. Whilst Daisy recognised that some children may overuse the word *"abuse"* when describing difficulties at home, she suggested that practitioners should have responded to the signs of neglect which she had recalled in herself. Practitioners should always bear in mind that a family member might be acting to block the child from getting help. Daisy suggested that a parent can use a possible referral to social care as a threat to the child. She also referred to her own experience of not being allowed to access help from CYPMHS by her parents. She suggested that the non-acceptance of CYPMHS help for a child by a parent should be scrutinised further by practitioners as to *why* that parent might not allow a child to attend CYPMHS. These barriers to children telling their stories and accessing help from within the family are often considered in safeguarding training courses – Daisy's experience reflects what is known in research[2] about such barriers and emphasises the need for practitioners to hypothesise and reflect further on the possibly harmful

[2] IICSA, NSPCC

dynamics in families and test those hypotheses out in practice, both with the family and with other professionals.

**Learning: Practitioners should not take a refusal or non-acceptance of help at face value. Rather, they should explore with the family the reasons behind the non-acceptance or refusal of help, which might support future acceptance of intervention for the child.**

## Think family. The importance of a whole family approach to risk.

35. This is a key theme for the Child Safeguarding Review Panel, who identified from their review of reporting in 2022-3 that this is cross-cutting: *"The most common issues featuring in review reports in this latest analysis concerned assessments not involving all family members or carers and not considering the impact of identified vulnerabilities on household dynamics."*[3] Whilst the focus of this review is on these two children, from a family of six children, it should be noted that midwifery and health visiting services were involved within the timeframe of the review due to Mother being pregnant with the youngest sibling. It was evidenced that there was good communication between services, especially midwifery, Early Help and the Health Visiting Service within the younger siblings' records. The record keeping for the younger sibling's evidence 'think family' whereby the Health Visiting Service made enquiries regarding the older siblings within the household. Perhaps less obvious is a focus by those in practice of the experience of the older children in terms of changes in their family due to the birth of younger siblings.

36. The maternal grandparents offered a useful reflection: that the nature of relationships of different family members to the children should prompt curiosity by practitioners, especially when there is an observable caring role for a particular adult. Throughout the period under review, and especially during the last 15 months of Ruby's life, there had been concerns regarding both girls from within the extended family network. There was some good practice in this: it was understood by the school that the maternal grandfather was a stabilising feature and was adored by Ruby, but the mother used this relationship as a bargaining chip by preventing Ruby from seeing him when the mother felt Ruby needed to be disciplined. The maternal grandparents recalled their concerns about the poor home conditions but could not share that with agencies while the mother and stepfather lived next door to them with the children. They shared that Daisy is now asking them: *"Why didn't you do anything?"* The maternal grandparents spoke of the ongoing challenge of balancing the children's well-being versus keeping relationships as positive as possible with the parents to avoid ramifications within the family. The grandparents mooted a potential barrier: how might telling a practitioner about the concerning parenting style of a family member be perceived? The maternal grandparents stressed that to report a family member to the police or social care is a counter-intuitive act, but perhaps may be easier in the context of a positive relationship with, for example, a school.

[3] National Panel: Annual report 2022-3 para 5.51

**Learning: In any setting that the child attends, there is nothing to prevent practitioners from conversing in a more informal way with extended family members who appear relevant to the child in order to build relationships with them: "Who is the child to them?" "What do the grandparents mean to that child?"**

**Learning: All practitioners working with children should remember how conflicting it could be for a family member to raise their concern about, for example, the risk to their grandchild. Practitioners should be curious about this and any other barriers to families raising concerns.**

37. There was a further helpful observation by the grandparents about practitioners who might assume the protective influence of grandparents in any child's life and, therefore, could be reassured by this. Many practitioners saw the maternal grandparents as a protective factor for the child due to their involvement – picking the child up from school or attending health appointments with the child. In discussing this point with the maternal grandparents, there was a reflection on how a practitioner such as a GP may have felt reassured when they knew the grandparents were involved. The maternal grandparents suggested that a grandparent should not always be automatically assumed to be something protective, and that their curiosity should prompt this thought:

**Learning: Any practitioner working with a family should consider why they might be looking for protective factors in the child's experience—what might the child need protection from?**

38. As referenced in paragraph 35, a highlighted common issue in recent LSCPRs is that assessments do not involve all family members or carers and do not consider the impact of their identified vulnerabilities on household dynamics. The Rapid Review regarding Ruby and Daisy also identified this: *"There was a lack of consideration given to dynamics of harm experienced by all the siblings when referrals were being made in respect of mental health of the older children. Focus was on the risks to the children presenting with low mood, self-harm and suicidal ideation, obscuring what may have been contributing to it from within the home, which would likely have implications for the other children living there."* There are two areas to consider here – firstly, the experiences of all the children in the family were not given equal attention. Secondly, the management of presenting symptoms of possible harm took priority rather than an exploration and response to the possible causes of their poor mental health, for example, unwanted parental behaviours.

39. There was some feedback from the family, backed by some of the information from agencies, suggesting that no single agency fully understood the family's different members and their experiences over time. Some practitioners did understand aspects of the family dynamics and noted them, e.g., the family's financial situation was reported to have changed when they moved away from next door to the maternal grandparents in that the family began to need food parcels. Some practitioners did see the similarities between Daisy's and, subsequently Ruby's journey of declining mental health in early adolescence. However, there was also a point raised by the grandparents that not all practitioners in the school had understood that Ruby and Daisy were siblings and in CYPMHS, family records had not been linked, so that similar patterns in their developmental trajectories had not

been identified in those agencies. There were also examples where practitioners did not seek out a family history when it should have been fundamental to assessing that child's presentation and any risks.

**Learning: Practitioners should be supported in individual practice and multi-agency work to think across the family's history and network for patterns of incidents and events. This review emphasises the need for practitioners to utilise chronologies and tools such as genograms and eco-maps to support practitioners to assess risk – particularly of cumulative harm.**

40. Other examples were given of the need to 'think family,' such as considering seeking help for the adults in the family when helping the child. The mother disclosed to one agency that she had a mental health condition and was taking medication for this, however, this did not prompt further curiosity about any intervention she might have been receiving to help her, liaising with the organisation(s) providing it, or what the impact of her difficulties might be on her parenting of her children. There is little evidence in this review that any agency was curious enough regarding the stepfather's role in the family or in considering if he had any vulnerabilities that could compromise the children's care. He was present and spoken to at Early Help visits and when he attended Emergency Department with Ruby, but the depth of conversation is not evidenced. The mention of his use of drugs by Ruby to a practitioner at the out-of-area burns unit, although recorded, it is not clear if it was reported to Early Help during a follow-up conversation.

41. One specific incident highlighted the need to ensure practitioners fully understand the family composition. When Ruby presented at the Emergency Department with her stepfather, there was good practice asking the question of him whether he was her father and whether he held Parental Responsibility (PR)[4]. However, practitioners and the acute trust reflected that this was not the *right* question. In a discussion with the independent reviewer, the stepfather confirmed that he felt like Ruby's dad as he had been part of her life since she was very young. He and the mother also confirmed that he would not have understood that the question had a legal origin and did not understand the concept of PR. The acute trust has identified more consideration is required about the 'right' question or questions to ask in that circumstance so that the adult might understand the concept of PR, keeping in mind one approach will not suit all circumstances e.g., where PR was acquired via a court order, or adoption. Similar questions should also be asked of the child, if at an appropriate developmental stage, to ascertain their understanding of an adult's relationship to them.

## Making referrals or Requests for Support and decision-making.

42. The evidence offered to the review suggests that referral practice and the understanding of pathways is variable across the multi-agency network. This may be due to interchangeable used of language around referrals to different agencies. Across the different processes that have taken place since this review, there had been information about how many referrals

[4] Children Act 1989 s3

for emotional health and well-being and Requests for Support have been made. Ruby and Daisy's school suggested that there were 12 referrals made to ICS regarding Ruby. However there were only five referrals – called 'Requests for Support' to ICS's Front Door Service regarding Ruby and an additional one made for Daisy when the case was open to Early Help. There were also 3 made regarding Daisy from other agencies. Alongside this, the school also made several requests for services to CYPMHS and KCHFT School Health Emotional Health and Well-being Service for therapy or counselling as well as three other in-school counselling services for both Ruby and Daisy.

43. There is also evidence to suggest that at points the agreed pathways to help and intervention were not always used when they should have been, e.g., around possible extra-familial harm that Ruby may have been experiencing involving indecent images seen on her phone, and some of her circulated.

**Learning: That all practitioners are offered developmental opportunities to understand how to make Requests for Support to Integrated Children's Services and use the Support Level Guidance to support threshold decision-making. This should always include the pathways to further help or support after referral (NB: this links to paragraph 70 below regarding thresholds).**

## Making sense of the child's lived experience: triangulating information.

44. Although seeing a child alone is vital, the importance of observing children in different environments, with and without parents or family members, is highlighted throughout Ruby and Daisy's journeys. It is also important to note that children present differently in different contexts, so reconciling the different observations is vital. At the practitioner event, several observations shared of Ruby and Daisy were striking. For example, the primary school noted that Ruby, a former pupil, came to the school with her mother to collect her younger half-sibling. Ruby was observed as *"watchful and insular,"* which school practitioners noted as surprising – the difference in the relationship between the mother and Ruby had previously been more "fun." A counsellor observed Ruby's body language changed when the mother was in the room. Also, the mother's tone with Ruby was stern, but polite and *"smiley"* towards the counsellor. In marked contrast, the sports club recalled there was no real sign of Ruby's distress observed the weekend before she died, despite Ruby's mother telling the club she was trying to get emergency help for Ruby. The club was a positive 'safe space' for Ruby, so for at least a short time, Ruby seemed to be able to put her distress to one side.

**Learning: When the opportunity arises with colleagues or family members, practitioners should seek to triangulate information from their observations with information from other sources.**

45. Multi-agency meetings are central to making sense of these contrasting observations, what they mean for the child, for the effective alignment of individual agency interventions and monitoring their impact and outcomes for any family member. There was one multi-disciplinary meeting with Daisy and her mother, called by CYPMHS according to records

though Mother suggests she herself requested it, when it was felt Daisy's mental health needs met the CYPMHS Tier 3 threshold. However, that was the only such meeting across the period under review, and no minutes were held on the Early Help record. Around this time, Daisy was said by the school to have often arrived "hysterical and unregulated" and wanting to move to her grandparents. Whilst Early Help held discussions with other agencies and a meeting with the school, they did not hold a multi-agency meeting during their five months of intervention, which may have helped to understand Daisy's distress further. This predated the update to ICS guidance in June 2023 that emphasises Early Help practitioners must hold an initial review of their plan and then one every 6 weeks. The guidance also gives a clear directive about inviting other agencies to Early Help reviews and ensuring they are part of Moving On Plans. However, it is also important to acknowledge a collective responsibility upon all agencies to be proactive in multi-agency work.

**Learning: Any practitioner working with a child should work to understand what other agencies are offering to the family[5] and if needed can arrange a multi-agency meeting to devise a shared plan with the family to ensure the child's needs are met.**

## Challenging parents and carers around inconsistency and non-acceptance of help.

46. Over the period under review, there were multiple times when the multi-agency system became aware of the girls' needs. From the evidence seen, (which cannot be confirmed as entirely accurate) there were:
    - Approximately 13 occasions where either a practitioner or the family sought help for Daisy. Of these, 3 resulted in intervention from counsellors (from the private sector), 1 acceptance of Early Help and 1 seeking of help for Daisy when an Early Help episode was already open.
    - Approximately 25 occasions where either a practitioner or the family sought help from another professional for Ruby. Of these, 7 resulted in the 'acceptance' of interventions.
    - There were further occasions where the school sought consent to refer to CYPMHS from Mother, but were not successful.
    - There were further occasions where the mother did not take the advice of an agency, e.g., a school advising the mother to take a child to Accident and Emergency.
    - The mother also declined the suggestion of Early Help 3 times but accepted the offer once, and declined longer-term CYPMHS intervention for Daisy and for Ruby on a total of 5 occasions.
    - Two referrals by Mother/parents into a Tier 2 counselling service when the level of risk suggests it was not appropriate – the message had been given by practitioners that CYPMHS Tier 3 support was the best source of help.
    - Mother did not accept the decision for a child and family social work assessment on at least two occasions. The maternal grandparents posed a legitimate question to

[5] See Working Together 2023 – Expectations of practitioners to collaborate, para 19-27

the safeguarding system: "How many times can a parent decline the help it is clear a child needs?"

47. Several agencies have identified that the lack of structured multi-agency conversations meant information was not triangulated either with records of previous interaction with the family, between different agencies, or with the child (as above). There is a consistency in the analysis offered by the agencies that participated in this review, that the mother's ability to articulate also supported that over-reliance upon her narrative around her children's needs, despite some practitioners identifying in supervision there were concerning patterns common in both girls' trajectories, and there was concern the children were experiencing more adversity within the home than they had shared with practitioners. The mother and stepfather dismissed the severity of Daisy and Ruby's presentations as 'behavioural' and 'acting up' at different points. There is a suggestion that the mother was difficult to challenge as she was bright and articulate, and practitioners did not appear to challenge either parent on their account of what 'behavioural' might represent.

48. The evidence presented to this review suggests the mother was not entirely honest with professionals regarding intervention for the girls. For example, she suggested the children were receiving help from elsewhere when that help had not yet been started. She was sometimes vague, for example, telling a health practitioner that she did not know the telephone number of the Early Help Worker despite knowing the worker's name – Mother disputes this. The mother also suggested to the Burns Unit in West Sussex that Ruby had been to the GP, who could not refer her there. Ruby and her mother had been to the Urgent Treatment Centre, who documented that Ruby reported she had been staying with a relative in Dorset over the half term and decided to take part in a TikTok challenge by spraying deodorant onto her thigh. Ruby was also seen alone as part of this attendance. Ruby gave a different account to practitioners at the Burns Unit of burning herself before the family holiday whilst in her bedroom, listening to her mother and stepfather arguing.

49. After the first appointment, a practitioner from the Burns Clinic called the mother to clarify and triangulate what Ruby had shared with them. The mother denied that Ruby had depression and anxiety, but the Urgent Treatment Centre had reported this to the Burns unit as part of the referral. At the Burns unit, Ruby agreed to the in-unit psychology therapies offered. Her mother told the practitioner that Ruby herself had had a bad experience with CYPMHS and that Ruby herself had not accepted help from CYPMHS. Ruby told the nurse she didn't know if she had seen CYPMHS. The Burns Unit nurse did attempt to clarify these inconsistencies with the mother who portrayed Ruby as presenting with mental health difficulties as a result of not getting her own way. This depiction of Ruby by the mother appears as similar as other reported episodes where Daisy and Ruby's needs were minimised by the mother and stepfather. Mother's recollection of the interaction and offer from the Burns Unit is different, suggesting she and Ruby initially understood the offer of psychological therapy to be generic and an alternative to CYMPHS and on learning its purpose was specifically in relation to the impact of the burn, Ruby declined the service.

50. Other inconsistencies in the family's acceptance of services and plans are evident. Ruby's school suggested that Ruby sometimes wanted help from CYPMHS and expressed this to the school staff. The school recall that the mother consistently refused to give consent for a

referral for this despite the school's observation of a decline in Ruby's well-being – perhaps noticed in the first ten months before her death, however, very obvious from the start of Year 9, aged 13, – just over two months before Ruby died. The mother had reported to the independent reviewer that her school was moving towards arranging a directed placement in another school via the Fair Access Panel. The mother said Ruby had been desperate to stay at the school and that this is evidenced in minutes from meetings shared to her, but the school wanted her out. The school refutes this account – they recall that Ruby was keen to move – she wanted a fresh start, so much so that she tried to suggest to school staff some of the other schools for a directed placement that might be acceptable to her mother. Mother said she was resistant to the idea of a move as the alternative school suggested has a poor reputation. It appears the school worked hard to maintain Ruby in the school, keen to avoid a permanent exclusion for her, despite understanding that the school was no longer a good placement for her.

51. Practitioners noted the mother's behaviour in that she would attempt to be "ahead of the game"—setting up the narrative around an incident to manage how it might play out. Often these appear as attempts to pre-empt any information which the children might share with a practitioner and often took the tone of locating the problem in that child. At other times practitioners recalled the mother and stepfather as locating the problem in the agency – i.e., the teacher was wrong or there was bullying in the school. However, at other times there was an unusual extension of what Daisy recalled happening: threatening a child with a social worker who would take them away. On two occasions, the mother rang the school to tell them Ruby had done something wrong – taking a vape to school on one occasion and on another, being involved in making fun of a learning-disabled adult whilst in the local community. On the latter occasion, the mother phoned the police as well which resulted in a police conversation with Ruby, though Mother now regrets having done this. A practitioner that reflected on this was clear this was not a usual parental action. On one hand, the mother resisted intervention from helping services. On the other, she utilised their authority and included them in punishing her child.

52. If it feels difficult for the reader to unpick these emerging complexities in the lived experiences of these girls. It is vital to emphasise to the reader the impact of these stressful experiences on the child of constantly navigating the mixed messages and inconsistent behaviours of their parents, parents who did not seem to grasp the child's need for consistency and honesty. It is not known the extent to which Daisy and Ruby experienced such distortions of their world but there are many stark anomalies in the information offered by the mother as compared to what agencies have recorded and shared for this review.

***Recommendation: KSCMP Business Team to produce a SWAY learning briefing based upon "A typology of emotionally abusive parenting,"[6] which offers clear descriptions of harmful parental behaviours, and the Learning and Improvement sub-group evidence how practitioners have been supported to consider it.***

[6] Emotional abuse and neglect: Identifying and responding in practice with families: Frontline Briefing (2014) p.2

53. Amongst the practitioners at the learning event, there were both reflections and unanswered questions about prioritising the child's voice where the parent dominates any interaction with agencies and declines the identified help for their child. How should practitioners raise their concern around the regular refusal of a service offered to a child? For some agencies working in Kent, their practice models will emphasise the need to develop relationships within which challenges can occur and will support practitioners in developing techniques to preserve relationships with families they challenge. There is existing local guidance around recognising behaviours in families who do not accept help and refuse to engage [7], but in addition, some suggestions for practice are:

- Work to triangulate the information given to other family members and other agencies where possible, with the child's welfare as the priority.
- Be clear with families about how doing checks with agencies can help identify the right help for a child.
- For older children who are 'Gillick competent,' practitioners should always seek the child's views on accepting help, such as an assessment or intervention.
- Where clear needs have been identified, any non-acceptance of an offer to meet those needs should be explored with the family and the reasons recorded.
- Where there is a non-acceptance or refusal, the referrer should share information about any previous similar choices with the agency receiving the referral and that agency should also check for any prior history.
- In response, the agency receiving the referral should inform the referrer of refusal of service and also sign post the client to other similar services they can access for help if needed/appropriate.
- Previous refusals can indicate that the child continues not to have their needs met, potentially leading to cumulative harm, so it should be considered whether there is evidence of cumulative harm at the point of closure.
- Agencies should also consider who is best to facilitate acceptance of help.
- Some agencies are beginning to flag previously refused offers or help – this should be considered for feasibility by all partner agencies.

**Learning: It is recognised that to have such difficult conversations is a skilled task for workers. All practitioners should be offered the opportunity to reflect upon the KCSMP guidance regarding Courageous and Challenging Conversations.[8]**

54. There are some fragmentations caused by how information systems are used. The reasons for this resonate with the findings of the Child Safeguarding Practice Review Panel's annual analysis, where information is not shared and utilised effectively within linked [often health] agencies[9]. The evidence in this review suggested that the electronic recording systems used did not support practice. For example, the child's care record for the acute trust record does not access the records of the CYPMHS Crisis Team to understand their interventions. There is some work underway to link these two areas together as practitioners responding to

[7] KSCMP Refusal to Engage
[8] KSCMP Training Resources
[9] National Panel Annual report 2022-3 para 5.57

children presenting in crisis must be as informed as possible regarding past and current risks. Whilst there was good practice in the sharing of risk assessments by the CYPMHS Crisis Team, with other agencies when Ruby had presented in mental health crisis, these risk assessment were not consistently recorded or shared between the CYPMHS Crisis Team and the Emergency Department, so previously completed risk assessments could not be seen by Emergency Department practitioners.

55. Some agencies identified an absence of a "was not brought" policy in operational practice. This was relevant to Ruby for her physical health needs. Examples for Ruby included that she was not brought twice to a hospital appointment with a urologist. This was sent to the GP but not effectively scrutinised or responded to. Offers of intervention not accepted by the family should trigger action and a follow-up conversation with the family by the referring agency. There was also a similar pattern of behaviour, in that the family were not contactable by CYPMHS despite at times agreeing to the referral to that service for Ruby. KCHFT Targeted Counselling Service are progressing with flagging cases where a generic agreement to a service, e.g., targeted counselling, has been agreed upon by a family and consent subsequently withdrawn. This will support identifying patterns of refusal and non-acceptance and should be considered by other agencies, both those making referrals, e.g., the GP, and the receiving agency.

***Recommendation: KSCMP to consider how a pattern of refusal of intervention by a family can be systematically reviewed and acted upon across agencies.***

56. A query was raised at an LCSPR panel meeting as to whether the help (in this case, a medical appointment) was accessible to the family. In this case, the mother had small children and a baby during the last year of Ruby's life. However, other adults in the family were able to help the children get to appointments. It is a helpful reminder for all practitioners making referrals or Requests for Support - considering the key concepts of *awareness, accessibility and acceptability*[10] from the Early Intervention Foundation may benefit those referring families to further offers of help. It is unlikely that the parents did not know what some of the offers were, for example, Ruby was not brought to the planned hospital appointments regarding Ruby's urinary difficulties – which had been requested as the mother had supported Ruby in attending the GP regarding this matter.

57. However, in the case of both Daisy and Ruby's mental health, it appears that the *acceptability* of the offer of CYPMHS was not a given for this family – the reasons for this are not entirely clear. There is a narrative from the parents, explored below (see paragraph 83), regarding the dangers they identified as inherent in how safety planning was carried out. This narrative was seemingly not explored further with the mother to determine how she felt the family were let down by previous intervention or what sort of help she felt the girls may have needed. Across the period under review, the mother had sought alternative help from the first time Daisy was known to be struggling to seek support from another agency, not CYPMHS. The mother had already refused or avoided CYPMHS before there could have been a negative experience of safety planning. Whilst she accepted her children having counselling from voluntary and private sector providers as well as KCHFT Tier 2 counselling,

[10] Early Intervention Foundation 2019

the mother's avoidance of some statutory and public services for their children is of note but was not really truly understood or explored with her.

58. Balancing expectations of the family of what constitutes 'help' is also crucial when considering addressing adversity in the child's lived experience. The mother reported being dismayed when the GP suggested to Ruby that she might also *"have to help herself,"* feeling that this was the practitioner's role. This was regarding looking up some of the online resources the GP had shared with her. It should be noted that the GP did not know the family had not engaged with several attempts by the local CYPMHS team to offer help to Ruby. However, in other evidence heard as part of this review, there appears also to be some responsibility put upon Ruby to help herself from other agencies, e.g., a referral from Early Help to KCHFT for counselling requested help for Ruby so she could learn to understanding and manage her feelings, in some ways ignoring the fact those feelings could be underpinned by family dynamics. When Ruby was seen alone, she wanted help from practitioners. Her mother did not always support her in accessing this help and, at times, was the barrier to that help. However, the mother also said to the independent reviewer that when she requested the family be referred back to the same Early Help Worker they'd had previously when declining a Child and Family Assessment at the end of the summer term of Year 8 when Ruby was aged 13, she was told that unless she could identify *what* particular help she needed, Early Help would not re-open the case. This narrative is not shared by ICS, and the social worker who spoke with Mother said that during one of 3 conversations with her, she indicated she had not wanted to return to Early Help as she had her own plan for support.

**Learning: It cannot be assumed that families can access or fully understand the offer of help or intervention they are being asked to accept. Clarifying the purpose of help, i.e., what the offer consists of, is vital, as is understanding what a family's expectation of help is.**

59. Other aspects of the refusal of help could have been explored more. A possible factor, founded on something the mother mentioned to a CYPMHS practitioner, was that the stepfather did not want any practitioners working with the children in the family, as the intervention by an Early Help worker was said to have caused tension within the family. This is despite the two girls' significant presentations and changes in those children over time and some faint evidence of the possible causes of the changes seen in the girls. This was not queried with the family to understand the stepfather's reticence.

60. The parents repeatedly minimised the poor mental health presentations of both Daisy and Ruby on several occasions. They were not challenged due to the compounding factors of practice, which focused on *individual children, individual agencies*, and *individual incidents.* Parents located the child's difficulty as their behaviour. A challenge could be made to a parent that a child's behaviour should be viewed as a form of communication, arising from difficulties the child might face. There was a stark observation made by the school of Ruby's decline from when Daisy moved to the maternal grandparents. Whilst this may have been communicated to other services in the referrals or Requests for Support, it is not clear that the parents were effectively challenged or helped to understand or think differently about

the changes in her presentation, what the changes might be caused by, or the increasing severity of the risk.

## The importance of the multi-agency assessment of risk.

61. Daisy described her experience of the limitations of Early Help and targeted support – responding to one problem and singularly pursuing the solution. Whilst individual agencies had their own risk assessment and the Emergency Department diligently shared their risk assessments of these girls when they presented in crisis, the family's refusal of CYPMHS and Children's Social Work Services meant there was no multi-agency assessment of the family, nor the risks within the family, or from the child to themselves, which Tier 3 services would have provided. It is noted that Kent ICS will be supporting the development of alternatively qualified staff, such as some Early Help staff, to lead Child and Family Assessments under s17 Children Act as per Working Together 2023. This in turn may support the acceptance of such assessments by families who are reticent to accept services. The Kent thematic report regarding suicide highlighted the importance of a good quality assessment contributing to *"the diminishment of risk and meeting the complex needs of young people. Suicidal ideations and suicidal plans may not be reliable indicators of chronic intent to commit suicide. Therefore, a comprehensive assessment is required involving actively listening to parents and young people, crosschecking and cross-referencing at an individual and systems level"*[11].

62. The risk of suicide was not the only risk for these girls; there were several other safeguarding concerns raised. The Early Help Worker had previously discussed stepping the case up due to the possibility of physical abuse by the stepfather to Ruby, Daisy and a half-sibling, however, this was denied by a manager. It appears that not all of the relevant information was shared to inform that decision. Ruby later told the Burns Unit practitioner that her stepfather had hit her in the past. Another Burns Unit practitioner did speak to the Early Help Worker, but Early Help records do not confirm Ruby's disclosure regarding his physical abuse or that he had used drugs in the past was shared during this conversation, and the records at the Burns Unit do not suggest their practitioner had questioned if this disclosure had previously been referred or fully assessed. Had this been referred to ICS as a new disclosure to this agency of historical abuse, this may have prompted a change of case direction. The family were closed to Early Help a week later, given information from the mother and children about improvements in their situation and plans for alternative support. It is recognised by these agencies that responses could have been different.

63. Additionally, when possible, extra-familial risk was identified by the school and by clinicians at CYPMHS, but the recognised pathways to help for exploitation were not followed by those agencies. This has been identified in other learning reviews and emphasises the need for all practitioners to apply thresholds and follow processes such as the Exploitation Toolkit where they have identified risk to the child, even when there is already agency involvement.

[11] https://www.kscmp.org.uk/__data/assets/pdf_file/0014/112046/Suicide-in-Children-and-Young-People-Thematic-Review-Executive-Summary.pdf

64. The possible experience of sexual abuse within the family environment has been suggested as relevant to both Ruby's and Daisy’s experiences, as well as possibly regarding a younger sibling, whose presentation was causing concern for her primary school at the same time Daisy and Ruby were struggling. Concerns raised by her primary school with the parents often resulted in parents making allegations of bullying in school of their children. After Ruby’s death, police investigated this further, however, the evidence did not lead to a subsequent prosecution.

**Learning: All practitioners should be familiar with the evidence base regarding CSA within the family environment and the barriers children have in communicating their experience of CSA[12].**

65. It is also a theme across the individual agency reports that other possible risks were not explored as in-depth as they might have been, particularly around the use of social media. While the parents felt this was detrimental to the children, it does not seem to have been a focus. There was a clear identification of Ruby made by other parents at the school on their child’s phone, and the police decided to speak with Ruby about this when they planned to talk to her about an allegation of sexual assault. This conversation was delayed by the mother, identifying that Ruby did not wish to talk about the assault yet, and that they were then on holiday during the half term. This meant the concern around images of Ruby being shared on social media went unaddressed with her. The school knew of instances where her presence on social media was of concern. The mother made practitioners aware of her steps to ensure the safety of Ruby online, however, there was no honest exploration with Ruby regarding her virtual world experience or of the sanctions her parents utilised to prevent online harm. Her use of social media was a significant factor in the events during the last two days of her life and appears to be a reason for the increased difficulties in relationships in the home. Daisy suggests that Ruby was being bullied online. A child’s online world is significant in terms of impact, potentially even more so when facing behaviours such as Ruby is reported to have done – which were both potentially shaming and out of her control, for which she may have been blamed rather than supported.

***Recommendation: Where relevant, referrals into services and assessments by services (including of risk), must consider and clearly reference the impact of the online world and social media on children and families.***

66. There are other aspects to online risks and how safeguarding systems can challenge messaging. Evidence from the Emergency Department practitioners and feedback from the Burns Unit is that burns can be deliberate self-harm, sometimes influenced by online content, and sometimes result from online ‘challenges,’ such as receiving burns from aerosols, highlighting the importance that professionals explore the relevant context and intention. Specific responses that combat harmful messaging can be issued locally, using the same platforms that present children with harmful content.

67. There is another aspect of online risk that has emerged from the evidence shared in this review around the influence of social media on adults and children. There are instances of

[12] Centre for Child Sexual Abuse Communicating with Children Guide; P Henshaw in SecED The 12 Barriers Preventing CSA Disclosures 18.10.2023

the misuse of media by adults in this case in contacting other unrelated children and informing them of Ruby's death by suicide. There are examples of the spread of misinformation regarding self-harm and suicide that may have a negative impact on children and there are instances of the targeting of particular practitioners or agencies by Daisy and Ruby's mother. Whilst the freedom of speech is of course important, libel or the possible harassment of a practitioner is not acceptable. Any initial multi-agency processes after a child's death should consider how best to manage the potential for such behaviours, including preventing them, as well mitigating the negative impact on children and adults in the family, children and adults affected in the local community, and professionals.

## Considering a family's culture.

68. Another aspect of the girls' lived experience was a lack of exploration of the family's culture, religion or ethnicity. For this family, the visibility has been bound up throughout their history. The mother went to live with her father and his wife (the maternal grandparents) when she was a child as a result of private family law proceedings. The mother's mother (maternal grandmother to the girls) is Jewish, but it remains unclear in reviewing the practice in this case, the extent to which the mother herself felt part of the Jewish community. NB: Judaism is cited as an ethnic-religious people, including aspects of culture, nationality, ancestry and religious beliefs[13]. It can mean many different ways of being, depending on how that person or a family identifies themselves – the term 'community' is used here to capture this. This prompts even more reason for a practitioner to explore that with this family to understand what Judaism means to them. The mother sought help from a Jewish community organisation herself. She spoke with warmth regarding the support the family had received in the hospital from women from the Jewish community, particularly in their tending to Ruby's body by Jewish custom. However, the agency analysis suggests that practitioners did not seek out the meaning of the family's community to this family, for example, did the family experience discrimination? Did Jewish culture influence the child's lived experience? Did their culture affect their views on mental health, acceptance of help, or feelings of intervention?

69. It is not clear the extent to which this was significant for the children and this is a point to consider in practice, as there is no evidence that during agency involvement anyone ever asked. When the independent reviewer asked her about Judaism and her family, Daisy did not believe this was a particular feature of her up-bringing. However, there is an episode for Ruby where she appears to be subject to an antisemitic slur in the context of negative peer relationships but it is not clear what impact this had upon her as it was not seemingly explored.

**Learning: Practitioners are reminded of the importance of being curious about a family's race, ethnicity, culture and religion – all of which may influence their perspective on accepting help.**

[13] https://www.jewfaq.org/what_is_judaism

## Referrals and Thresholds, decision making, disagreements and escalation in safeguarding practice.

70. When reviewing the Kent Support Levels Guidance, descriptors to guide practitioners regarding a child who is experiencing poor mental health, self-harming or having suicidal thoughts features across Tier 2, 3 and 4[14]. Every Request for Support will have required a professional judgement to be made about the way forward, and practitioners acted upon these. There were also pathways to Tier 2 and Tier 3 mental health services and a confusing use of voluntary organisations by the family. Often the family had an alternative plan to help, although these plans increasingly did not appear robust enough to support Ruby's declining presentation. It is of note that her sister Daisy's outcomes improved when she left the family home, which suggests the focus on the mental health presentation of both girls may have distracted from the wider experience of adversity. Tier 3 CYPMHS may have explored this further.

**Learning: When making a Request for Support using the Kent Support Levels guidance, practitioners should be reminded to note patterns in a child's presentation, and including any observations or information regarding any causal factors as explanation for the presentation.**

71. A particular concern in the journeys of Daisy and Ruby is the inconsistency across agencies regarding the number of concerns raised, with whom, and whether any professional challenges made followed the Kent Escalation and Professional Challenge policy[15]. There were several escalations made – the school were rightfully advised by the Education Safeguarding Service to follow the policy, however, it does not seem this was expedited effectively. The school attempted to challenge the decision to close the Children and Family assessment with the local Children's Social Work service Team Manager, however, the communication between the two stopped. The school report no further response from the Team Manager. The escalation policy advises to go up the stages of escalation, including the KSCMP Business Team in communications at Stage 3 and beyond. This did not happen. It is suggested this attempted escalation could be walked through again with the relevant parties, to identify if there is any more to be done in terms of embedding this in practice.

**Learning: It is useful for the decision and outcome of referrals to be shared with the referrer and discussed so they can challenge the decision. It is vital that all agencies are aware of the Escalation process.**

## Theme Two: *What does this case tell us about the effectiveness of the multi-agency safeguarding response to poor mental health or mental illness?*

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[14] Kent Support Level guidance

[15] Kent Escalation and Professional Challenge policy

## How does the system respond to mental illness and suicidal ideation?

72. This theme focuses on the response to children's mental health, more specifically around children who self-harm and experience suicidal ideation. Much of the challenge for the children in this case lies in the mother's antipathy towards CYPMHS and the avoidance of that service, despite clearly understanding at times that her children needed Tier 3 support. It should be noted here that the KSCMP has many good resources arising from their previous work on teenage self-harm and suicide prevention from 2019-2021 and practitioners should be offered the opportunity to revisit this work and the resources on offer.[16]

73. The presentation of symptoms in both girls was visible to many of the practitioners in the system. Daisy recalled her experience and suggested that seeing a child as "misbehaving" should prompt the question, *"What's going on in her life?".* Many of the practitioners understood their presentation was rooted in trauma arising from adverse experiences during childhood, but this understanding was too often on an individual agency basis and not shared or discussed between them. However, it is not only behaviours – Daisy clearly stated to practitioners that she "wanted to die". There were at least five instances regarding Daisy's mental health and at least ten instances regarding Ruby when a practitioner sought help for the girls' mental health difficulties from another agency or organisation. Ruby was said to have requested help from CYPMHS in school on two or three occasions. There were further instances when the mother or maternal grandparents also did this. On some occasions, the mother appears to be offering an alternative plan, perhaps to avoid the intervention of another agency. The grandparents sought help in the private sector to get some help for Daisy, but as a compromise, due to resistance from the mother.

74. Family members had some practical observations regarding the response to mental health. Daisy had considered her response to *what is good and what could be different.* When speaking with her, Daisy said she currently works with a CYPMHS therapist, whom she finds helpful. This is because this therapist is skilled in various interventions, which she uses to make a difference in her symptoms. Daisy's (maternal) grandfather identified that this practitioner is gentle and adept at finding the right balance with Daisy; for example, when introducing a new idea or method, the clinician will suggest and explain it well, ensuring it is understood. She will then allow Daisy the time and space to consider the new idea.

75. Daisy gave feedback about what had not generally worked well for her and other children. She emphasised the importance for practitioners to take a child seriously and not minimise in response to a child's expression of mental distress, for example being told: *"It's your age, it's your period."* Daisy suggested that practitioners needed to think differently in two ways:

    *i.* Practitioners need to consider that it is not just more apparent outward signs of distress that indicate a child might be struggling with their mental health—more outward symptoms of distress do not always indicate the most scared or ill child. Her message to practitioners is that it is not only the child who draws their attention that may be most unwell.

[16] KSCMP training resources

*ii.* Practitioners need to keep in mind that the child might be experiencing several challenges at the same time and that practice needs to address these simultaneously, not just one issue, e.g. the child's mental health symptoms.

76. Daisy also highlighted that some children are able to mask but that the system is not geared up to respond to children who mask or internalise their emotions. Daisy now has a diagnosis of autism herself. Recent research cannot emphasise enough the stress and potential for harm to a neurodiverse person who constantly attempts to adapt to a neurotypical world[17] . The impact of this harm can significantly increase the risk of self-harm and suicidality[18]. Daisy's presentation was observed as outside what might be expected of a child of her age by the school in Year 8, however it does not appear that neurodiversity was considered at that point. The independent reviewer has recently reviewed another child's experience in another area. A key message from that review identified key learning: that practitioners who are working with children with mental health presentations should not only view the child's observed behaviours and mental health symptoms through the lens of possible childhood trauma but should also consider these through the child's possible neurodiversity.

77. There is also some feedback from family members regarding needing more consistency in practitioners between different incidents. The quality of their practice that the family experienced felt like a "lucky dip". There was also a description of some of the CYPMHS practitioners as not appearing to be authoritative enough with the child in that situation, and at times, the family felt that the practitioners sought to minimise and talk down the level of risk to the child. Whilst the family member acknowledged that some of the practitioners that have had contact with the family appear to be overworked and overwhelmed and that this might be a reason for such responses, it is a salient point and a reminder to those in practice and to their supervisors to consider the need to reflect on how the context of practice might affect their judgement of risk so that high-risk situations *under-whelm*. Other instances were cited where the adverse experience of poor home conditions observed by family members was seemingly not seen in the same way or acted upon by any practitioner visiting the home[19].

**Learning: For those supervising and managing practitioners working in challenging roles, it is vital to explicitly address the impact of working context upon practice and decision making.**

78. This review has highlighted a challenge for the safeguarding system in Kent, which is potentially more widespread than only this case, especially where children are felt by their families to be too unwell to wait for services. Daisy had intervention from two private practitioners: a psychotherapeutic counsellor and a psychotherapist. Whilst this appears in the main to have been with the intent of ensuring timely help for Daisy by the family, albeit in the context of the mother not wanting CYPMHS, it appears to be the case that to commission private practitioners runs the risk of all of the child's needs not being met if

[17] Damien Milton – Double Empathy Problem National Autistic Society
[18] National Autistic Society
[19] Scourfield, J. (2000). The Rediscovery of Child Neglect. The Sociological Review, 48(3), 365-382. https://doi.org/10.1111/1467-954X.00221

offered therapy in isolation. Those offering clinical support are not part of the multi-agency system around a child. The Rapid Review understood there appeared to have been a lack of contact by the private clinician with the public safeguarding system. However, the first private clinician who worked with Daisy identified the difficulty they had in being heard by the system when she wanted to report concerns. They attempted to speak with the school and the GP but did not receive a response. They also consulted with the NSPCC, their supervisor and the BACP regarding their concerns.

79. A subsequent psychology assessment received by the GP recommended that Daisy had Reactive Attachment Disorder and should be offered systemic psychotherapy with a focus on attachment-based family therapy. The psychotherapist offered this to the family, but the mother declined to take part. Daisy had six more sessions, similar to the first offer of private intervention. This did not seem to impact her and was only partially what was identified as needed. Offering this service in isolation to a vulnerable child appears to be a poorly informed decision. At the practitioner event, it was noted that private practitioners' expectations to share information and contribute to safeguarding processes are minimal. Safeguarding is reflected in the BACP ethical framework, however, it was reported to the practitioner learning event that private practitioners only have to share their notes at the instruction of a court. In a time of high demand and limited resources to meet the needs of children with mental health difficulties, some consideration should be given to offering guidance to practitioners in schools and public services as to the possibility of engaging with counsellors in multi-agency work as far as proportionate confidentiality allows.

***Recommendation: As part of ongoing work in KSCMP to develop a communications strategy with the 3rd sector highlighting local pathways for guidance and referral in relation to safeguarding concerns, consideration should be given to how this can be expanded to include private sector services for children.***

80. Evidence suggests good practice in risk assessment on the part of both the targeted service and the first private counsellor. In slightly different ways, one with Ruby and one with Daisy, both services made risk assessments which guided their decision to end their intervention – both because the risk was more significant for the child than the service was designed to offer. The private counsellor shared her careful decision-making process to end her intervention with Daisy with the independent reviewer. The KCHFT targeted counselling service identified a more systematic approach in that they could not continue to work with Ruby, who had six medium risk flags on the system by this time, signifying the need to step-up to Tier 3 intervention. However, the block to CYPMHS by the family is an example of the finding from the Kent thematic review regarding Suicide: "*The interface between different specialist health services and other organisations is a vital, but vulnerable line of demarcation, and may be decisive in determining effective service response and blue-light actions. Whether this is seamless, integrated or obstructed will determine timely or delayed service response within the suicide trajectories of young people. How one removes these barriers to service is worthy of discussion and action*"[20]

[20] Kent thematic review regarding Suicide in Child and Young People: 1.4.3 ibid

***Recommendation: KSCMP revisit this learning in Kent's Thematic Review of child suicide and review any guidance e.g., the Support Level Guidance, to ensure they reflect the concept of decline and its significance.***

81. It may also be worth revisiting how the mental health system works, its legislation, and its application in practice. There was a degree of frustration at the practitioner learning event regarding the fact that in the 36 hours before her death, Ruby's presentation at the hospital did not meet the criteria for mental health practitioners to restrict her liberties under the Mental Health Act 1983. Her presentation was deemed to be 'chronic' rather than acute. Mental health practitioners were careful in explaining how 'sectioning' a child is the absolute 'last resort,' how it can be a very distressing process, and the benefits of detention against the child will have to outweigh the risks. It was not only Ruby's mental health symptoms that were the concern, there was adversity in the family environment, an experience for which mental health legislation does not apply. The response to Ruby during the days before she died included the Emergency Department nurse making a good referral to the CYPMHS crisis service escalating their concern, advocating for Ruby and representing her experience well. The CYPMHS Crisis service also made a prompt referral to the Intensive Home Treatment Team, and Ruby was seen the next day. More consideration of practice in this critical period will be seen below.

82. The most recent iteration of Working Together 2023[21] continues to emphasise the broad range of activities that are safeguarding measures. The essential tasks are to '*help, protect and promote*' the welfare of children—the promotion of the good mental health of children featured in Ruby's journey. There is much evidence of the benefits for children engaging in sport in or outside school[22]. The sports club that Ruby enjoyed engaged fully with the review process and was able to share how it, part of a county-wide network of clubs, prioritised giving children a safe space and a positive and fun experience. The impression of the club and county organising body is of a caring culture but also where there is a clear articulation of the position of adults in terms of safeguarding and approach to well-being, e.g., so that physical well-being checks for injuries at the beginning of each session would note any self-harm injuries. The safeguarding lead for the county body recalled the family were open about Ruby's self-harm. They also detailed the training that all adults had around the observation of children and their families to promote and protect, so that all adults noted the children's presentations, the language being used by family members, and how children respond to criticism or encouragement.

**Learning: The sports club's safeguarding approach should be shared as an example of good practice for voluntary organisations, i.e., activity clubs that seek to promote the wellbeing of children.**

## Safety Planning with children at risk of self-harm or suicide.

[21] Working Together to Safeguard Children 2023

[22] E.g. research commissioned by the Youth Sport Trust and Heads Conference 2023; NHS Healthier Families; Sport England Active Lives.

83. Ruby's mother believes that when practitioners made a safety plan with Ruby, they gave her the tools to kill herself. She described this as a "list of murder weapons." The mother said that her reason for refusing offers of CYMPHS support for her children was based on an experience that Daisy had, where she was shocked by the detailed consideration that a CYPMHS practitioner gave to the means of suicide, naming everyday articles that a child might be able to access within the home. Whilst the mother believes this is contrary to a child's safety, the evidence from national organisations that focus on practical advice and resources for a child that is suicidal suggests that one way to make the environment safer is for the child to put away items that could be used to try suicide[23] and for the language used when talking to a child about this to be "*clear and direct words"*[24]*.* This was echoed by practitioners at the learning event – that there was a need to be *"black and white"* about the nature of the child's thoughts to be able to help them best. One practitioner suggested that being 'confronted' with straightforward questions about their intent can assist the child with thinking differently rather than being consumed in the thought process, as well as helping the practitioner gauge the level of risk.

84. In discussing this, the advice within safety plans is consistent across the safeguarding system, and there is confidence amongst practitioners in mental health agencies in this area of practice. However, what needs to be clarified is how safety planning travels with the child or whether there is a consistent approach to embedding them and reinforcing strategies with the families. Daisy had a safety plan from working with CYPMHS early in her journey, but she also formulated one with a private psychotherapeutic counsellor. That practitioner described safety planning with a child as a therapeutic tool, i.e., to promote the type of direct discussion about suicide and risk between the child and the therapist. In contrast, safety plans in other agencies appear to be intended to be shared with the family and with the practitioners working with the child, e.g., in the school, through the practice of simply sending a safety plan. Uploading a safety plan onto a recording system appears to be a paper exercise, and all agencies should consider how they use such information in practice.

85. Ruby had a safety plan from her presentation at the Emergency Department in school Year 8, aged 12. That plan, linked to a risk assessment by the CYPMHS crisis service, was shared with KCHFT school health and uploaded to her care record, but potentially only as an administrative process. However, the KCHFT counsellor later updated this when their intervention started. Mind and Body in their initial assessment, asked Ruby about safety planning and she told the practitioner she had a safety plan, which her mother confirmed. Towards the end of her life, Ruby received some counselling from a service commissioned by her school, and confirmed with that counsellor that she had a safety plan and that practitioner reminded her of her "*safety/protection factors."* The school confirmed they had a risk assessment/management process for the children in the school. The sports club also recalled checking with Ruby that she had and used a safety plan. There was a suggestion by the GP practice that GPs could also ask a child about their safety plan.

[23] Papyrus: What is a safety plan
[24] Young Minds A Parents' Guide to Suicidal Thoughts

**Learning: A practice enhancement could be to ensure a child is asked if they have a safety plan and to check it with them. Ask the child how and if they think it works to keep them safe. Where appropriate, agencies should share the child's safety plan.**

86. Ruby knew what her a safety plan was, but spoke to many practitioners regarding her mental health during the last year of her life. The significance of a safety plan may have been diluted as there was no single shared plan. Practitioners who spoke with Ruby included an Early Help Worker (unknown number of meetings but mental health referenced); CYPMHS crisis workers (on three occasions); a CYPMHS worker conducting an assessment (1 session); a CYPMHS Intensive Home Treatment Team (1 session); a nurse and a psychologist at the regional Burns Clinic in a neighbouring county; her GP (6 consultations regarding mental health); a targeted counsellor from KCHFT (12 sessions), a counsellor from Mind and Body (1 session); and an in-school counsellor from Kent Counselling in Schools (4 sessions). Additionally, there were repeated interactions with several practitioners at school, including a 'trusted adult' (pastoral care) and staff from the sports club.

87. Another challenge to the effectiveness of safety planning and in actually getting the intervention that may have helped Ruby was that she told some practitioners that she did not wish to engage with CYPMHS either, as she felt they would discuss her self-harm with her mother. Ruby had referenced that on occasion, her mother responded negatively to her self-harm. Due to the erratic pattern of the acceptance of help by the family, it is unclear whether practitioners ever had a real opportunity to discuss with the mother as to how she could support Ruby, or shift Mother's thinking on mental health, although some of these practitioners above did meet with the mother. This type of conversation would have happened at Tier 3 intervention, however, the mother had refused this on several occasions for both children. The mother informed the independent reviewer that since Ruby's death she has undertaken a suicide prevention course and feels that she'd had no information or help with supporting a child with mental health needs, including the specific practical responses. There are many national resources for parents, however, the mother also suggests that online resources are not helpful.

## Families and safety planning.

88. Practitioners may need to place greater emphasis on checking how parents implement safety plans when working with a child and when ending intervention. However, there is also some key consideration to be given to exploring the family's perceptions of mental health—what do they understand it to be and do they have a sense of stigma or fear around it. This conversation does not seem to have been held with the mother.

89. The mother recalled trying her best with Ruby in attempting to manage her mental health and keep her safe. The parents recalled the negative impact of social media on Ruby. Like many other parents, they remembered how they attempted to manage this, including locking down social media and internet access so that Ruby would go to sleep earlier on a school night and that the impact of her spending more time in the living room with her siblings was positive. This impact of social media upon Ruby did not appear to feature so much in any other interventions with Ruby to understand these experiences, even when

these were the subject of a Request for Support from the school at the beginning of Year 9, aged 13.

90. There were points that her parents confiscated her mobile phone: this had been the case during the episode before her death. An important point was raised regarding this during the practitioner learning event. A child with mental health concerns and a safety plan should have been asked the numbers they might call when feeling unsafe and unable to manage negative or suicidal thoughts. Ruby had her maternal grandfather as one of those numbers, but that would have been stored in her phone rather than her memory. Children do not tend to remember numbers as they are stored in the phone, so this is an area of vulnerability for any child. Further, Daisy's reflections included that whilst there are clear benefits in restricting use of mobile phones and access social media, some young people are "addicted" to it in a way that causes panic when it is removed, which can exacerbate other emotional wellbeing and mental health issues. Confiscating a phone may compromise the ability of young people to keep themselves safe. Alongside considering what might need to be removed from the child's environment to keep them safe, it may also be helpful to consider what items should remain to help them.

**Learning: Practitioners need to work with families to consider any unintended consequences of restricting a child's access to a mobile phone based on the child's safety plan.**

91. Like another concurrent review in Kent during 2024, which identified "*learning in relation to information sharing about safety plans and ensuring they are 'joined up' and potentially standardised",* this review has shown some good practice in agencies in terms of safety planning. There is much evidence that Daisy and Ruby understood their plans. The mother was also aware of the plan, although it is unclear whether there was enough rigour to check the potential risks in all the environments. It is vital that safety plans intended to help keep the child safe are standardised and travel with the child, and that practitioners and families make it their business to understand what the safety plan is.

***Recommendation: KSCMP Learning and Improvement sub-group should expedite recommendation 1 from its review 'Jasper Red,'[25] and further, agencies must consider what to do with a safety plan once received.***

## Noticing a child in decline.

92. During the learning event, practitioners reflected on Ruby's deterioration, which was observed to have impacted every aspect of her development: her physical presentation, social interaction, and emotional frame of mind. Ruby's presentation from the beginning of that term had caused the school to be concerned. The description given of her *"dishevelled, dirty"* physical presentation and her *"challenging"* social interactions was of a child *"clearly*

[25] NELFT to provide an update to the Kent Safeguarding Children Multi-Agency Partnership on the work being undertaken to ensure improvements in safety planning for children who are known to be a suicide risk. This should include the forming of next steps within the plans and more effective sharing and communicating of the safety plan.

*in decline.*" In a separate conversation with the independent reviewer, the school offered a more detailed and sad account of Ruby's experience during her last term in school. Her behaviour continued to decline – Ruby was recalled to have sworn at a staff member. At the beginning of the year she had been suspended, however, from that point onwards, the school understood this behaviour to have an underlying cause outside the school environment. Her ongoing behaviours were then managed using internal sanctions – the school recalled having to balance the risk from the child in school with the risks to the child in the home and community, and from her mental health. The school describe repeated refusal by the mother to consent to a referral to CYPMHS. Ruby struggled to maintain the pretty low expectations of her behaviour support plan – to wear the correct uniform and not swear at staff. The school attempted to explore Ruby's need and wish to move school, however, the mother resisted this. She was reported as fixated upon Ruby staying there. This contradicts the mother's account that Ruby wanted to stay at the school.

93. These descriptions suggest that Ruby's experience aligns with previous local learning [26], where a concept or theme named the "Rising Tide of Risk and Concern" suggests, *"there is a suicide trajectory wherein opportunities exist to prevent suicide. This review found that whilst single and 'Discrete Trigger Events' (DTEs) may account for a tipping point, consideration should be given to a 'Trigger Event Phase' (TEP) that may capture deterioration in presentation and a sea change in individual presentations and suicidal intent".* Using this idea, consideration should be given to how practitioners recognise and respond to such changes in a child and how this should prompt a review of a child-centred safety plan across agencies.

## Theme Three: How does the multi-agency safeguarding system respond to the impact of other children's suicides upon their friends, peers and the wider community?

94. As background research for this review, the independent reviewer and KSCMP Practice Review Manager met with Kent's public health colleagues to learn about good practice in responding to a child's suicide. There is a high-level Suicide Prevention strategy[27] engaging all the key partner agencies and a commissioned service[28] to support a whole community response to schools and the individuals affected by a child's suicide. However, it is not clear that this is fully understood or consistently embedded across all schools in Kent. From evidence shared during the review process, it does not appear that all schools access that service. However, there was information that schools had previously had advice from the Suicide Prevention Service and that after Ruby's death, the school contacted the Education Safeguarding Service seeking guidance and support.

95. As previously noted, Ruby had been adversely affected by the suicide of a peer at her sports club. The feedback from Ruby's family and Ruby herself was that she did not receive any

[26] Kent Suicide in Children and Young People – A Thematic Analysis summary, 1.4.7
[27] Kent Suicide Prevention
[28] Amparo: Support following Suicide

specific direct support from any practitioner working with her regarding the impact of the suicide of her friend. However, she discussed with her KCHFT counsellor the impact this had on her, and worked with her on this within the more comprehensive mental health intervention. This was the critical practitioner that Ruby was engaged with during the months after that child's death. Ruby had also mentioned this child's death to the GP not long after that child had died. This was not revisited with Ruby in subsequent GP appointments. Good practice might have involved a return to her sense of loss as a stressor for Ruby. As earlier mentioned, there is something about the expectation of 'getting help' versus the help not having the desired effect or not being the proper intervention. It is not known if the impact on other children was considered within any multi-agency processes after this child's death. However, there is evidence of good practice after Ruby died within the s47 strategy meeting, where the negative impact of Ruby's death upon two friends involved in the sports club was considered and acted upon. All three schools that Ruby and her siblings attended worked together to respond.

96. During 2023 there have been a number of child suicides in Kent. ICS have supported practice initiatives such as Early Help and the District Social Work teams' joint mapping of children where suicide or attempted suicide occurred, to think about the broader support, risk management and safety plans for other children in the community that may be affected. There is also the option to consider children at meetings with other agencies to look at implications and safety planning as well as risk factors. It is vital that this planning starts at the point of the first responses to a child's death by suicide.

97. There was also good practice between the three schools that Ruby and her siblings attended, as well as contacting the sports club. Though regretting the need to develop an approach, the sports club reports being much more responsive after Ruby's death than previously. There is an open approach to sharing information, and the club considers the presentation of each child about the subject of a child's suicide. Children need different types of support: some are observed as glorifying peer death, some are witnessed to process the loss in a typical way, and others show more significant concern. The child's experience and processing of a peer death is not predictable; for Ruby, this loss appeared to increase the impact it had had on her over the following months, perhaps compounding her other difficulties.

98. However, this good practice by the sports club has been developed reactively due to presenting needs rather than as part of a coordinated preventative response. The club noted they had struggled to get support for the children at the club when Ruby's peer died, and that more was available for adults. A nurse linked to the club helped to adapt an adult-focused Samaritans programme for the children. Sadly, the club's response is to become more prepared and skilled due to the number of children who have died by suicide. The value of such settings in terms of suicide prevention should not be underestimated. Children attend, usually willingly, and have positive relational contact with adults whom they often trust. The sports club also identified that the summer holidays would be a critical period for some children. Ruby herself had experienced an escalation in her distress during that time, where her needs had not been met as she was not seen by practitioners regularly, apart from a presentation for a suspected overdose.

***Recommendation: Kent and Medway Child Death Review (CDR) Team and ICS ensure any relevant groups, e.g. sports clubs, are considered in the CDR process and strategy meetings respectively, after a child's death by suicide, to ensure relevant support and signposting has been offered and vulnerable children identified.***

99. As well as a strategy meeting, there was also a Joint Agency Response (JAR) a week after Ruby's death as part of the Child Death Review process. One health agency acknowledged that this had supported a more effective response. Staff involved with the child's case were invited to the JAR meeting to share information surrounding the circumstances of her death. This supported sharing information across the Emergency Department, raising awareness of possible attendance from the child's peers. Following Ruby's death, a peer presented to the acute trust Emergency Department in a mental health crisis, and staff were able to identify the link and make appropriate referrals for support.

100. Ruby did not receive intervention from CYPMHS community services, although she did see the CYPMHS crisis team when she presented to the hospital Accident and Emergency department, but did not talk to the practitioners about her friend's suicide. Currently, CYPMHS do not routinely become involved with the school regarding a child's death unless directed to do so by senior management. The locality CYPMHS team do have good communication links with the safeguarding leads at local schools and remains vigilant regarding new referrals from schools that have previously been affected by a child's death. A review of this should be considered as a reliance on information from schools may not consider the needs of other children who are not in school, perhaps due to their mental health or other reasons for persistent absence. It was suggested that the CYPMHS clinical lead for Kent could look at the most appropriate resource, including locality teams across Kent, to be involved in any coordinated response to the evidence arising after a child's death. Therefore, their invitation to strategy meetings or death review processes should be systematised.

101. Ruby's mother wanted to highlight the good practice Ruby's sibling experienced at school after Ruby's death. She described how school practitioners worked at the sibling's pace, for example, understanding school absence as part of grief, signing the child on to early study leave so that other practitioners in other agencies wouldn't misunderstand their absence as a safeguarding concern, consistently "checking in" with the child during the school day, offering additional tuition for some subjects, and providing an exam compliant transparent pencil case just in case this was forgotten. The mother noted how the attendance officer, the school's Designated Safeguarding Lead and the school librarian all became trusted adults for that child after Ruby's death.

102. Feedback regarding other services used by schools and the sports club noted good practice from the third sector, which specialises in this practice area. Large organisations such as the Samaritans and Mind supported practitioners significantly affected by her death. Mind were noted to have developed a preventative intervention, with one of the schools noting how they were supported in making sense of some of the children's responses after Ruby died. A smaller local charity, Holding on Letting Go, spent time with children in the school.

## Theme Four: What does the period from the final 48 hours of Ruby's life to the immediate response by agencies after her death tell us about the effectiveness of multi-agency safeguarding processes and practices?

103. It should be noted that this period was a focus of the coroner's inquest. It should also be noted that the police referred to the Independent Office for Police Conduct, who referred back to Kent police for an internal investigation and a Professional Standards process. There has also been a serious incident review within NELFT in response to Ruby's death. However, given the unique access, as requested by agencies, to their records that give an account of Ruby's last few days, it seems important to clarify and summarise their account.

104. The timeliness of some of the agency responses to Ruby during the difficulties she experienced in the 36 hours before she was found in her room where she had hung herself, appears as appropriate from her arrival at school until her discharge from the Emergency Department approximately 12 hours later. However, there were some significant lapses in the process and investigation, which meant that after this point, during that night, Ruby was not seen by all of the agencies who should have seen her to check on her welfare. It is also suggested that more authoritative practice, i.e., practitioners acting decisively and asking different questions of Ruby, may have led to other actions being taken.

105. At the beginning of this 'critical period,' it is known that Ruby had attended her sports club on Sunday, however, her mother recalled that she had not wanted to go. The mother told the club she was trying to get Ruby some help. At the club, her "*safe space",* the staff there did not recognise the description of Ruby's presentation that the mother had shared with them. Ruby was observed to have had a good session. The emphasis is that children can present differently to different people in different contexts. However, it is also suggested that something was happening within the family regarding content found on Ruby's mobile phone by her parents, but it is not clear how this played out over the weekend.

106. On the Monday morning, the mother met on the telephone with the school SEND lead regarding Ruby's behaviour support plan. Her mother informed them that Ruby would probably be "grumpy," that she had been found to have information on her phone connecting her to children at another school who had been taking drugs. Ruby presented at school on Monday morning and was open with staff about her distress. It appears that at the point of leaving home for school, her mother had warned her that they would discuss her mobile phone when she got home. Ruby disclosed to the school that she wanted to go to the hospital. She was fearful and wanted to end her life, so the school contacted the mother, who said she could not attend and asked the maternal grandfather to pick Ruby up from school. He collected Ruby. The mother then refused permission for the maternal grandfather to take Ruby to the hospital and her stepfather collected her from the maternal grandparents' house and took her to the hospital. The school have reflected on how this played out, and it is clear that they were reassured by the maternal grandfather coming to collect Ruby. They said they "trusted him 100%." Had they known that the stepfather was to take Ruby to the hospital, the school suggested they would have taken her themselves. The

school made a Request for Support to the Front Door Service, primarily regarding their concerns for Ruby's mental health.

107. The Front Door Service screened the school's referral in a timely way. The referral was not deemed as urgent as appropriate interim safety measures had been put in place to respond to Ruby's mental health crisis, i.e., school had appropriately requested that a family member take Ruby to hospital. As a stand-alone decision, this appears proportionate regarding her mental health. The Front Door Service advised speaking to CAMHS and had considered the previous mental health referral, nothing the immediacy of the escalation of Ruby's distress. However, ICS have also reflected that there should have been further enquiries made and consideration of a Children and Family assessment to commence given there had been several concerns raised about Ruby over the previous 4 months regarding mental health and other presenting risks. No agency checks were requested e.g. from KCHFT, who had had some significant involvement during the year.

108. Ruby appears to have spent approximately three and a half hours at the hospital, firstly with Emergency Duty and then with practitioners from the CYPMHS crisis teams. Ruby was very open with the hospital nursing staff about difficulties at home, at school, about the sexual assault, about self-harm and about how her mother and stepfather minimised her concerns about her mental health. Ruby said her stepfather (in the waiting room) would be "pissed off" when he heard that she was talking about her mental health. The Emergency Department nursing staff felt that Ruby had shared information with them, which they felt may have been a disclosure of her plan to kill herself, although she was not explicit about this. In referring to CYPMHS crisis triage, the nursing staff relayed that the stepfather had minimised Ruby's distress as *"behavioural"* as something had been found on her phone by her parents and had also been seen minimising Ruby's account. Again, behaviour is a form of communication and practitioners could challenge themselves to consider what Ruby's behaviours might mean in the context of that situation.

109. The referral by the Emergency Department to the CYPMHS crisis team was prompt, and the information shared was suitable to form the basis of the mental health assessment. The CYPMHS Crisis team assessed Ruby promptly, and Ruby appeared to disclose more information about how her *"life had not been great."* She disclosed the sexual assault and how she was due to speak to the police about this in a few weeks. She spoke of challenges at school and teachers that she found unsupportive. Her mother told the independent reviewer that Ruby had said to practitioners at the hospital that "*she couldn't keep herself safe.*" This statement has been checked with the hospital and CYPMHS however it has not been evidenced. However, she did say she did not want to go home. Ruby spoke of her sibling receiving preferential treatment over her at home. She talked about not having any bereavement counselling after her friend killed herself. Her stepfather told the staff about what he felt was the negative influence of her friends. He suggested that he had predicted that Ruby would end up in the hospital that day due to her behaviour, and that the family could manage the situation. Practitioners had some concern regarding the interaction between the stepfather and Ruby.

110. CYPMHS identified learning about how some cues from Ruby could have been examined in more depth in conversations and how they could have been better highlighted in the

referral to the CYPMHS Intensive Home Treatment Team for that practitioner to pick up. Additionally, the Crisis team had gathered some information from Ruby, which warranted a referral or, at the minimum, liaison with other professionals to triangulate information. There is also the possibility of reflecting on this type of presentation with the Out of Hours team. However, the Crisis team had a response, which was to offer the Intensive Home Treatment team, aware of the difficult dynamics in the family and that Ruby's parents did not accept her concerns. Ruby cited potential risks in the community from peers, challenges at school, and concerns about her parents' response to her mental health. All practitioners must recognise their role in sharing and triangulating information, including the child's perspective, fears, and what they see as risks. This information gathered from hearing Ruby was considered in isolation, and a medical judgment was made about her mental health without fully considering the social and environmental factors.

111. Ruby returned home with her stepfather in the early evening of Monday. Her parents recall confiscating her mobile phone after she returned from the hospital. Her parents said the stepfather noticed Ruby had run away at about 10pm, escaping the house through the bathroom window. The mother had gone to a friend's house, reportedly to avoid further argument, and the stepfather was home with the children. The police record suggests that Ruby went to the local police station which was closed at the time, borrowed a passer-by's mobile phone, and called 999. She was distraught, saying she had run away, her father had been threatening her, and she believed he was going to hurt her. She persisted and borrowed a second phone to make a second call when she was cut off. Ruby's mother arrived, spoke to the call operator, and provided a partial address. Ruby was heard to say, *"Don't let her take me."* The police have identified several concerns in their processes and less than effective practices around the recording and linking of information (such as the misspelling of Ruby's surname) and pursued one strand of investigation. A further task was created to look for Ruby at a different address (with a similar street name) in a different town. Ruby was not located and the initial report was 'pended' (held on a separate list until a specified time) and not given the continuous high level of priority that the initial one had been given at the beginning of the incident.

112. The maternal grandparents recall another significant event that evening: Ruby's mother rang them at around 10 p.m. and screamed, "*She [RUBY] is never coming to live with you."*

113. It is not known what happened overnight for Ruby. Her mother had found Ruby quickly that evening while driving with a friend and took her home against the request of the police that they wait there. There was no police activity or follow-up on the case between midnight and 7am. The following day, that car was traced using CCTV, and the driver contacted who then contacted the mother. Shortly before 9 am the mother then telephoned the police to confirm that Ruby had run away after an argument with her stepfather. The mother admitted to having grabbed Ruby's face in frustration during the incident. Mother agreed to a welfare check, however, a welfare check was not made by police before Ruby was found in her room at approximately 3 pm (though she was seen by a CYPMHS practitioner in that timeframe). Her maternal grandparents are keen to understand why there was no welfare check.

114. A referral about the management of this incident was sent to the Independent Office for Police Complaints (IOPC). They returned this to Force for an internal Professional Standards Investigation to identify if there had been any missed opportunities to safeguard Ruby. The initial report from the internal police review has been submitted to the IOPC for their review and assessment. The report is not finalised until such time as the IOPC agrees with the report and its conclusions. It is hoped the agreed outcome from the IOPC can be added to once the coroner has completed the inquest into Ruby's death. A complete exploration is ongoing and information will be shared as part of concurrent processes. This may counter any misinformation that may be harmful to other children or the community regarding Ruby's death.

115. It is also known that during the morning of the serious incident, Ruby texted friends to say she wanted to come to school but was not allowed to. The school recalled that Ruby's mother had called and reported her absence. Ruby was visited at home at 2 pm and went out for a walk with the CYPMHS Intensive Home Treatment Team worker. That worker was relying on the information from the Crisis team, and Ruby recounted some of the previous evening's events, saying she had been worried that her stepfather was going to hit her, he had been "shaking" with rage and so she was scared. Ruby also alleged past physical abuse by him to Ruby and Daisy to this worker. Ruby was clear she did not want to live at home anymore and wanted to go to her grandparents or prison. Ruby told the practitioner she felt suicidal and would harm others to go to jail. This worker heard Ruby and recognised the concern. They returned to the office and after a consultation with the Safeguarding Lead in NELFT, they made an urgent referral to the front door at 16.55 pm.

116. It is not commonplace for a child to say they do not want to be with their family. In the last 36 hours of her life, Ruby told at least five practitioners, in different ways, but essentially that her home life was bad and indicated a level of fear of her stepparent to at least 3 or 4 of those practitioners. Where a child expresses this sort of fear, which is also observable, the triangulation of information should take place quickly and does not require consent. Whether a clinician calls a school or a teacher calls social services, this use of information is to promote the well-being of and prevent harm to that child and is a *public task* [29] and a legitimate reason to share information without consent.

117. Ruby's mother told the independent reviewer that when the CYPMHS Intensive Home Treatment Team worker had left, Ruby had been *"left without hope."* However, perhaps lack of hope may have been for a different reason – Ruby had expressed fear and distress regarding being at home. She had consistently told practitioners over several months that she did not wish to live at home. These were calls for help. From Ruby's perspective, she may have lost hope in anyone doing so.

118. There is also some learning around the coordination of processes after the child's death. There was a suitable response in terms of a Section 47 strategy meeting. The inclusion of the GP and the CYPMHS service could have enhanced this. Action was taken to ensure that they were fully involved, however, this echoes the theme from the Suicide in Children and Young People Review around the role of GPs with children who are mentally unwell and/or

[29] Non-statutory Information Sharing Guidance

suicidal[30] and who are often the first port of call. Ruby saw the GP several times in the seven months before she died, yet the GP was not included in the initial strategy meeting after her death, reflecting the lack of understanding of their role and centrality to safeguarding processes for children.

119. Similar to other reviews recently lead by the independent reviewer, the different responses to Ruby's death suggests that there are too many processes that conflict or duplicate after the death of a child. There was a Section 47 strategy meeting the day of Ruby's death and a follow-up review strategy meeting 9 days later. These meetings were the immediate operational response to ensure the safety of all the children in the family and any other deemed at risk, including planning any investigation and making practical arrangements for the children. Multi-agency safeguarding practice over those first two weeks appears as timely and effective in keeping Ruby's siblings safe.

120. There was also a Joint Agency Response (JAR) meeting held a week after her death, led by NHS Kent and Medway Child Death Review (CDR) team as part of the Child Death Review[31] process due to the unexpected initial circumstances of Ruby's death. There was then a KCSMP Rapid Review a month after Ruby died and this subsequent LCSPR commencing 5 months later. Then there was a Child Death Review Meeting 8 months after Ruby's death, part of the same process that had been commenced at the JAR meeting convened by NHS Kent and Medway CDR Team but chaired by the Kings College Child Death Consultant, at the hospital where Ruby spent her final 24 hours. This was attended by Kent practitioners from a range of agencies. This series of meetings that were not co-ordinated with one another appears to have created a muddle and led to the system relying on information that was not completely accurate. Additionally, there has been undue pressure on some practitioners, some of whom have attended all of the meetings. Some meetings have had the same agencies but different representatives. These tangled systems arise from the structure of governmental departments – the requirements of the Department of Health and the Department for Education, who issue similar guidance to one another which is then implemented in varying ways and often with an element of "mission creep." The Child Death Consultant described the objective of the Child Death Meeting in a similar way to which this review might be described. In a very useful discussion with the Child Death consultant there was some reflection on who might be best placed to take the Child Death Review forward after the death of a child not known to that hospital apart from during the last few hours.

121. There have been additional investigatory processes within agencies, including an internal Police professional standards investigation and a NELFT Serious Incident Review. The Coroner's Inquest was completed in December 2024. What has become very apparent is that information does not flow easily between all of these processes, although upon request the JAR minutes were shared with the KCSMP for this review. It is not clear how the systems might ensure consistency across these processes as well as ensure there are no gaps in the response.

[30] Ibid Summary 1.5.3
[31] Child Death Review Statutory and Operational Guidance (England) 2018 Chapter 3

122. The feedback from practitioners is mixed. Some agencies had a negative experience, some had found different meetings more useful. Some meetings appear to not have invited the appropriate personnel for the purpose of the meeting – i.e., practitioners involved only after Ruby's death invited to a meeting regarding events prior to her death. Some practitioners have not understood why they have had to repeat the same information several times.

***Recommendation: The Independent Reviewer to write to Child Safeguarding Practice Review Panel to flag the overlap and duplication in reviews (CDRP, LCSPR, Coroner's Inquests, etc).***

123. There is also some learning for the 'media' strategy after a child dies. There was a proactive attempt to manage the information: On 17.11.23, a press alert was completed, and the ICS Team Manager consulted with the Social Work Standards Officer, the Area Safeguarding Advisor for Education and the CYPMHS Head of Service. The impact of information sharing, which is unplanned or expected, has been significant in this case. The mother asked everyone not to share the information, then did so herself in a way that substantially impacted children and adults who knew Ruby. The mother contacted another player from Ruby's sports club and shared it with them. That child then who shared it in a way that was not coordinated or managed. It is challenging for all involved to balance and respect the family's wishes whilst balancing the needs of other vulnerable children. For many practitioners, this will be a new experience for them. It may be that there is a role for a specific practitioner (perhaps a Family Liaison Officer), as well as supporting them more generally, to guide a bereaved parent in the sharing of information in those days after a child's death from suicide. Certainly, management of sharing /broadcasting of the news of a death must be considered at any Section 47 strategy meeting or the JAR.

## Summary of learning points

| That practitioners should be clear as to their role in assuring that the child's legal rights inform practice decisions and actions. |
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| Being 'reassured' about a child's lived experience can stifle the professional curiosity of any practitioner. Practitioners should seek out the child's lived experience when making key decisions about the child's case. |
| Considering a longer-term view of the child's journey will support practitioners in identifying any patterns or differences in the presentation of a child and potentially, any decline in their development trajectory. |
| Practitioners should not take a refusal or non-acceptance of help at face value. Rather, they should explore with the family the reasons behind the non-acceptance or refusal of help, which might support future acceptance of intervention for the child. |
| In any setting that the child attends, there is nothing to prevent practitioners from conversing in a more informal way with extended family members who appear relevant to the child in order to build relationships with them: "Who is the child to them?" "What do the grandparents mean to that child?" |
| All practitioners working with children should remember how conflicting it could be for a family member to raise their concern about, for example, the risk to their grandchild. Practitioners should be curious about this and any other barriers to families raising |

| concerns. |
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| Any practitioner working with a family should consider why they might be looking for protective factors in the child's experience—what might the child need protection from? |
| Practitioners should be supported in individual practice and multi-agency work to think across the family's history and network for patterns of incidents and events. This review emphasises the need for practitioners to utilise chronologies and tools such as genograms and eco-maps to support practitioners to assess risk – particularly of cumulative harm. |
| That all practitioners are offered developmental opportunities to understand how to make Requests for Support to Integrated Children's Services and use the Support Level Guidance to support threshold decision-making. This should always include the pathways to further help or support after referral (NB: this links to para below regarding thresholds). |
| When the opportunity arises with colleagues or family members, practitioners should seek to triangulate information from their observations with information from other sources. |
| Any practitioner working with a child should work to understand what other agencies are offering to the family and if needed can arrange a multi-agency meeting to devise a shared plan with the family to ensure the child's needs are met. |
| It is recognised that to have such difficult conversations is a skilled task for workers. All practitioners should be offered the opportunity to reflect upon the KCSMP guidance regarding Courageous and Challenging Conversations. |
| It cannot be assumed that families can access or fully understand the offer of help or intervention they are being asked to accept. Clarifying the purpose of help, i.e., what the offer consists of, is vital, as is understanding what a family's expectation of help is. |
| All practitioners should be familiar with the evidence base regarding CSA within the family environment and the barriers children have in communicating their experience of CSA. |
| Practitioners are reminded of the importance of being curious about a family's race, ethnicity, culture and religion – all of which may influence their perspective on accepting help. |
| When making a Request for Support using the Kent Support Levels guidance, practitioners should be reminded to note patterns in a child's presentation, and including any observations or information regarding any causal factors as explanation for the presentation. |
| It is useful for the decision and outcome of referrals to be shared with the referrer and discussed so they can challenge the decision. It is vital that all agencies are aware of the Escalation process. |
| For those supervising and managing practitioners working in challenging roles, it is vital to explicitly address the impact of working context upon practice and decision making. |
| The sports club's safeguarding approach should be shared as an example of good practice for voluntary organisations, i.e., activity clubs that seek to promote the wellbeing of children. |
| A practice enhancement could be to ensure a child is asked if they have a safety plan and to check it with them. Ask the child how and if they think it works to keep them safe. Where appropriate, agencies should share the child's safety plan. |
| Practitioners need to work with families to consider any unintended consequences of restricting a child's access to a mobile phone based on the child's safety plan. |

## Conclusions and recommendations

Learning about Daisy and Ruby's journeys has been hard for all involved in this review - their experiences, their complicated family life, and their struggles to find the right intervention and support. The outcome for Daisy appears positive. She is settled and well cared for within her family as she approaches adulthood, and she is accessing support she finds helpful. The outcome for Ruby is tragic. She was a child who clearly had huge potential and was very loved. Several factors compounded so that Daisy and Ruby were seen as individual children rather than siblings part of a family. Individual incidents were sometimes reported to different agencies when help was requested, so the full picture of the family's situation was not always known by everyone. At times, practitioners were kind, and listened, and offered support which was well received, but that was aimed at helping each girl manage their difficulties and the adverse experiences they were open about, individually, rather than intervention which sought to change their circumstances as a family. Practitioners were also influenced by the dominant narrative of the mother and step-father – the challenge to that narrative may have been strengthened by effective multi-agency working. This examination of Daisy and Ruby's journey suggests a system that maybe listened to children who said they needed help, however, did not respond accordingly, even when the risks increased.

## Recommendations

***Recommendation 1: KSCMP Business Team to produce a SWAY learning briefing based upon "A typology of emotionally abusive parenting,"[32] which offers clear descriptions of harmful parental behaviours, and the Learning and Improvement sub-group evidence how practitioners have been supported to consider it.***

***Recommendation 2: KSCMP to consider how a pattern of refusal of intervention by a family can be systematically reviewed and acted upon across agencies, taking into account consent, thresholds, and possibility of increasing risk.***

***Recommendation 3: Where relevant, referrals into services and assessments by services (including of risk), must consider and clearly reference the impact of the online world and social media on children and families.***

***Recommendation 4: As part of ongoing work in KSCMP to develop a communications strategy with the 3rd sector highlighting local pathways for guidance and referral in relation to safeguarding concerns, consideration should be given to how this can be expanded to include private sector services for children.***

***Recommendation 5: KSCMP revisit the learning in Kent's Thematic Review of child suicide and review any guidance e.g., the Support Level Guidance, to ensure it reflects the concept of decline in relation to children's mental health, and its significance.***

[32] Emotional abuse and neglect: Identifying and responding in practice with families: Frontline Briefing (2014) p.2

***Recommendation 6: KSCMP Learning and Improvement sub-group should expedite recommendation 1 from its review 'Jasper Red,'[33] and further, agencies must consider what to do with a safety plan once received.***

***Recommendation 7: Kent and Medway CDR Team and ICS ensure any relevant groups, e.g. sports clubs, are considered in the CDR process and strategy meetings respectively, after a child's death by suicide, to ensure relevant support and signposting has been offered and vulnerable children identified.***

***Recommendation 8: The Independent Reviewer to write to Child Safeguarding Practice Review Panel to flag the overlap and duplication in reviews (CDRP, LCSPR, Coroner's Inquests, etc).***

[33] NELFT to provide an update to the Kent Safeguarding Children Multi-Agency Partnership on the work being undertaken to ensure improvements in safety planning for children who are known to be a suicide risk. This should include the forming of next steps within the plans and more effective sharing and communicating of the safety plan.