Pan-Dorset Safeguarding Children Partnership

Pan Dorset Safeguarding Children Partnership

Local Child Safeguarding Learning Review

Ashley

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Contents

1. Ashley

Ashley was a 16-year-old who was described by family and friends as a warm, cheeky, jokey, kind, funny, perceptive, empathic, chaotic (in a good way), and comical young person with a happy vibe. Ashley had the ability to raise the mood of a room and was charismatic. Ashley was academic and conscientious and had a very keen interest in French. They were part of the school council and student leadership group and were a strong advocate for the school. Ashley's 'bubbliness' hid a deeply rooted anxiety and they suffered from mental ill health which manifested itself in intrusive thinking patterns with low mood and ongoing suicidal thoughts. Ashley had some obsessive-compulsive traits. Ashley was living away from home when they sadly took their own life. Ashley's death has had a profound and devastating impact on family, friends, professionals, and the wider community. There is a need to understand what happened to Ashley and why. Agencies also need to focus on what can be learned to prevent future deaths. Ashley was a transgender young person and whilst they had a positive view about their gender identity, there were challenges that Ashley faced because of this. Ashley had strong views on the use of pronouns to describe themselves. Whilst we respect these views, we are using the pronouns of 'they/them' in the report to maintain Ashley and their family and friends', confidentiality.

2. Introduction to the review

2.1 This Learning Review was commissioned by the Pan Dorset Safeguarding Children Partnership and sought to identify learning for agencies following the death of Ashley. A review panel was established and met 5 times. The report author met and engaged with Ashley's mother and father, friends, and the family they were living with for this review. The report author held 1:1 conversations with all the professionals who had some contact with Ashley and their family. There were 2 practitioner learning events. The report author cannot thank Ashley's family and friends enough for their contributions to help understand Ashley's story. Expert advice was provided by a charity supporting LGBQT+ young people and the report author also met with young people who were supported by that organisation. This added enormous value in understanding the support and services available for children and young people who are trans.

3. Brief chronology

- 2012 – Ashley's birth father left the family home.
- 2014 – school referred Ashley to Children's Social Care following disclosures from Ashley regarding mother's partner. No further action following assessment.
- 2015 and 2016 – maternal grandmother referred the children to Children's Social Care because of the concerns about mother's partner. No further action was taken following assessment.
- 2015 – Ashley was experiencing suicidal thoughts and was struggling with issues related to their gender identity.
- 2018 – Ashley's older sibling disclosed ongoing verbal, emotional and physical abuse from mother's ex-partner. This was referred to Children's Social care and following assessment, early help support was offered to Ashley's younger sibling.
- 2018 - Ashley accessed the support of the Health Care Officer at school, regularly seeking support when they were feeling low.
- 2018 - Ashley told their mother that they wished to be a different gender.
- 2019 - Ashley was referred to the Child and Adolescent Mental Health Service (CAMHS)via their GP. CAMHS referred Ashley to the Tavistock Clinic.
- 2020 - The Health Care Officer noted that on Ashley's record there were 29 individually recorded 'concern' entries on their school profile, including Ashley being fearful of attending an engineering class for fear of self-harming themselves with sharp objects.
- May 2020 - CAMHS made a further referral to Children's Social Care following Ashley's disclosures that mother's new partner was displaying similar behaviour to her ex-partners and this was triggering memories of previous abuse and Ashley wanted to move out of the family home.
- May 2020 – Ashley left the family home and moved in with their best friend and their family.
- June 2020 – Child and family assessment completed as Ashley was wanting to move out of the family home. Private Fostering Assessment not considered as Ashley was over 16. No further action was taken by Children's Social Care following conclusion.
- July 2020 – Ashley had a month's supply of Sertraline[1] before changing GP surgery.
- July 2020 – Ashley had a CAMHS therapeutic intervention, and they were risk assessed as 'medium' risk of harm to themselves.
- August 2020 – Ashley's prescription for the Sertraline was delayed owing to the changes in GP surgery and pharmacy and they had no medication for 4 days.
- August 2020 – Ashley took their own life.

4. Emerging Practice Themes

[1] Sertraline is an antidepressant that belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It is used to treat major depressive disorder, obsessive-compulsive disorder (OCD), panic disorder, social anxiety disorder (SAD), and post-traumatic stress disorder (PTSD).

Understanding of the impact of early childhood trauma and the wider systemic issues for families. How much do we consider this in our assessments and interventions?

4.1 There is evidence that the verbal, emotional and at times, physically abusive behaviour towards all the family members by birth mother's ex-partner, had a significant impact on Ashley's emotional wellbeing, mood, and self-confidence. The whole family were impacted by this behaviour and they all struggled to openly talk about the impact on each of them. The assessments reflect that Ashley's mother struggled to provide warmth, care, love, and physical cuddles to Ashley, yet she was parenting from a position of trauma herself and this was not well understood by the professional network. Verbal, physical, and emotional abuse would trigger Ashley and Ashley reported experiencing this in their mother's new relationships. Ashley consequently struggled to engage with men and particularly those who exerted excessive power and control.

4.2 Ashley's engagement with CAMHS had been since October 2019. Friends of Ashley report that Ashley found this intervention unhelpful and the strategies to maintain their mental ill health unsupportive. CAMHS maintained Ashley's engagement in direct work up until the death and appeared to understand Ashley's history and needs. Ashley sought additional help from CAMHS when struggling with their mental health. Ashley was prescribed Sertraline medication to manage their fears, anxiety, and intrusive thoughts. Ashley was also offered a range of interventions and strategies to help manage anxiety. There were proposals for trauma focused cognitive behaviour therapy but CAMHS professionals indicated that Ashley had to be in a period of stability before this could begin. CAMHS intervention was designed to promote Ashley's resilience and enable some stability. The term 'stability' needs to be better explained to others by CAMHS practitioners as it can be interpreted differently by some professionals. Ashley was unlikely to be 'stable' in their context for some considerable time and therefore the most appropriate therapeutic intervention may not have been as effective. This has been an ongoing issue for practitioners who have worked alongside CAMHS and this may be an area for further development and understanding.

4.3 Ashley's close friends and family who were spoken to describe a young person who was fun, engaging, and kind who presented with a happy vibe. In significant contrast was a young person described by their CAMHS worker as empty, flat, angry, with feelings of worthlessness. This presentation is echoed in most of the agency information and agencies have been challenged by Ashley's outward presentation versus the wish to end their life. Everything learnt about Ashley's presentation and personality describes a young person in a constant state of worry and anxiety, yet this was often hidden by smiles, laughs, extrovert behaviour, educational success, and nervous energy. Ashley consistently feared the worst, worrying that they had done something wrong and had fears of causing 'bad things to happen'. Ashley's closest friend

describes Ashley as two separate people. This presentation did not match with Ashley's outward presentation to others. There was a sense of deep shock and surprise from Ashley's wider friendship group when the news about their death became public knowledge. Friends would say Ashley hid their mental ill health very well.

4.4 During the CAMHS intervention, Ashley communicated the difficulties they had with their gender identity and this was a source of distress. CAMHS referred Ashley to the Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust.[2]

4.5 CAMHS also worked with two of Ashley's siblings, yet there is no indication that the systemic and historic issues affecting all the family members led to a more joined up and systemic approach to understanding the family. There was a recognition that systemic work with the family, particularly Ashley's relationship with mother was needed but developing a trusting relationship with Ashley was the priority. There were no links made between the interventions with Ashley's siblings and their relevance to understanding the family as a whole system. Ashley's mother did not participate in most of the CAMHS interventions with the children, explaining that she was working when most of the appointments were made and her view that there was little flexibility in those appointments.

4.6 There was a view from the professional network that professionals who engaged and worked with Ashley's family did so in isolation of each other and failed to consider the family as a whole system. Early help assessments, child and family assessments and direct work occurred with individual members of the household and there was no one professional who held a comprehensive picture of the whole family in the context of their community and wider network, up to and including the most recent child and family assessment. Ashley's request to not involve their mother in that assessment, reflected a deep worry and anxiety about how she would react and in that same sense, how statutory intervention would impact on them and the siblings, particularly given their previous experiences of children's services intervention. It was reported that Ashley did not feel listened to by children's social care and that this left them and the siblings vulnerable. This assessment was focused on Ashley in isolation and there was no evidence that the other children's risks and needs were fully considered. This issue was identified in the Rapid Review process and it recommended the use of family-based chronologies by all agencies to better understand risk and need.

4.7 The fact that Ashley was 16 and receiving support from CAMHS was deemed a protective factor by children's social care. The comment in the child and family assessment that at 16, young people can make their own decisions, places an unnecessary burden and responsibility on vulnerable young people and this should be seriously considered by social workers when making

[2] The Gender Identity Development Service provides support to children and young people experiencing difficulties around their gender identity development

judgements about risk, need and safety in the context of a child's history. Multi-agency chronologies offer the opportunity to reflect on the presenting issues. This approach may have highlighted for example that having a male social worker carrying out the child and family assessment may have not been the best option for Ashley, given Ashley's past traumatic experience with their mothers' ex-partners.

4.8 At the time of this child and family assessment, there were some significant transitions that Ashley was experiencing. Ashley was only 16, was a vulnerable young person with significant mental ill health, about to leave the safety of school, was about to leave the family home against birth mother's wishes and was desperate to seek medical interventions for their gender identity.

4.9 Whilst there was regular liaison evidenced between the school and CAMHS regarding Ashley and this was a positive working relationship, there was limited evidence to suggest that there was a good multi-agency understanding of the family dynamics and history and, therefore, how each of the children and birth mother presented in that context. The school was described as a haven for Ashley, and they responded well to the nurturing and sensitive approaches by support staff. Schools in Dorset now have access to the mental health in schools' team and Ashley's school has since benefited from their multi-agency approach to supporting children in school with mental ill health.

4.10 It was reported that Ashley had 'chronic suicidal ideation' in the previous 5 years before they died, including hearing voices telling them to kill themselves. Whilst Ashley had not made a previous suicide attempt, CAMHS report that they did use 'low levels of self-harm'. This terminology would suggest an established and long-standing significant risk, yet it is not clear that the multi-agency network and/or the family were fully aware of these distressing, intrusive thoughts and behaviour despite Ashley communicating with professionals and trusted school staff about their ongoing suicidal ideation. A safety plan was in place for Ashley, their family and school yet this was not shared with the new care givers. Given Ashley's presentation, it is possible that professionals, family, and friends discounted the possibility of them making a serious attempt on their life and became immune to the regular statements Ashley made about ending their life.

4.11 The issues emerging from this analysis indicates the need to ensure that assessments and interventions are systemic and holistic, which places the needs and risks of individual children in the context of their history, their family, the dynamics, and a more thorough analysis beyond the presenting issue.

How do the family and friends support network get their own support when living with a child or young person who struggles with emotional regulation, trauma, and mental ill health?

4.12 Both Ashley's mother and the family with whom they moved in with, reported having no full sense of the distress and anxiety Ashley was experiencing. Ashley's mother describes not being fully aware of Ashley's suicidal thoughts

and whilst she was aware of their mental ill health, Ashley's presentation gave no hint to them of their desire to end their life. Ashley's mother appeared not to be aware of the 'chronic suicide ideation' described in the CAMHS records. Ashley's mother and new care givers both quoted separately an element of frustration and distress that whilst privacy and confidentiality in the direct work with Ashley was maintained, they feel guilt that they 'could have done more' to support Ashley if they had known more details about their anxiety and suicidal thoughts. Whilst safety plans had been developed with the CAMHS worker, this was not shared with care givers and close friends when they moved home prior to their death, possibly losing the opportunity for a wider 'safety net' for Ashley. It is not clear whether Ashley was comfortable with others knowing about the risks and how to mitigate them.

4.13 This issue is also reflected in Ashley's closest friendship group. Ashley regularly talked about suicide with close friends, yet this information was not shared with trusted adults. There was a sense that these statements became part of everyday language and that perhaps, as considered earlier, friends became immune to the possibility. Ashley's friends believe that professionals had this view too. They disclosed that they struggled to know how to manage and respond to Ashley's consistent statements about ending their life. Ashley's presentation was described by closest friends as 'exhausting'. It was evident that they felt they had an unenviable responsibility for preventing Ashley's death and not truly knowing how to respond or react to Ashley's more distressing presentations. The fact they were children themselves should be recognised and the impact and burden on them to keep Ashley safe.

4.14 This suggests that more support is required to the friendship groups of children and young people whose best friends are struggling with mental ill health. It may be appropriate, with young people's explicit permission, to draw in the wider family and friends' network in any intervention plan so that risk is shared, and young people do not feel isolated and burdened with a responsibility that they are ill- prepared to manage. Separate support should be put in place to help young people manage this.

4.15 Ashley was positively supported by friends in their gender identity and decision to transition. Whilst there was no evidence provided by professionals of bullying of Ashley because of this, the friendship group did report that Ashley was subject to social media bullying by other young people and at times in the street. This apparently bothered the friends more than Ashley and they became angrier about this and responded to the bullying themselves rather than Ashley.

What is needed for young people estranged from their families at aged 16, particularly in relation to the legal, financial, emotional, and practical support, including issues such as health support, GP registration and medication?

4.16 Ashley's move from the family home was considered very positively by professionals and it made a difference in Ashley's presentation. However, Ashley did not want to cause difficulties or feel a burden to the family who took

them into their house. As a result, Ashley took responsibility for organising most aspects of the move, including the transferring of GP surgery. Ashley's father did financially support Ashley but there was no contact between mother and the family they moved to throughout the period Ashley remained there. Ashley's mother was not happy with their decision to move out of the family home and was not supportive of this arrangement.

4.17 These issues bring into question the appropriateness of how the arbitrary age of 16 is judged to be an appropriate age for young people to make their own decisions, arrangements for care, practical, emotional, and legal aspects of their care without an adult holding a level of parental responsibility. This is even more stark with a young person with vulnerabilities. The private fostering regulations are for children under 16 and that assessment might have flagged the vulnerabilities of Ashley and put in place arrangements to support them. It could be argued that children under these circumstances are children in need under the Children Act 1989, who require multi-agency planning and support, yet Ashley was assessed as not meeting the threshold for Children's Social Care interventions.

4.18 Gillick competency principles[3] exist to help professionals assess whether a child has the maturity to make decisions and understand the implications of those decisions. They support professionals who work with children in balancing the need to listen to children's wishes with the responsibility to keep them safe. There are no set criteria to assess Gillick competency, yet factors such as mental ill health should be considered an important need. It may be helpful for assessments to reference a young person's ability to make appropriate decisions using this framework given the experience of Ashley.

4.19 When Ashley moved accommodation, they decided to change GP surgery. Ashley was issued with a one-month supply of Sertraline on the 2 July 2020. Unbeknown to Ashley, the national NHS IT database automatically stopped the repeat prescription for the Sertraline, and this could only be reinstated following a new GP consultation with the patient. The national IT system does automatically reinstate the repeat prescription note which would appear in Ashley's new GP records when they registered. Once Ashley left the GP practice, that surgery no longer had access to Ashley's notes and could not prescribe any further medication. Ashley completed a new GP registration form and had an 'E-Consult' with the new GP surgery on 14th July 2020, and at this first virtual conversation Ashley was requesting blood tests as they were planning to self-finance a private appointment with a Gender Identity Clinic. Ashley made no mention of the fact that they were on Sertraline and the prescription would run out at the end of July. The new GP surgery issued Ashley with a new prescription for Sertraline on the 4 August 2020, the day they died. This was via a text message to Ashley with a barcode to present to the pharmacy.

[3] Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984] Q.B. 581. As cited in Children's Legal Centre (1985) Landmark decision for children's rights. Child Right, 22: 11-18.

4.20 On the morning of the 4 August, Ashley went to collect the Sertraline, and this was refused by the pharmacy as it would appear Ashley's birth name and old address remained on the electronic systems. As a result of this review, the Clinical Commissioning Group (CCG) pharmacist has agreed to alert GPs and pharmacists in Dorset to ensure that messages on electronic prescription notes from the GP to the pharmacist are read on receipt (see addendum on page 21 for update on this action). This is also being taken to the national team as inclusivity is on the pharmacy agenda and there needs to be a wider conversation about the issue of gender identity and patient records.

4.21 Ashley's friends felt that this added to Ashley's anxiety. Potentially there would have been 5/6-day gap in Ashley not taking the Sertraline and this would have impacted on their mental health even though they may have had sufficient quantities of Sertraline in their system. Ashley's friend described a previous episode where Ashley had a 'seizure' when not taking the Sertraline and it was very distressing to observe.

4.22 Ashley's friends believe that Ashley took the lack of medication issue as a 'sign' that they should take their own life. This may have reflected Ashley's intrusive thoughts.

4.23 The GP has reflected that more enquiry and curiosity is needed when young people aged 16, who are vulnerable and with no apparent person with parental responsibility, seeks to register with the GP surgery. They also recognise that young people may need additional support to understand and complete the GP registrations forms. The GP also noted that at this time owing to the pandemic, the GP surgery was open only for telephone consultations and this would have had an impact on the assessment of the patient. Alongside this, we know that Ashley did not like using the telephone as a communication method, preferring face to face contact. When considering the safeguarding of vulnerable children and young people it should be an expectation that direct face to face contact is made to assess risks, needs and vulnerabilities.

How do we repair trust and confidence in professionals when children and young people feel let down by supportive agencies and those there to safeguard them?

4.24 Ashley's experience of services was mixed. They had good relationships with some school staff. Ashley's experiences of CAMHS and children's social care suggests they felt let down after they made the allegations about the children's experiences at home. Ashley had told friends that the CAMHS interventions were not helpful. They believed Ashley 'reached out for help' but this help was not forthcoming. Ashley did feel let down by the actions of children's social care and trust and confidence was eroded when Ashley perceived the adults were believed and not the children in the household. This made any future contact with children's social care problematic and led to the most recent child and family assessment not involving any of Ashley's family members, at Ashley's request. Ashley stated they would be scapegoated if information was

shared with their mother. Ashley's closest friends described feeling frustrated that Ashley wasn't listened to more or what Ashley said was not taken seriously.

4.25 Ashley also had significant challenges with some school policies, the GP, and the pharmacy. Primarily, this was regarding the continued use of their birth name despite the notifications to agencies of the deed poll name change. Ashley also worried about the barriers placed in their way such as gender-neutral toilets and personal changing spaces for physical education at school. Trans young people interviewed for this review feel that these are subtle 'micro-aggressions'[4]. Friends and family reported that these issues caused Ashley additional stress and anxiety and some issues were not resolved for them up until their death.

4.26 This review has highlighted the lack of trust and confidence Ashley had in some agencies and how this led to missed opportunities to assess, plan and intervene effectively. Listening and understanding children and young people's previous experiences of services can inform and enhance future engagement.

4.27 Some practitioners interviewed for this review acknowledged that because of this review process, they have an increased recognition and understanding of the impact on children of adverse childhood experiences[5]. Trauma informed practice has focused on neuroscience, the impact on the brain of adverse childhood experiences and the biology of stress. This approach also recognises how professionals unknowingly can re-traumatise children, young people, and adults by their interactions. It reflects the need for professionals to take a trauma-informed approach when interviewing children, young people and adults and understand the triggers that can lead to more negative responses and behaviours. Ashley was described as 'crying and emotional' and 'very anxious and found it difficult to talk' in the conversation with the social worker in the most recent assessment. This is vital information in which to make analyses and place Ashley's experiences and current behaviour in the context of their history. The focus on the immediate and presenting issue can deflect from the reality of a young person's experience. The fact that this was a male social worker, and the assessment was being made via the telephone owing to the Covid-19 pandemic should have been considered as part of the assessment process.

[4] Microaggressions are defined as the everyday, subtle, intentional — and oftentimes unintentional — interactions or behaviours that communicate some sort of bias toward historically marginalized groups.

[5] Trauma-Informed Social Work Practice, Jill Levenson, *Social Work*, Volume 62, Issue 2, April 2017, Pages 105–113,

How do we raise the understanding and profile of gender dysphoria [6] in the professional network and develop a better understanding of the challenges children and young people may face?

4.28 Ashley presented as very positive about their gender identity, yet there remained a consistent worry that they were in some way 'not normal'. They experienced challenges, frustrations and distress whilst celebrating their gender identity and keenness to fully transition. They were very frustrated with the slow progress of clinical intervention and friends financially supported Ashley in seeking the deed poll name change and private consultations with a Gender Identity Clinic. Ashley presented differently in different environments and situations and this may have hidden Ashley's sense of anxiety about their gender identity. CAMHS reported Ashley struggling with their gender identity and Ashley had reported that their mother and her current partner were not supportive or understanding of the issues. This conflicts with Ashley's mother's report which highlighted that whilst she struggled initially, she was accepting of Ashley's decision to transition and actively supported them.

4.29 Most professionals interviewed for the review, noted their lack of knowledge and understanding about trans young people and since this review have requested additional training on the subject. There was also a request to improve multi-agency policy and practice guidance regarding working with trans young people. Trans young people would like to be involved in that development and this presents a real opportunity to make practice better informed and co-produced.

4.30 The current 'pathway' for children and young people who are trans or questioning their gender identity is not clear. The current default position is to refer to CAMHS and/or the GP and then onto the specialist Gender Identity Development Service (GIDS) at the Tavistock. There are long waiting lists for initial appointments at the Tavistock of nearly 2 years. Blended support options need to be available that match children and young people's needs, alongside referrals to specialist services. Whilst a 'clinical' model may be appropriate for some children and young people with gender dysphoria, there needs to be a multi-agency framework to support children and young people as they may have multiple needs. This may include appropriate clinical, psychological, and social support being made available at a local level. Focusing on the issue of gender dysphoria does risk other complex needs and issues for children and young people being missed.

4.31 There is ongoing work via the CASS review,[7] the independent review into gender identity services for children and young people. The safeguarding

[6] Gender dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity. This sense of unease or dissatisfaction may be so intense that it can lead to depression and anxiety and have a harmful impact on daily life. NHS 2020

[7] CASS Review Interim Report 2022 https://cass.independent-review.uk/publications/interim-report/

partners in the Local Authority may wish to wait for this to conclude before making any significant policy or practice decisions. However, it may well be worthwhile to use the interim report with young people to start designing the most appropriate support frameworks.

4.32 Young people engaged in this review indicated the need for professionals to understand their own assumptions and prejudice when working with young people. Young people expressed a view that professionals spent little time getting to know young people. There was a specific request for professionals to spend more time with young people who are trans or needing support with their gender identity and ask appropriate questions and seek to improve their own knowledge about trans young people. They expressed the view that there should be more trans education for professionals and for them to have more understanding of the barriers and discrimination trans young people experience.

4.33 The professional network was not aware that Ashley was the subject of trans bullying. The friendship group report that Ashley was the subject of trans and homophobic bullying online and whilst referring this to the school, they feel that this was never appropriately dealt with. It is not clear whether trans and homophobic bullying is fully considered in anti-bullying material provided to professionals and the community.

How well do the support services in parts of Dorset that are more deprived, support children and young people living there? Are there opportunities to build upon, kick start or develop services through the context of this learning review?

4.34 Ashley resided in a part of Dorset that is not only beautiful but is also amongst the 10% most deprived communities in the country.

4.35 Data provided by children's social care indicates that this area has the highest contact rates per 10,000 children in Dorset and significantly higher numbers of Early Help Involvement Requests per 10,000 children. The issues faced for children and young people living there are acknowledged by the multi-agency partnership and there are several initiatives to support the community. However, family and friends interviewed had little confidence in the support of statutory services and the availability of support to children and young people locally. Most services are an expensive bus ride to a nearby large town, and this can be an additional barrier to accessing support. The Partnership Coordinating Group led by the Community Safety Partnership has gone some way to identify the places and spaces that young people congregate and there is some detached and targeted youth work happening. Targeted youth workers have a real understanding of the community and can engage and support young people and signpost them to services. Some professionals have highlighted the need for services to be more 'present' in the community and be engaged and interested in the community. They are encouraged to engage more with community initiatives and be part of local community groups.

4.36 Children and young people have access to some of the most beautiful coastline, yet this comes with its own risks and dangers. There may be an opportunity to work alongside young people to identify, audit and understand the spaces and places that young people 'hang out' and whether appropriate safety mechanisms are in place. This wider safeguarding agenda may be something that the community could also engage in.

How do young people understand the use of Helplines and Mood Apps and the use of social media to find out and use information?

4.37 Ashley preferred direct face to face contact with people but used social media and this was the communication tool most used for contact with their mother. Ashley had social media accounts and on at least one occasion did a live discussion about gender identity and set up group accounts to 'call out' individuals that were making homophobic comments. Ashley's friend noted that Ashley was subject to online bullying through these media platforms, yet Ashley was apparently less concerned about this than the friendship group. Ashley's friends noted that they had alerted the school to these issues but didn't feel it was adequately addressed.

4.38 Ashley also used 'Mood Apps'. These Apps can be very beneficial to support a person to monitor their moods over time and identify the 'trigger' points or issues that can affect how they feel. Ashley used such an App which provided a daily 'score' and graph plotting how Ashley was feeling. Prior to their death, the family friend noted that Ashley had 'flatlined', effectively the App graph was showing how flat Ashley was feeling.

4.39 There is no available evidence that this had any influence on Ashley's decisions, yet for a young person with chronic suicidal ideation alongside intrusive thoughts of worthlessness, it must be worth considering the efficacy of these Mood Apps. Some studies have highlighted the need to 'share' the data with clinical professionals to support the management of anxiety and mood[8].

4.40 Mood tracking is used as an approach to help individuals stay in healthy emotional states. The data can help individuals gain understanding about their mental health and develop an awareness of their emotional wellbeing. The finding from a study in 2018 suggests that the Apps would benefit from providing more advice, guidance, and support on how to handle crises and improve emotional wellness.[9]

4.41 We know that on the day they died, Ashley did communicate with a close friend and the content of those messages is distressing, highlighting Ashley's

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[8] User Perspectives of Mood-Monitoring Apps Available to Young People: Qualitative Content Analysis 2020

[9] Mobile apps for mood tracking: an analysis of features and user reviews Clara Caldeira, BS, [1] Yu Chen, PhD, [1] Lesley Chan, BS, [1] Vivian Pham, BS, [1] Yunan Chen, PhD, [1] and Kai Zheng, PhD 2018

feelings of being at 'breaking point'. However, these messages were nothing new for this friend and were a constant reminder of how Ashley was feeling. Significantly, Ashley had stated they had called 111 on the day they died and was asking for a suicide hotline. Part of the content of this Snapchat message reads "I don't know what to do. I don't feel like me. I called 111 and asked for a suicide hotline and they gave me the wrong number and it didn't ring, that sounds like a sign".

4.42 It is reported that there was an IT issue in the call handling for 111 calls made between May and August 2020. The server was full, and calls were only 'saved' on temporary files which have since been deleted. This significant 'system failure' does not appear to have been risk assessed and was not known to health agencies at the time. This does require further investigation and mitigating factors put in place. Therefore, we have no detail regarding those calls Ashley made to 111 that day. It is believed that one call was diverted to a 'mental health pathway' via a Steps to Wellbeing which was an adult only service and Ashley made a 3-minute call to the Samaritans.

4.43 Professionals working with children and young people should be more aware of what support is available to children and young people who feel in mental health crisis.

How did the pandemic impact and influence support to children, young people, and families?

4.44 There is no doubt that services and support to children and young people were significantly impacted during the COVID-19 lockdowns. Ashley described 'hating' the lockdown periods and missed going to school and seeing friends. It was during this time that Ashley also moved home address and there was little face to face contact with professionals. Some of the CAMHS meetings, the assessment with social care and the GP registrations all occurred via the telephone or virtually and this was always challenging for Ashley. The school did accommodate Ashley for some days of the week as they were identified as a vulnerable young person but none of Ashley's friendship group were present at school.

4.45 It was intended for Ashley to remain with the family friends for a short period only whilst lockdown was occurring. Ashley's mother found lockdown very difficult, and she was highly anxious that Ashley did not contract the virus as she was pregnant. At times, she stopped Ashley from going out altogether. There is no doubt these issues affected Ashley's mental health.

4.46 Ashley's school have identified positives that have emerged from the lockdown period, particularly for those young people who have issues with their gender identity. The fact that children and young people had to arrive in school in their PE kit, rather than having to endure the challenges of changing with other pupils, was a positive. The local school has now identified that there

needs to be gender neutral changing areas and this should be encouraged across the school population.

4.47 For some young people the 'opening up' of communication methods which are less face to face has been very positive and the use of social media to share information and support has been welcomed. One professional noted that COVID-19 had offered the opportunity to ask young people 'how they were doing/feeling' which felt more justified because of the pandemic. This must be balanced against the need for continued 'relationship based' practice with children and young people, who truly benefit from a trusted adult who builds relationships over time.

4.48 The Association for Young People's Health concludes in their 2021 report[10], 'Summarising what we know so far about the impact of COVID-19 on young people', that the "*slow burn impacts are likely to be the most damaging. Young people are amazingly resilient, but the long-term impacts on trajectories and opportunities are critical, particularly for those already subject to inequality. Lots of young people are going to need help in the months and years ahead. Some of the workforce/organisations best placed to deliver this, such as the youth sector, have been hardest hit. This needs acknowledging and correcting. There is not one programme or intervention that is going to be the "quick fix". We can start to put mitigating actions in place now. It is likely that we will need a sea change in how we think about support for the 18-24 age group who will bear the brunt of the educational and economic effects, to reconsider their situation and how they find their place in our world*"

How well understood are the needs of children and young people with mental ill health? Do professionals and agencies understand the pathways for children and young people?

4.49 Given the statement above, agencies, alongside colleagues from the voluntary and community sector, should consider developing a coherent strategy to address the needs of children and young people who would have been adversely affected by the COVID-19 pandemic. This is a wider public health issue but this needs to engage all partner safeguarding agencies.

4.50 The review has highlighted that it may be worthwhile reinforcing and better understanding the care pathways for children and young people with mental ill health. Whilst Ashley received appropriate support from CAMHS, some practitioners interviewed for this review appeared to have a lack of understanding about when a child should be referred to CAMHS. They had expectations on the specialist CAMHS service which were unrealistic and unnecessary. The responsibilities and accountabilities of the wider community of support need to be reinforced and whilst expert advice and guidance may

[10] https://www.youngpeopleshealth.org.uk/wp-content/uploads/2021/02/Impact-of-Covid-19-on-young-people-briefing.pdf February 2021

need to be provided to practitioners, many children do not need specialist CAMHS interventions. The pathways need to be clearer so that children with mental ill health get a robust wrap around package with other agencies contributing and understanding the need.

4.51 The CAMHS service has already progressed their considerations for support to children and young people who are gender dysphoric and have lead practitioners in the service. There is a need to increase the depth, knowledge and understanding of a wider group of professionals to address children and young people's needs who are gender dysphoric and the Pan Dorset Safeguarding Children Partnership may be best placed to develop this with the multi-agency input. Agencies are encouraged to use the CASS review recommendations as a template for future policy and practice guidance.

4.52 Findings from a comprehensive report into childhood 'maltreatment' and suicide ideation, highlights that there was an urgent need to ensure suicide prevention strategies were in place for children with mental ill health who have experienced abuse in their childhood. These findings include policy action on raising public awareness to the issues of teenage suicide and developing multi-agency protocols and treatment plans for children and young people at risk of suicide.[11]

5. Conclusions and summary of learning

5.1 Any death of a child or young person has a devastating affect and impact on those around them. These feelings are heightened when young people take their own lives and there is a real need to understand why. Suicide in young people can evoke significant and intense emotions with a sense of responsibility and accountability. Hindsight bias is always challenging when undertaking learning reviews, yet there needs to be a recognition that sometimes, family, friends and professionals cannot alter the sad outcomes for some young people. Throughout this review, there has been a real openness and willingness to learn from what happened to Ashley. Friends, family, and professionals have been very reflective and honest. The learning has been richer for it and it will go some way to supporting children and young people in the future.

5.2 There have already been positive changes and responses to practice because of this learning and these will be built upon with the recommendations of this review. There were some positive aspects to agency engagement with Ashley. Ashley's school has been commended for their compassionate and sensitive responses to Ashley's needs. There was good liaison between the school and CAMHS and this contact was focused on the needs of Ashley. There was also

[11] 'There is clear evidence that children and young people who have experienced abuse, neglect had higher rates of suicidal behaviour' Association of Childhood Maltreatment with Suicide Behaviours Among Young People, Iohannis Angelakis, PhD1; Jennifer L. Austin, PhD1; Patricia Gooding, PhD[2,3]

a willingness to learn more about gender identity and the issues faced by young people.

5.3 Ashley had struggled with their mental ill health over several years, experienced an abusive and low warmth household as a child, was trans which led to several complex issues for them both emotionally and practically, was estranged from their family and experienced significant transitions in their life in a very short timeframe. Ashley hid these issues from most people with a presentation of humour, fun, bubbliness, and charisma. It would seem only those closest to Ashley really knew the struggles they faced daily. The almost daily references Ashley made to friends about taking their own life became part of everyday language and they, alongside others, became somewhat immune to this reality. They have been impacted significantly by Ashley's life and death particularly as they feel they held and managed the risks for Ashley alone.

5.4 Summary of learning:

- Ashley's presentation sometimes hid a deep sense of worthlessness and anxiety. Agencies need to be attuned to how the presentation of a young person can deflect the reality. Open and transparent conversations with care givers about risks need to be developed. Balance of risk versus confidentiality needs to be well evidenced in case records.
- There were missed opportunities to consider the involvement of family in Ashley's safety net. The sharing of information about Ashley's risk could have been enhanced and allowed for a more developed safety plan.
- With that responsibility comes the need for more enhanced support to family who are included in the safety plan. Close friends of young people who have suicidal ideation may need additional support to manage the responsibility they may feel for holding the risk. Consideration should be given to how family and friends work alongside the agency network with the agreements of all concerned.
- Agencies need to be cognisant of chronological age versus vulnerability and consider assumptions that young people aged 16 or over can make informed decisions. These considerations need to be well recorded and evidenced on young people's records using the Gillick principles.
- The term 'stability' needs to be better understood and explained by CAMHS professionals when considering appropriate therapeutic input. This term means different things to professionals and families and should be better explained in the child's context.
- Agencies need to be reassured that when young people are estranged from their family, there are appropriate support mechanisms in place both formally and informally. This includes ensuring practical and legal considerations are made. All professionals need to be curious when young people disclose that they are estranged from their family.
- GP surgeries and pharmacies need to ensure that children and young people who have changed their names by deed poll are reflected on case records.

- GP surgeries and pharmacies should make it more explicit to patients that when transferring GP surgeries, consultations need to take place with the patient before repeat prescriptions can be reinstated.
- GP surgeries and pharmacies are encouraged to ensure the electronic record is reviewed for new patients.
- Agencies need to be aware of the impact of multiple transitions affecting young people at once and consider those experiences against the backdrop of their history.
- in very complex situations, a multi-agency chronology template should be introduced to bring together the collective chronologies from partner agencies to give a clear account of the significant events in the life of children and young people. Single events or incidents may have a far larger significance in the context of their history.
- Child and family assessments should consider the risks and needs of all the children in the household, be considerate of the history against the presenting issue and take into consideration the wish for confidentiality balanced against risks and needs.
- When undertaking direct work with children and young people, professionals need to consider the wider context and ensure there are wider discussions with the professional network.
- When children and young people disclose their wish or desire to end their life, there should be a multi-agency prevention strategy put in place that involves their care givers, family, and friends. Repeated statements about suicide, however stated, need to be taken seriously.
- Professionals need to be aware of trauma informed approaches which recognises that all interactions may have adverse impacts on children, young people, and carers.
- All professionals need to develop their understanding of trans young people, the implications on young people challenged by their gender identity and develop opportunities to listen and talk to young people about their experiences.
- A graduated and clearer pathway for children and young people who are trans or questioning their gender identity should be developed which will need to involve all agencies and will include the resources of early help.
- Bullying of trans young people needs to be incorporated in PHSE lessons and be more explicit in education awareness.
- Care givers, family and friends need to be offered additional support and awareness raising if their child or young person expresses a wish to transition.
- Agencies supporting communities where there are high deprivation indicators need to actively engage further with the community to ensure support and services to children and young people are accessible and co-produced.
- Safeguarding agencies need to work alongside the community safety partnership to evaluate safe places and spaces for children and young people.

- There needs to be consideration on how agencies engage with and consider the efficacy and safety of Mood Apps and ensure they are part of an ongoing support plan and used appropriately.
- Safeguarding agencies need to reinforce the availability of emergency support for children and young people, and advertise through effective communication methods to inform children and young people.
- Professionals need to ensure there is a balance between effective communication via virtual communication tools and face to face contact. Relationship based practice should be maintained.
- Professional agencies should consider developing a strategy to address the likely impacts on children and young people of the COVID-19 pandemic.
- Safeguarding partners should review the draft recommendations of the CASS review and engage young people in the co-production of effective 'pathways' for support and services for trans young people.

6. Recommendations

a. The Pan Dorset Safeguarding Children Partnership should commission an appropriate organisation, involving young people with lived experience, to provide learning events for professionals focused on gender identity, including trans and non-binary.
b. The Joint Commissioning Board should consider establishing an effective multi-agency 'pathway' for children and young people around gender identity, including trans and non-binary using the CASS review as a template for action. This should include support services to parents and care givers.
c. The Dorset Suicide Prevention Strategy and Implementation Plan would benefit from having a specific child and young people workstream addressing the recommendations and learning from this review.
d. Dorset Healthcare undertake a review of and the use of guidance around recommended Mood Apps. The production of the Dorset Suicide Prevention Strategy and Implementation Plan offers the opportunity to review the use of Mood Apps and define an agreed protocol for their use with children and young people.
e. The termly Team Around the Schools Meetings should sensitively identify and appropriately address, within the confines of confidentiality, the needs of children and young people who are close friends or within the friendship groups of children experiencing suicidal ideation.
f. Children's social care should consider a dip sample to gain assurance that child and family assessments undertaken for young people aged 16+ appropriately assess young people's risks and needs based on their vulnerability and their history and not their chronological age. Learning identified to be fed into the Quality of Practice and Action Group to consider where practice needs to be strengthened.
g. The Pan Dorset Safeguarding Children Partnership is encouraged to develop a partnership wide strategy on trauma informed practice.

h. Using population health management, the partnership agencies should identify the places and spaces that present a risk to children and young people and work alongside Public Health and the Community Safety Partnership to address those risks.
i. The recommendations from this review should be considered in the post COVID-19 strategy to address the likely impacts of the pandemic on children and young people and consider what prevention services may need to be in place.
j. The Pan Dorset Safeguarding Children Partnership should develop a multi-agency chronology template and protocol for use in certain circumstances to support informed decision making by all partner safeguarding agencies when working with complex situations.

Ian Vinall - Independent Review Author - June 2022

Appendix

6.1 Interviews took place with the following:

- Ashley's mother
- Ashley's closest friends and care givers
- Young people, staff and the CEO from a local charity supporting young gay, lesbian, bisexual, transgender, and questioning (LGBT+)
- School Nursing
- School staff x 2
- Police
- Early Help Practitioners and managers x 2
- GPs x 3
- Health Visitor
- CAMHS Practitioners and managers x 3
- Advanced Nurse Practitioner x 2
- Children's Social Care managers x 3
- Targeted Youth Support Practitioner

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Addendum

Following agreement at the PDSCP Executive meeting on the 29 February 2024, the following point of clarification to page 9, paragraph 4.20, of the report should be noted.

On page 9, paragraph 4.20, the following point is made: *As a result of this review, the Clinical Commissioning Group (CCG) pharmacist has agreed to alert GPs and pharmacists in Dorset to ensure that messages on electronic prescription notes from the GP to the pharmacist are read on receipt. This is also being taken to the national team as inclusivity is on the pharmacy agenda and there needs to be a wider conversation about the issue of gender identity and patient records entry*.

The new Chief Pharmacist for NHS Dorset has reviewed this in February 2024 and clarified that this is not achievable for the following reasons:

- Electronic prescription is not a reliable way to communicate with electronic prescriptions and was never intended to be so.
- A pharmacy may download hundreds of prescriptions in one go and it would be impossible to seek out messages on anyone.
- This is a national system and not something we can amend locally.