Child Safeguarding Practice Review

Sam[1]

Contents

Introduction

1. The South Gloucestershire Children's Partnership (SGCP) agreed to undertake a local Child Safeguarding Practice Review (CSPR) to consider practice and systems for working with children and their families where there are concerns about the child's mental health along with child protection concerns at home. This follows a serious incident in 2024 where a 14-year-old child attempted suicide, resulting in potentially life-changing injuries. She was known to have made previous plans/attempts to end her life.

2. The child was adopted in 2011. Since then, Sam and her siblings have been on child protection plans on three occasions due to concerns regarding the quality of care provided by the adoptive parents. In 2021 the Local Authority had issued care proceedings due to the severity of the concerns. The court decided that the child and her siblings must remain at home throughout and at the conclusion of the proceedings.

3. Sam and her siblings, and her adoptive parents, are white British.

4. The learning from the consideration of agency involvement with Sam is in the following areas:
   - The particular needs and vulnerability of children who are adopted
   - Responding to child protection concerns in an adoptive placement
   - Children living with domestic abuse
   - Working with and understanding risk to children with mental health issues who voice suicidality
   - Social media and on-line activity

The Process

5. An independent lead reviewer[2] was commissioned to work alongside local professionals from South Gloucestershire to undertake the review alongside a panel of South Gloucestershire managers and

[1] The name for the review was chosen by the child.
[2] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the SGSCP.

safeguarding leads. The panel worked with the lead reviewer to identify the overall learning, and the recommendations included in this report.

6. The Rapid Review process that preceded this CSPR included the submission of detailed agency chronologies. These and further information shared at the Rapid Review meeting was the starting point for the CSPR. Each agency involved was also asked to provide further reflection on their agency involvement and consider whether any single agency recommendations were required.

7. A face-to-face multi-agency meeting was held with South Gloucestershire professionals who had been involved with Sam and/or her family. The meeting included discussions about this involvement and about the wider systems in which they work. There was much good practice identified, and it was clear that those working with Sam knew/know her well.

8. The lead reviewer and a representative of the SGCP met Sam during the review and very much appreciate her openness and honesty. They hoped to meet with her parents, to identify learning from their perspective, but they did not respond to the Partnership's requests.

The Learning

Learning area: the quality of processes of assessment and matching when the children were placed for adoption, and response to child protection concerns

9. Sam had been placed for adoption along with her older sibling in 2011, and adoption orders were made the same year. The younger sibling was placed with them later in 2012. The prospective adopters had been assessed and approved in line with expected processes at the time, and no concerns were evident in the assessment or from the references that were taken. The Local Authority who completed the assessments[3] told the review that local and national standards for assessing adopters have improved significantly since 2011-13. South Gloucestershire did not complete the adopter's assessment and were not involved in the processes for approving either the adopters or the match with these children, meaning the children had not been the responsibility of South Gloucestershire prior to their adoption. This CSPR did not initially intend to consider the decision making prior to the children going to live with their adoptive parents, or the response to concerns about physical harm prior to the adoption order being made in respect of the youngest child, who was placed in 2012 and adopted in 2013. However, it was then acknowledged that there is a need to reflect on the serious impact on Sam of the decision making at the time.[4]

10. Post-adoption support was the responsibility of the other Local Authority for three years after the adoption orders was made. Following the youngest child being placed with their prospective adopters, there were concerns about physical harm to the children and about the couple's relationship. The responsibility for investigating was South Gloucestershire's. The first child protection plan was made in 2012, shortly after the youngest sibling was placed. This was managed by South Gloucestershire, with the other Local Authority remaining involved and part of the core group, as they continued to

[3] The lead reviewer and a representative of the SGSP met them as part of the review.
[4] It is acknowledged that processes have changed since the children were adopted in 2011/13.

provide post adoption support for the older two children and due to the youngest children being in their care as it was prior to an adoption order being made.

11. Their child protection category was physical abuse. The resulting assessments included a psychological assessment of both parents and a parenting assessment which noted the significant challenges in parenting three adopted children. It was perceived that there had been progress made over the ten months of child protection planning, and so the third adoption order was made in respect of the youngest child, and the child protection plans ended. As the family address was in South Gloucestershire, local services continued to be responsible for responding to any further child protection concerns.

12. When reflecting on the concerns about the placement and early child protection planning, it seems that the wish for the children to remain living together was the priority for professionals. There was a commitment for the youngest child to remain with her siblings, who were already adopted, and this appears to have dominated thinking. There was a delay in the adoption order being made in respect of the youngest child, but ultimately it was agreed that it was in the best interests of the youngest child to remain with her siblings. To remove all the children from the adopters would have involved care proceedings, as the adoptive parents had parental responsibility for the older two children. Those involved thought that there may not be grounds, but no legal advice was sought or planning meeting held. There was no evidence of any challenge from any agency at the time, including CAFCASS, from the adoption panel, or from the court who made the adoption order for the third child.

13. It is now known that the parents separated shortly after the child protection plans ended and the youngest child was adopted. The adoptive mother has since made allegations of significant domestic abuse in the relationship, including physical abuse towards her that had put the children at risk of physical and emotional harm. The review reflected that her being care experienced and adopted herself, along with her sharing details of the domestic abuse, means she had her own vulnerabilities that required consideration. The children remained living with their mother and continued to have family time with their father following the divorce, despite the concerns. Domestic abuse is considered further below.

14. Between 2015 and 2018 there were further concerns identified about physical harm to the children, perpetrated by their mother. She found parenting on her own a struggle. She often presented as overwhelmed and resorted to physical abuse. Her supervision of the children was known to be poor, and she did not always provide adequate emotional care. Child protection plans were again made in January 2019 under the category of physical abuse. There were also known concerns about the relationship between the father and his new partner, due to domestic abuse and the impact of their alcohol use, which the child protection plans addressed. The plans were in place for around 10 months, and again there was felt to have been progress made and there was a step down to child in need planning. The plan at step down included both parent's agreeing to 1-1 parenting support. Mother then declined, saying she was too busy and didn't think it would help. Father attended 2 sessions but never implemented the advice and then stopped attending. The planning did not result in any positive changes for the children. This was a recurring pattern for these children, and it is a challenge locally

and nationally, when a family withdraws consent or does not engage with child in need planning, but the threshold is not met at the time for a step back up to child protection planning.

15. In March 2021 the children were once more made the subjects of child protection plans, this time under the category of neglect. It was at this stage that the Local Authority, with the support of other agencies working with the children, issued care proceedings. It was acknowledged that the three children had suffered significant harm and that there had not been sufficient progress to safeguard them in respect of identified concerns. Reflections on this process are considered below.

Learning area - adopted children's specific needs and vulnerabilities.

16. Research shows that children who are adopted will have experienced trauma, and this was the case for Sam and her siblings. The eldest child experienced abuse and neglect when living with their birth family, followed by the impact of separation and loss due to their removal. Sam was removed at birth[5] and placed with her sibling in foster care. They stayed there until they were introduced to and placed with their prospective adopters. Any child having a change of primary carer at a young age will have experienced trauma, and caring for traumatised children is a skilled task. They will require the support of a loving and nurturing family who can understand the impact of abuse and neglect, and any changes of carer, on children. Adopted children need help to work through this trauma and the ongoing and evolving impact of their history, which can potentially be neurological, developmental and psychological.[6] As stated by Howe and Cairns (2006 and 2009) 'carers need to understand their children and commit themselves to a mindful relationship with the child so that they can offer sensitive and reflective parenting to help their recovery. Successful care requires emotional attunement, creativity, and a willingness to understand how the world feels from the child's perspective. The children need caregivers who both co-regulate with them and teach them to manage their anxieties'.[7]

17. Sam was removed from her birth parents at birth and from her foster carers before her first birthday. She did not then receive the reparative care she required from her adoptive placement. Abuse, neglect and emotional harm were likely to have been part of her lived experience. Little was known by professionals in South Gloucestershire about Sam's experience prior to her adoption placement, beyond there being significant concerns about neglect in her birth family. It is now known that abuse was experienced by the older sibling, not directly by Sam herself. There was a need for those working with the children to know exactly what they experienced in their early years before they were placed for adoption. The responses to issues in the adoptive placement, pre-2020, tended to be to a single event, rather than part of a much more concerning and cumulative pattern of inadequate care and poor parenting, which added more harm and trauma to a vulnerable care experienced child. Those working with the children in recent years, however, have clearly recognised that they were likely to have experienced significant trauma both before the adoption placement and while in the care of their adoptive parents.

[5] It is acknowledged that Sam was likely to have experienced neglect whilst in utero.
[6] Pennington E (2012) It Takes a Village to Raise a Child: Adoption UK survey on adoption support.
[7] https://fosteringandadoption.rip.org.uk/wp-content/uploads/2014/04/Early-childhood-trauma.pdf

18. All professionals working with children who have been removed from their birth parents hope that they will have the stability and care they need. Adoption is designed to provide this, and it is particularly distressing for professionals to have to acknowledge that a child may need to move from their adoptive placement. Sam told the review that she was aware she was adopted, and sadly of her understanding that she could not therefore expect to have the love and affection that non-adopted children had. The decision to start care proceedings in 2021, with an initial care plan for a supervision order but with the view that removal may be required, was a very difficult one for those involved, but it was made in the children's best interests. Care proceedings also gave the opportunity for a specialist psychological assessment of the adopters (and to a lesser extent the children) to help with care planning going forward. The review was told that the assessment undertaken was comprehensive and gave a detailed insight into the carers, the children and their previous and ongoing care. The psychologist sought the views of each child. They all said clearly that they wished to remain where they were and did not want to come into foster care. They also wished to remain together as a sibling group, to stay in the area and at their schools. Due to the limitations of what can be shared without the permission of the court, this report was not shared more widely. It would have been helpful for permission to be sought to share the report with Sam's therapist and with CAMHS. The psychologist did not undertake any specific assessments of Sam or her siblings so there was no insight into Sam's processing issues or potential neurodiversity.

19. The CAFCASS Guardian met with the children several times, consulted with the social worker to complete their own assessment, and advised the court. It was acknowledged by the court that the children had suffered or were at risk of suffering significant harm in their parent's care. It was decided on the recommendation of the psychologist and the CAFCASS Guardian, and with the acceptance of the Local Authority, that Sam and her siblings would likely experience more harm being removed from their adoptive parent's care as opposed to the harm they experienced living with them. During the proceedings the siblings both stated that they wished to remain with their mother. Sam was not so clear, and it was noted that she had asked several teachers at school if they would adopt her.

20. The court acknowledged the limitations in respect of the parent's ability to care for the children as they required but concluded that the children should remain with their parents to avoid the disruption and serious impact of them being removed. While this view was accepted by the Local Authority, serious concerns remained about the quality of care and the emotional vulnerability of the children due to their ongoing lived experience. They remained on a child protection plan when the proceedings ended.

21. The professionals spoken to as part of this review shared that while they had considered challenging the conclusion of the psychological assessment, and asking for removal of the children, they had to acknowledge that very few options of alternate placements were available. They wanted to keep the siblings together, and this was going to be difficult, if not impossible. They knew the children needed stability, and they optimistically hoped that the adoptive parents could and would do better, particularly following the intervention of the court and the insight provided by the court appointed psychologist. Ultimately, while they had serious reservations about the care the children received and were likely to receive, they did not believe that there were likely to be significantly better options for them. The

national CSPR panel's most recent annual report[8] has focused on the insufficiency of suitable placements and service provision for children with complex needs, as it features so often in CSPRs nationally. No specific sibling Together and Apart Assessment was undertaken. This was because of their ages and clearly voiced views on the matter.

22. This is a significant issue when working with older children and may account for why they are not often the subject of care proceedings, or removal when they are. In October 2021, the Nuffield Family Justice Observatory reported however that the number of teenagers subject to care proceedings had increased significantly, with the number of 15-year-olds growing by 150 per cent and 16-year-olds by 285 per cent. In 2010 adolescents constituted 18% of all children in care proceedings in England. This had risen to 27% by 2020. An examination of some of the children's records found that most of them had faced long-term neglect and trauma at home. The report raised issues about the ability of the system to manage these increases, and this was reflected in the decision making about Sam and their siblings and the shortage of viable alternative homes for the children.

Learning area - responding to children with mental health issues

23. Concerns about Sam's emotional wellbeing were first identified while she was in primary school, and she was initially seen by Thinking Aloud (an Avon and Wiltshire Mental Health NHS Trust service that is part of CAMHS) when she was eight years old. Thinking Aloud provides emotional support to children in care or who have been adopted. She received this support for around two years. The focus of the support on Sam having been adopted needed to be alongside acknowledgement of the ongoing harm she was subjected to and issues with the parenting she received from her adoptive parents. By the time Sam was eight years old she had been on a child protection plan for physical harm from her mother, had been a child victim of domestic abuse, and had to negotiate contact with her separated father who was in a new abusive relationship with a woman who appeared to abuse alcohol, and where there was domestic abuse.

24. When Sam started secondary school, she had been on a child protection plan for the second time in her adoptive placement, also for physical harm, although domestic abuse also featured. She was seen by Thinking Aloud /CAMHS again due to ongoing worries around her mental health and wellbeing, with evidence that she was self-harming through banging her head. CAMHS workers had an understanding of her background, but the work concentrated on her current experiences, including a focus on her experiences at home, including parenting style and parenting dynamics, as the immediate issue that needed resolving. Sam was also assessed for and given an EHCP[9] so that she could receive additional help in school. Sam told the review that the option of going to the learning support area rather than attending classes was helpful to her but recognised that she would do this to avoid certain lessons and difficult relationships with other pupils.

25. It was recognised by professionals in 2018 that all the children may benefit from interventions from a specialist adoption service. At the time post adoption therapeutic support was funded by the Adoption

[8] https://assets.publishing.service.gov.uk/media/6756f937f1e6b277c4f79a3d/Child_Safeguarding_Review_Panel_annual_report_2023_to_2024.pdf

[9] Education, Health and Care Plan – sets out a child's special educational needs and the support they require.

Support Fund but provided by the local authority. It was taken on by Adoption West in 2019. The provider of support changed in 2022, but the new service worked hard to ensure as much consistency as possible for children receiving the service. For Sam this meant that she was able to remain with the same psychotherapist, which is good practice. Sam told the review that she liked the therapist and that she helped her. The Adoption Support Fund was implemented in 2015. It is not known why Sam and her siblings were not referred for support sooner.

26. In 2024 Adoption England published a report that considered the national picture of commissioning adoption support.[10] Their conclusions included the variation in the quality of provision, capacity issues, the administrative burden of the application process, limitations in the eligibility criteria, and the nature of funding cycles creating uncertainty for service delivery, for professionals and ultimately for children and families. Concerns remain about the impact on adopted children of the current ambiguity about ongoing funding, with the UK government yet to confirm (February 2025) funding beyond March 2025.[11] This is a concern both for the children being considered here and for others receiving this support.

27. The COVID 19 pandemic and the resulting restrictions undoubtedly had an impact on Sam and her family. Working with the family during lockdown posed some issues to professionals, and to the children themselves. They were having to travel between both parent's addresses for contact and there were increasing concerns at the time about the domestic abuse and alcohol misuse in Father's home. It is acknowledged nationally that the most vulnerable children became more vulnerable during the pandemic and the impact on school transitions and mental health support are well documented nationally. It is not well-known what life at home was like for Sam and her siblings during the periods of national lockdown. They were invited into school (primary) during the first national lockdown and attended three days a week. They also attended school during later national lockdowns. The school believe that it was a difficult time for the family, and there were concerns about a decline in the children's behaviour during the pandemic. Sam was still seeing her therapist, via virtual technology. The children were not on a child protection plan at the time, so the school made a referral to CSC, sharing their concerns.

28. Sam received good and consistent support from a psychotherapist employed by Headsight. They have developed a good relationship with Sam and her family members. There was also meaningful involvement from the psychotherapist in the multiagency planning for Sam and a clear awareness of the impact of the child protection issues that Sam has faced since being adopted. The work with Sam focused on her unprocessed trauma and attachment difficulties, her struggles to regulate and manage her emotions, difficulties in her relationships with friends and family, and her voiced feeling such as 'I hate myself' and 'I wish I was dead'. There was a period where things were more stable for Sam in the second half of 2023 into 2024, and the work appeared to be helping her with her feelings. Although

[10] https://www.adoptionengland.co.uk/sites/default/files/2024/1/National%20Picture%20of%20Adoption%20Support%20Commissioning.pdf

[1111] https://www.communitycare.co.uk/2025/02/03/concerns-over-future-of-adoption-and-special-guardianship-support-fund-with-resourcing-unconfirmed/

there were indicators that Sam's behaviour suggested a need for concern. The GP records show that in December 2023 she pushed her grandmother over, resulting in an injury.

29. CAMHS were again involved with Sam following more recent incidents, including when she has voiced her intent to end her life. She has shared specific plans about this since January 2023, and a referral was made to CAMHS by her social worker in the March due to her suicide thinking and the stockpiling of medication. No further support was provided by CAMHS at the time as it was recognised that she was receiving therapy via the Adoption Support Fund, which was assessed to be the most appropriate treatment for her. Sam also had an allocated social worker due to being on a child in need plan. CAMHS were again involved in June 2023, when Sam was admitted to hospital from school because she had stated she wanted to kill herself. She was discharged home with safety planning, and at a follow up appointment discharge from CAMHS was agreed. This was because her mother said she felt that Sam was improving. Sam was not spoken to. It was again noted that Sam was already receiving regular therapy from Headsight.

30. In April 2024 CAMHS contacted Mother, suggesting that they meet to offer support around managing Sam's dysregulation. This was following the school sharing concerns about Sam in a core group, and agreement that a request be made to CAMHS to speak to Mother. Again, Mother said that she felt Sam was in a better place and declined the offer. Sam was not spoken to. This reflected a pattern of Mother downplaying concerns about her daughter's mental health, not recognising the severity of the issues, and not engaging with CAMHS. The psychological family assessment undertaken during care proceedings in 2021 identified that Mother is not emotionally attuned to her children's needs when they are more complex. It also identified child blaming and a lack of any responsibility for the child's trauma and distress. Father also disputed the seriousness of his daughter's needs. For example, stating she was wasting ambulance service time. It is known that Mother was adopted herself, and those involved recognised that she was not willing to recognise the trauma she too would have experienced. It is not known if this was considered in the adoption assessment of Mother in 2010.

31. CAMHS were again involved from August 2024, when it emerged that Sam had ongoing suicidal ideation with intent to end her life. A multiagency response followed that included the ongoing involvement of CAMHS. A safety plan was made including detailed consideration of a holiday the family had planned, and liaison with CAMHS in the area the family were going to be visiting. CAMHS remained involved, attending multi-agency meetings and providing regular Risk Support sessions to Sam (three were held prior to the serious incident), where she was able to discuss her feelings, her relationships and triggers for her sadness and despair leading to suicidal intent.

32. While there was evidence of good safety planning around the family holiday in August, which involved Sam, Mother, the Local Authority and CAMHS, additional learning was identified during the Rapid Review meeting held in respect of Sam. This focused on the need to always set out clearly what the risks are and what the safety plan is, so that all involved professionals know what to do when a child expresses that they want to die. The plan for Sam was being developed when the serious incident happened. It had been agreed that CAMHS would undertake six risk support sessions and that the outcome of these would be fed back to the network, in collaboration with Sam, who would then plan

how to respond to Sam when she was expressing her distress. No professional knew that Sam intended to kill herself on the day of the serious incident.

33. The review has recognised that safety planning which focuses on alleviating risk in respect of one incident or increased concern will not make an overall difference to a child or young person's own sense of safety. It is this that needs to be focused on to prevent ongoing suicidality. Sam was regularly voicing her intention to die at school, to her parents, her friends, her therapist, to CAMHS and to social workers. She imagined and described dying. Sam told the review that her biggest pieces of advice for professionals is that they should always 'listen' and 'take a person seriously' if they say they want to die. She said, 'people must give a kid help BEFORE it gets really bad'. She was clear that she had been honest about her intentions, as indeed she had.

34. During her CAMHS sessions Sam stated that she did not have a plan or intention to take her life but expressed not knowing how to deal with the intense feelings which lead her to feeling suicidal, and the difficulties in navigating relationships around her. The sessions then focused on finding ways to help manage those intense feelings. CAMHS has reflected on their work with Sam and identified 'significant learning' about the need to also consider a child's online life as well as their 'real life' when considering risk.

35. Those involved acknowledged that they got used to Sam speaking about imagining dying as part of their conversations with her. It can be seen now that she was building her own capacity to end her life, along with sharing her perceived sense of burdensomeness[12], including voicing this on social media. It is possible that she was building her own capacity and tolerance to be able to implement a dangerous and painful action, which is what happened on the day of the incident that led to this review. There is a need to have a more systemic view of assessing suicidality which includes seeing it in the round and recognising when it is increasing. Responses tend to focus on removing the opportunity and external risk factors, rather than addressing the person's increasing capacity to undertake an action that may lead to their death.

36. Sam had received regular therapy from a psychotherapist who knew her well. This is not a case where there was a negative impact caused by a lack of resources, waiting lists, and inconsistency of support. However, it is noted that there is a more general increase in the complexity of presentation of young people's mental health and insufficient capacity and resources to support them all.

Learning area – the need for transparency with children about their history and birth family

37. The review is aware that very little information is known by Sam and her siblings about their birth family. At adoption it was agreed that there would be no face-to-face contact. It is not known if there was an expectation for indirect contact, but there was none. The Local Authority who made the placement told the review that their records report that a later life letter and life story books were available, but little is known about if they were received by the children and how they were supported to make sense of them. Sam told the review that she knew very little about her birth family. She has one photograph but

[12] This where a person believes that the world would be better off without them in it.

has no memory of seeing any letters or life story books. Sam remembers being told that her birth family could not care for her but knows little else about her origins or why she was adopted.

38. This review has found that there was significant information that has not been shared with the children during their childhood, that should have been available to them. Not understanding their origin story may have had an impact on their development, attachment and in forming the secure emotional base they required. Knowing about their birth family is important to a child's sense of identity and self, helping them to integrate their past into their current life. Children need to be able to have open communication with their adopters about their birth family, to talk about why they can't live with them, and reassurance about the commitment and unconditional love of their carers. A therapeutic life story work model 'facilitates and contains the child's exploration of information about their past, making sense of it and creating a narrative from their view.'[13] This would have been helpful for Sam and her siblings. Sam told the review she would like to know more but does not expect that anyone would be able to help her with this. She has low expectations of professionals and of her adoptive parents in respect of this.

39. It has been found that not only were the children not aware of significant parts of their birth family make up and history, but those involved with them in South Gloucestershire were also unaware. This means that the extensive work being undertaken was impacted by 'secrets'. Single agency learning has been identified, and action is being taken in respect of decisions made in the 2021 care proceedings to keep historical information from the children and professionals involved.

Learning area - children who have lived with domestic abuse

40. Although it was not known at the time, it is now known that the children experienced domestic abuse when their adoptive parents lived together, and occasionally during family time with their father. Children who witness domestic abuse experience emotional harm and are at risk of both short and long-term mental health problems. Living with domestic abuse can also impact on a child's brain development due to living with consistently raised stress hormones (cortisol) when being in a permanent state of 'fright or flight'. Sam and her siblings were adopted during their formative years, so it is likely that this impacted upon their cognitive development.

41. For children who are already vulnerable due to other trauma, as was the case for Sam, exposure to domestic abuse can lead to significant cumulative harm. This is where children are exposed to repeated abuse and neglect, or other forms of trauma, and the negative effects accumulate over time, leading to more severe and long-lasting psychological and emotional damage. Consideration of Sam's likely and known lived experience from a very young age provides a clear picture of cumulative harm, requiring intensive and sustained interventions to support her recovery and well-being.

42. Those working with the family at the time of the parent's separation were aware of the allegations made by Mother of domestic abuse but supported Father's ongoing contact with the children. It emerged in 2017 that his new relationship was also violent, and that the domestic abuse was exacerbated by his partner's use of alcohol. A MARAC was held in South Gloucestershire, and information was shared with CSC, including his conviction for assault. A resulting social work

[13] Handbook of Therapeutic Life Story Work. Burley and McGladdery. 2024

assessment identified that the children were being exposed to domestic abuse in their father's relationship and ongoing concerns around Mother's sole parenting, with physical abuse evident. It noted that the children's school had concerns around the children's emotional and social development. There was no child protection response, with the children on child in need rather than child protection plans for most of the next 16 months. The CSPR was told that the history and the ongoing concerns should have led to an initial child protection conference in 2017, and it is believed they would now.

43. There were over 40 known incidents of domestic abuse between Father and his partner between the start of their relationship and the serious incident. Information shared with the review implies that the partner was the alleged perpetrator on most occasions when the police attended. The reported abuse was verbal and physical. Most of these were not in the presence of the children. A safety plan was made that the children would only have contact with their father when his partner was not at his home. There was no evidence of them having any contact with her after the agreement was made, and the children confirmed this was the case. On balance it was recognised at the time that contact with their father was of benefit to the children, if his partner was not present. It had been observed during visits that Father was attentive to the children and had parenting skills. It was also known that Mother was struggling to manage parenting alone and needed help and support.

44. Information sharing at the time was mostly good. Neither Sam's nor father's GP records had any flags about domestic abuse, but there was a free text comment available about one domestic abuse incident that happened in South Gloucestershire[14]. The GP surgery acknowledge that it was not coded as it should be on the father's records. There were flags on the children's GP records, for their child protection plans. There is an acknowledged systems issue in South Gloucestershire where there is no process for ensuring information about domestic abuse is shared with GPs. (It happens with pre-school children, via the health visiting service) Sirona are working to address this information sharing issue.

45. For Sam and her siblings, there was no new child protection response until January 2019. It was then that it was recognised that nothing had improved for the children, leading to a second period of child protection planning. Since the Domestic Abuse Act 2021, children exposed to domestic abuse are now recognised as victims of domestic abuse in their own right. In 2023, the Office of the Domestic Abuse Commissioner for England and Wales published a report[15] stating that despite this change in the law, there is an absence of clarity, guidance and funding to accompany it, so it has had little impact on practice with children. Most childcare professionals recognised the emotional impact on children of domestic abuse however, and the need for a therapeutic intervention was noted for these children in 2019.

Learning area - other vulnerabilities

46. Children who have experienced trauma and cumulative harm due to abuse and neglect are likely to be more vulnerable than their peers. For Sam there have been several issues that have emerged over recent years that highlighted her ongoing vulnerability. Sam has spoken in the recent past about her

[14] Father's partner's address is in another area.
[15] https://domesticabusecommissioner.uk/wp-content/uploads/2023/10/Domestic-Abuse-Commissioner-Insights-Briefing-Children-and-Young-People-Subject-to-Domestic-Abuse-Oct-2023.pdf

uncertainty about her sexuality and has questioned her gender identity. Children who have experienced abuse or neglect are thought to be more likely to do this, and professionals need to recognise the impact of both historic and on-going trauma on a child's behaviour and development, which includes their developing sexuality and the gender they wish to identify as.

47. Children who are vulnerable are also more likely to be sexually abused. In January 2024 Sam disclosed a sexual abuse incident where she was touched by a family friend. This was investigated by the police and there was a S47 investigation led by CSC. Alongside the involvement of the Local Authority Designated Officer (LADO). Sam did not wish to give a formal statement to the police, so no further police action was taken. There was an awareness at the time that the incident was minimised by her mother and that the lack of support may have led to Sam's decision. The Rapid Review process identified that this was likely to have been experienced by Sam as further validation of her experience of adults not being trustworthy and safe, and of her parent's not supporting her. The Bridge (Sexual Assault Referral Centre) was offered but refused by Sam. Her therapist was aware of the allegations and included support in her sessions with Sam.

48. Those who know Sam well (including the therapist and social workers) believe she may have autism, and she is going to be assessed for this. Diagnosis can be complicated for a child who has also experienced trauma /attachment issues in their early years. This can lead to a delay in the identification of neurodevelopmental conditions. While it is important to recognise that not all children who have experienced neglect will require an autism/ and/or ADHD assessment, assumptions also should not be made that the child's responses are fully explained by trauma and their neglect history. There is also the possibility of a brain and neurological development impact for children who have been the victims of neglect in their early years. The consequences of neglect can include a 'lack of neurological development that negatively affects normal brain functioning and information processing'.[16] It is not known if this is the case for Sam, but may be and earlier screening for autism would have been helpful for her and for those working with Sam.

49. The review sought specialist advice from the Director of Headsight Therapeutic Services to understand both the needs of children and staff. He outlined the need for agencies and services to make plans and have strategies in place to detail their journey to becoming trauma informed, and stated the following that is relevant to what was found in respect of Sam: 'The knowledge and awareness of the impact of psychological trauma is growing year on year but this does not organically evolve into trauma informed practice. As a starting point services need to develop a common language across all staff to be used when talking about those effected. There is also a need to identify those within an organisation who need additional competences in becoming trauma skilled meaning they can recognise where and how trauma presents within their specific service area, this should include the presentation within staff and service users. Some professionals require enhanced or specialist skills due to their roles and responsibilities that mean that they are providing direct care to those who are presenting with trauma symptoms. The risk of not having a more strategic approach to trauma informed care is that the very services designed to provide care, support and treatment become unwittingly complicit in causing

[16] https://assets.publishing.service.gov.uk/media/5a7c0a0540f0b63f7572af54/n4_childrens_health_including_mental_health.pdf

sanctuary trauma. This is a term that describes the emotional and psychological harm experienced when individuals, who have already experienced trauma, seek support in what they expect to be a safe environment, but instead encounter further trauma and stress. This is often the case with agencies that are providing services to traumatised individuals.' A recommendation has been made.

Learning area - online activity and social media

50. Prior to the serious incident, Sam was posting videos of herself in risky situations to her many social media accounts. The understanding of professionals and the parents about her use of social media was quite different, with parents considering it to be a tool for self-soothing, whilst professionals were trying to support the child in regulating and reducing her phone use. Mother was challenged about her views by the school and by CSC. It was recognised that Sam posting videos of self-harm and suicide increased her vulnerability but also potentially increased the risks for other young people who viewed the content that she was posting. Mother told the school she was grateful to have an increased understanding of the dangers.

51. In 2023, the Samaritans in the UK published a report How Social Media Users Experience Self-harm and Suicide Content[17], the aim was to minimise access to harmful content online relating to self-harm and suicide and maximise opportunities for support. Their research found that children as young as 10 years old were accessing self-harm content on-line, that accessing such content impacted negatively on the persons mood, and that it would often (in over 70% of cases) lead to the viewer then self-harming. The report concluded with a request that any social media sites with user generated content take urgent steps to better protect users from the harmful impacts of viewing self-harm and suicide content online. The review has reflected and acknowledged that international events in 2025 means that there is likely to be less rather than more user protection, which will increase risks in this area of safeguarding.

52. The national CSPR panel annual report 2024 stresses the importance of schools in educating children about online harm and risks, but also in identifying early if there are concerns about a child due to their online behaviour. There needs to be a system of providing early help and support and swift action when a school identifies concerns. For Sam, there was work undertaken at school, and during her sessions with Headlight and CAMHS.

Learning area - information sharing and communication

53. While information sharing was largely good, areas for improvement have been identified. During the school holidays, particularly the long summer holiday, there needs to be responsibility taken for ensuring that information about a child is shared with the school, either by email for retrieval later, or when the new term starts. There is also a responsibility on the school, who need to ask other services if there was anything to know after a school holiday. The concerns in August 2024 were unknown to Sam's school until the meeting held following the serious incident in November 2024. The school had spoken to Mother who had not shared any information. This should have been triangulated with a professional. The review has also identified a need to ensure that all agencies working with a child/ren

[17] https://media.samaritans.org/documents/Samaritans_How_social_media_users_experience_self-harm_and_suicide_content_WEB_v3.pdf

be informed in writing when a CiN plan ends, with clarity regarding the responsibility for coordinating and leading the work with the family following the ending of social work involvement, and clear directions about what to do if any further significant concerns emerge.

54. The Rapid Review meeting recognised that the therapist working with Sam shared all safeguarding concerns, but that the social workers involved have not consistently asked the therapist (who saw the child weekly) her views about Sam's needs. All of those working with a child must try to understand their lived experience and seek their voice. Getting this from the professional who knows the child best and longest is good practice and essential in ensuring a better understanding of the child's current emotional wellbeing. In May 2024 the NSPCC published a report on the learning from safeguarding reviews about the voice of the child.[18] One of the issues identified was that the advice of professionals who worked directly with the child and who had developed trusted relationships with them were not always sought, pointing out that they could have provided opportunities to engage with the child, helped with communication, or been an advocate for the child's voice and lived experience. It is noted however that there were examples of good practice in terms of multi-agency working here, including between Sam's school and the therapist, and the joint working between CAMHS and CSC following concerns that Sam planned to end her life when on holiday in August 24.

55. Around a month before the serious incident, concerns were shared with the police by a friend of Sam's that she was suicidal and in a public place that could be risky should she take action to harm herself. In line with Right Care Right Person policy, the police control room called the Ambulance Service who accepted the incident. The paramedics who attended advised the police that Sam had run off. The police accepted transfer of the incident based on the change in circumstances. Sam was then considered to be a missing child. They were later informed by the family that Sam had returned home. The Ambulance service was contacted again and accepted the call. Learning has been identified by Avon and Somerset Police about the need to also attend the home address in line with the missing person procedure. The Rapid Review meeting questioned the police and ambulance response to the incident that day was as well coordinated as it could have been. It appears that it was, and that each agency was aware of their part in the plan as it evolved.

56. Learning was identified by Primary Care, including an appointment with Sam where she made a disclosure about suicidal intent, which was not referred onwards due to an admin error in the practice. This has been investigated by the surgery, and training and support has been provided. There were also occasions where the opportunity should have been taken by the GP to speak to the child alone, without her mother, and where a wider Think Family approach could have been considered. The surgery has reflected on this and are committed to doing more going forward.

57. It appears that school was a safe place for Sam, but that she struggled in the environment. She had long-standing and extensive support from key school staff. Her wellbeing and care was prioritised over her education, and she regularly used the school learning support space at unstructured times. Sam had an EHCP and received significant additional support in school. The review has found that the EHCP could have been shared with other agencies and the support provided for her SEND needs

[18] https://learning.nspcc.org.uk/media/ccqcd2e2/voice-of-the-child-learning-from-case-reviews-briefing.pdf

could have been more multi-agency. However, there was largely good inclusion of the school in planning and an acknowledgement that they knew the child well and were committed to meeting her needs as much as possible. In June 2023 CAMHS suggested the involvement of school nursing, but it was thought Sam's needs were best met by the more specialist services that were already in place.

Conclusion and recommendations

58. This consideration of practice with Sam has highlighted the complexity for professionals of understanding and supporting a child with complex emotional difficulties who states they wish to die. Working with a child who was adopted and remained living with her adoptive parents despite significant concerns about the care from those parents almost from the time they were placed, added complexity and challenges for agencies. Sam had many committed professionals who wanted to ensure she was safe and who were focused on her recovery from her traumatic history. Along with this, however, a degree of professional helplessness and fatigue about what else could be done to ensure her safety at home and due to her own suicidality was apparent. There was an understanding that there was a need for a clear **multi-agency** safety plan, which included all the professionals working with the child and the parent/s, and that crucially also recognised the need for the child to feel safer within herself.

59. Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. They include the ambulance service response to mental health crises, the school ensuring improved communication with other agencies about the specifics of safety planning, information sharing with and from GPs, and understanding and responding to suicidality.

60. While the adoption service in South Gloucestershire was not involved in the assessment of the adopters or the placement of Sam and her siblings, it is positive that it has been agreed that they will undertake a piece of work where the learning from this review is considered by the service and by the multi-agency adoption panel to enable reflection on their own practice and decision making.

61. This report has been shared with the court appointed psychologist and the designated family judge, so that they can consider any learning about the decision making in respect of this child in 2021.

62. Having considered the learning outlined above, the following recommendations are made:

Recommendation 1

This report to be shared with the Local Authority who were responsible for the adoption assessments and placements, so that they can consider their own learning.

Recommendation 2

The relevant agencies must outline how they will ensure that all appropriate staff are aware and competent, for their role, in respect of working with service users where trauma is an issue.

Recommendation 3

The relevant agencies must work together to agree an improved approach for understanding and assessing the increasing risks of suicidality, outside of responding to or safety planning for a specific incident or concern. The Partnership should be provided with assurance about improved systems and practice in this area.

Recommendation 4

The Partnership to consider how they ask agencies to identify and work with families where adolescent neglect features. This should include an addendum to the 2024 neglect tool kit which focuses specifically on identifying neglect and concerns within the home for older children.