

**CHESHIRE WEST AND CHESTER SAFEGUARDING CHILDREN
BOARD**

**SERIOUS CASE REVIEW IN RESPECT OF
*LAUREN***

OVERVIEW REPORT

REPORT AUTHOR : MAUREEN NOBLE

AUGUST 2017

CONTENTS

1. Introduction, Background and Review Process	3-8
2. Timeline of Significant Events Professional Narrative	9-14
3. Analysis of Professional Practice	15-21
4. Summary of Learning	22-23
5. Findings and Recommendations	24-27
6. Resources, Guidance and Toolkits	28-29

ACKNOWLEDGEMENT

The review panel offers sincere condolences to Lauren’s family on their sad loss and appreciation for their contributions to the review.

The panel also wishes to thank Child 1 for her input to the review.

Their input has helped to provide insight into Lauren’s life and enabled the panel to ask insightful questions of professionals.

NB: Lauren is the subject of this Serious Case Review however the panel recognises that Child 1 was subjected to the same level of harassment and intimidation as Lauren and that the events described in this report have had a significant impact upon her.

1 INCIDENT LEADING TO THE SERIOUS CASE REVIEW

Lauren was 16 years of age when she died in June 2016. Lauren had left school mid-morning following an examination and returned home. Sometime later a family member went into the hallway and saw Lauren with a scarf around her neck hanging from a coat hook. An emergency ambulance was called and an air ambulance was immediately dispatched. When paramedics arrived they attended Lauren however they were unable to resuscitate her and life was pronounced extinct. Lauren was taken to the mortuary where a Home Office post mortem was conducted. Lauren was found to have died of asphyxiation.

At the time of writing a Coroner’s Inquest has not taken place. It is not therefore possible for this review to comment on whether Lauren took her own life. It has however been established that there were no suspicious circumstances related to Lauren’s death. Lauren left a note to say that she felt she was a failure and that she wished to die.

1.2 Key People

Lauren’s parents asked that the published report referred to Lauren by name, therefore a pseudonym has not been used. All other young people referred to in the report have pseudonyms as outlined below.

Pseudonyms	Relationship
Lauren	Subject of the review
Child 1	Friend of Lauren
Child 2	Child charged with offences against Lauren and Child 1
Child 3	Child charged with offences against Lauren and Child 1

1.3 Brief Biography

Lauren lived with her mother, step-father and four siblings. She lived in a close and loving family environment. Lauren was said by her family to be sociable; she had good

relationships with her siblings and was described by her mother as ‘a normal teenager’. She was described as being assertive and a person who would not stand back or be taken advantage of. She had strong views and opinions and was loyal to her friends.

Lauren attended a local Academy (referred to as ‘high school’ throughout this report). Her attendance at high school was excellent throughout the events that are recounted below.

Lauren’s birth parents had separated when she was below the age of five. Lauren did not see her birth father for many years following the separation. Around 3 months before her death Lauren initiated contact with her birth father and had begun to have regular contact with him, which he welcomed. They sent each other messages and met face to face. During their conversations Lauren told him that she was being bullied at school and that she was afraid of the people who were bullying her. Lauren did not tell her mother and step-father that she was in contact with her birth father.

Lauren had experienced some issues with her emotional well-being in the latter years at primary school and shortly after transitioning to high school. Contacts with services in relation to emotional wellbeing are set out later in this report.

The family was not known to Children’s Social Care at any point and there were never any professional concerns around Lauren or any of her siblings being safeguarded by her mother and step-father.

1.4 Review Process

Following Lauren’s tragic death a referral was made to the Local Safeguarding Children Board for consideration of a Serious Case Review. The Board decided that the case met the criteria for the conduct of a Serious Case Review and that there was learning to be gained from the case.

The LSCB commissioned an Independent Reviewer to undertake the review using a hybrid of the systems methodology developed by SCIE¹.

A panel was established consisting of representatives from Local Authority Children’s Social Care and Integrated Early Support; the Clinical Commissioning Group; Youth Justice Service; Cheshire Police; Cheshire West and Chester Local Education Department; Cheshire West and Chester Local Authority Legal Services; and the Safeguarding Children Board.

The panel met on five occasions to oversee the review process and the production of the final overview report and multi-agency action plan.

1.5 Research Questions

The panel agreed the following research questions to be answered by the Review. These questions were kept under review and amended as new information emerged.

- (i) Is there a clear definition of bullying that is shared by all agencies (i.e. as set out in the Department for Education² guidance)?

¹ <http://www.scie.org.uk/children/learningtogether/>

- (ii) Do local schools have clear guidance/policies and procedures in relation to the management of bullying and were policies adhered to in this case?
- (iii) Do police have clear guidance/policies and procedures in relation to the management of bullying (guidance contained in Protection from Harassment Act 2012³, Malicious Communications Act 1988, Communications Act 2003 and Public Order Act 1986) and were policies adhered to in this case?
- (iv) Are links between schools and police robust in relation to the management of school based incidents of bullying and harassment?
- (v) What role do parents, families, and peers play in constructive interventions in relation to bullying and are there clear protocols within agencies for involving families and peers?
- (vi) What is the role of social media in bullying and intimidation?
- (vii) Are all agencies working in an integrated way to manage bullying and self-harm?
- (viii) Are there sufficient/accessible and appropriate services for victims of bullying and their families in the statutory and non-statutory sectors including mediation services?
- (ix) Did agencies attempt to understand Lauren's daily lived experience and act on her wishes and feelings?
- (x) Are schools (and other agencies) unduly influenced by individuals or groups within communities who exercise negative control (e.g. known offenders, anti-social individuals or groups, local people with negative community capital)?
- (xi) What learning can be drawn from other serious case reviews/research in relation to the links between bullying and suicide in adolescents?
- (xii) Were other events in Lauren's life sufficiently recognised as troubling her and were these acted upon by agencies?
- (xiii) Do GPs have a clear pathway in place to respond to concerns about low mood/emotional wellbeing?
- (xiv) Was information about self-harm sought and did this influence responses to Lauren?

1.5 Methodology

1.5.1. Information Provided to the Review

Following the initial scoping exercise an integrated chronology was compiled containing significant events.

High School provided copies of written records and reports. High school conducted an internal review and provided a copy of their report to the SCR.

Using systems methodology practitioner conversations took place with the following agencies.

²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623895/Preventing_and_tackling_bullying_advice.pdf

³

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623895/Preventing_and_tackling_bullying_advice.pdf

- General Practitioner
- High School (3 members of staff including the Principal, Learning Coach, ex Designated Safeguarding Lead, also an Assistant Principal at the Academy). A member of the Trust's Senior Management Team was present during all conversations.
- The Chair of the Statement of Action Committee of the Academy also spoke to the review although they had never met Lauren and their observations are not included in this report

Lauren's family participated in the review. The report author and LSCB Business Manager met with Lauren's mother and step-father on three occasions.

Child 1 contributed to the review. The report author and LSCB Business Manager met with Child 1 at her family home.

The LSCB Business Manager attended local meetings to discuss intelligence in relation to anti-social behaviour and street gangs (it was established that neither Lauren nor Child 1 had any contacts with so called gangs of young people in the local area).

A literature review was conducted in relation to bullying, street gangs and intimidation. This is attached at Appendix 2.

A learning event was held with professionals to discuss key issues emerging from the review.

1.7 Parallel Processes

1.7.1. Criminal Proceedings

Following Lauren's death three girls were questioned by police in connection with harassment of Lauren and Child 1.

Police charged two of the girls (Child 2 and Child 3) with offences of harassment with fear of violence contrary to Section 4 of the Protection from Harassment Act 1997. Both girls appeared in Youth Court for trial in April 2017 and both pleaded guilty to the charges. They were sentenced in June 2017 and collectively received community orders and a five year restraining order preventing them from contact with Lauren's family and Child 1.

NB: The review has noted that these charges do not imply a direct connection between the actions of the girls and Lauren's death.

1.7.2. Independent Police Complaints Commission Investigation

The IPCC investigation was ongoing at the time this review concluded, the outcome of the investigation is therefore not considered in this report.

1.7.3. Coroner's Inquest

A Coroner's Inquest was pended until the completion of criminal proceedings and the Serious Case Review. This report was shared with the Coroner's office at the point of completion.

1.8 Views of Lauren's Parents

Lauren's parents described her as a normal teenager, she got on well with her siblings and with both her mother and step-father although, like many teenagers, she was at times secretive and did not always share things when she was asked about certain aspects of her life.

When she was at primary school Lauren had experienced low mood and low self-esteem and had displayed behavioural difficulties in her later years at primary school.

Her birth parents separated when Lauren was under five years of age and she had no contact with her birth father in her early years. Lauren did not speak to her mother or step-father about contact with her birth father although she did initiate contact with him around 3 months before her death and began to see him. She also sent him messages saying that she was being bullied and that she was afraid.

When Lauren's parents became aware that she may be experiencing bullying at school (in January 2013) her step-father went into school straight away to express his concerns. Her parents knew the girls involved as they lived nearby and were from a family who had some notoriety in the area. Lauren had initially been part of the same friendship group as the girls (which included Child 2 and Child 3).

As time progressed Lauren's parents noticed a change in her. There were some negative reports from school about Lauren's disruptive behaviour and rebelliousness. Parents knew that Lauren was on a behaviour support plan and they worked with the school to improve Lauren's behaviour. They said that Lauren had always enjoyed school and her attendance was very good, however they increasingly noticed that Lauren's enjoyment of school appeared to be diminishing.

Lauren had told her parents that she was being intimidated due to a split in the friendship group. Lauren and Child 1 decided that they no longer wanted to associate with the other girls. Lauren's parents spoke to the high school about their concerns and remained in frequent contact to ensure that Lauren was safe and also that the issue of bullying was being dealt with. They told the review that they felt that school had not fully addressed their concerns and that they often felt that they weren't being listened to. (Child 1's mother had also raised her concerns with the school and had taken evidence of cyber bullying into school).

Lauren's parents spoke about the frightening nature of the intimidation. Child 2 and Child 3 lived close to Lauren's home and would often loiter outside the family home or across the road looking into the house. On one occasion they banged on the windows of the house. Mother said that they had verbally and physically assaulted Lauren and that on one occasion Lauren was so afraid that she was on the floor curled up into a ball. Step-father also witnessed a similar event at school when Lauren was shaking with fear. School told the

review that they were not aware of these incidents however step-father is certain that the final incident described took place at school and was observed by a member of staff.

They were aware that Child 1 was also being targeted by the girls and spoke to Child 1's mother about the school's response. Both families made their views known to high school but were not reassured that the school's response was improving the situation.

They knew that Lauren and Child 1 had become very close and that they spent the majority of their out-of-school time together. They were not aware that the two girls had developed unhealthy coping mechanisms to deal with their fears until after Lauren's death.

1.9 Views of Child 1

Child 1 met with the lead reviewer and the LSCB business manager a short time after Child 2 and Child 3 were sentenced in June 2017.

She told the review that she and Lauren had endured months of bullying and harassment and that they had been frightened most of the time, both at school and in their leisure time. They were constantly worried that they would be assaulted or intimidated and received many threats via social media (cyber-bullying).

Child 1 said that she and Lauren felt that they had no-one to talk to at school and that no-one asked them what they wanted to happen to stop the bullying from taking place. *She emphasised the importance of having the right person available to talk to, rather than someone designated by the school (this is a key learning point).* She said that separating the girls whilst in school did not address the problem as she and Lauren were still frightened and still received threats.

Child 1 said that during the period in which Child 2 was on bail the situation improved and the intimidation stopped. However it resumed again once bail was ceased and charges dropped.

There was no counselling or other emotional or mental health support services made available to Lauren and Child 1 and they spoke only to each other about the full extent of what was happening to them and how afraid they were. They tried to show strength and resilience but privately they were worried and afraid. Both girls developed unhealthy coping mechanisms. They had talked about suicide but said that neither of them would go through with it because that would mean leaving the other one behind to face the intimidation alone.

The review asked Child 1 what she thought would have helped the situation. She said that they both needed someone at school to talk to; they needed to be able to express their fears and to have them taken seriously. It would have helped them both if school and police had acted to remove the other girls from the school or to take formal action against them.

2. TIMELINE OF SIGNIFICANT EVENTS WITH PROFESSIONAL NARRATIVE

2.1 Contact with Agencies prior to 2012

Lauren was taken to see her GP in 2010, she was accompanied by her mother. Lauren was experiencing behavioural difficulties both in primary school and at home. On one occasion she had stayed out all night without letting her parents know where she was, they became concerned and reported this to the police. It transpired that Lauren had stayed with a friend and they had been drinking alcohol.

The GP made a referral to Child and Adolescent Mental Health Services (CAMHS) who responded saying that they felt it would be more appropriate for the Primary School Nurse to deal with the presenting behavioural issues. The GP record showed that mother had said she would contact the school nurse. However the GP pointed out that it was not clear whether CAMHS were suggesting that the GP should follow this up. Soon after this consultation Lauren transitioned from primary to high school.

Lauren's next presentation to the GP was 8 months later; she was accompanied by her mother who reported that the behavioural difficulties were continuing. Mother had contacted the school nurse, employed by the NHS, as suggested but nothing had really happened as a result of this. The school nurse recorded one home visit however there was no follow up when subsequent telephone contact could not be made. The school reported to the review that it has no record that it was aware of these events.

2.2 September 2012 – March 2015 (School Years 7-10)

Lauren appeared to settle well into high school and became part of a close group of friends with four or five girls who lived in the same area as her. High School did not notice any behavioural issues with Lauren during year 7 (the first year of high school when Lauren would have been 11-12 years of age) and the early part of year 8, she performed well and appeared to enjoy school. It was noted that in Year 7 Lauren had had a problem with a group of boys however this was resolved by one of the boys moving to another school.

From around the end of year 8 Lauren's friendship group increasingly came to the attention of school staff. The school safeguarding lead noted that they had quite a degree of influence in the school and that a lot of time was taken up in keeping an eye on their behaviour. At this time Lauren and Child 1 were not particularly close friends, although Lauren was part of the larger friendship group.

In January 2013 Lauren's step-father contacted police regarding bullying at school, he said he wanted advice on what to do as he said that school were not dealing with the issue. Step-father said that Child 2 had been jostling and intimidating Lauren whilst walking home from school and that Child 2 had been spreading rumours that Lauren had been making sexualised gestures to Child 2's father. Child 2 was spoken to by police with her mother present. No offences were recorded.

The following day Lauren's step-father spoke to staff at high school to say that he was concerned about Lauren being bullied, he said he thought that this had been going on for some time and that nothing appeared to be being done about it by the school.

Until March 2015 there were no further significant incidents recorded by agencies or by the family.

2.3 March 2015 – June 2016

In March 2015 Lauren received a fixed-term exclusion for disruptive and aggressive behaviour.

A new head teacher had recently joined the high school. The school was at that time in special measures and an improvement plan was in place. The head teacher told the review that she was immediately aware of the group of girls that included Lauren and Child 1. The group were visible for their behaviour, the main issues were wearing make-up, being late for lessons, and not wearing full uniform. These issues were taking place on a daily basis with all of the girls, not just some of them. In the summer of that year Child 3 left the school. A new pupil who had been transferred from another school joined the friendship group.

The head teacher identified all the girls (except Lauren who was described as coming from a stable home) as being vulnerable in some way. Two of the girls had been subject to Child Protection Planning in the past, the new member of the group had been moved on a transfer because of issues at her previous school and Child 2 was subject to a Team around the Family plan (TAF). Child 1 had no involvement with other agencies at that time. All the girls in the group were subject to school behaviour plans and were made aware of the impact of their behaviour on their school performance.

In the summer of 2015 Child 1 decided that she wanted to have some time away from home and she moved into foster care over the summer holidays. When she returned to live with her family she had made a firm decision to separate from the friendship group and to concentrate on her school-work.

Child 1's decision had an impact on Lauren as they were very close friends by this time. Lauren decided that she also wanted to move away from the friendship group and concentrate on her school work. This was at the start of year 11 (September 2015).

Shortly after the start of the school year Child 1's mother went into school (she saw the Assistant Principal) with a printout of material from Facebook about which she was concerned. The printout contained threats and intimidating remarks made to Child 1 (and Lauren) these threats were made by Child 2 and Child 3. Child 1's mother also informed the principal that the friendship group had broken up. She said that Child 1's decision had not been taken well by the rest of the group and she was concerned about this.

School said that they would support Child 1 and Lauren as they were both clearly worried about the threats they had received. School arranged for them to enter the building by a separate entrance and to have separate 'safe' spaces in the school. They were also offered support from a learning coach, this support was around ensuring that the girls were able to

participate in lessons and to prepare for examinations. School also advised Child 1's mother that she should inform the police about the threats that were being made as Child 3 was no longer a pupil at the school.

In October 2015 Police were called to an incident that took place at a local leisure centre where Lauren and Child 1 said they had been assaulted by the three girls, one of whom was Child 2. Police investigated the incident and spoke to the three girls accused of the assault warning them about their behaviour.

Three days later Child 2 was arrested for assault, criminal damage and witness intimidation. Child 2 was bailed with conditions not to approach Lauren or Child 1. Police did not immediately contact school about the incident nor was a vulnerable person assessment (VPA) made. (Ultimately no further action was taken by police due to a retraction of the allegation).

The following day Lauren's step-father went into school and spoke to the vice principal and the Designated Safeguarding Lead. He said he was very concerned for Lauren's safety following the assault and that he wanted school to take action to ensure the safety of Lauren and Child 1.

School contacted police and asked for a meeting with them to discuss the incident and the bail conditions. A police sergeant attended a meeting with school and informed them that Child 2 was subject to bail for charges of assault, witness intimidation and threatening to damage property. He explained that the bail conditions were about restricting access to Lauren and Child 1.

That same month Child 2 was given a fixed-term exclusion from school and arrangements were put in place to separate her from Lauren and Child 1 by teaching her in a specific room away from all other children. Child 2's mother was asked to come into school and did so to discuss what had happened and why Child 2 was being segregated.

Some days later there was an altercation in the school playground between Lauren and a boy who had shouted to her that she was 'a grass'. Lauren retaliated to this provocation and police were called. Everyone involved in the incident was spoken to by police and school staff. Both Lauren and the boy in question received a five day fixed-term exclusion as a result of the incident.

On return to school Lauren was offered a 'safe place' at lunchtime and after school however she refused this saying that she did not want to be separated from other pupils.

Within a few days of this incident Lauren and her mother consulted the GP with concerns about Lauren's behaviour. Mother said she was concerned that Lauren may have Attention Deficit Hyperactivity Disorder (ADHD)⁴. School were not aware of this consultation (this is not unusual as Lauren was not subject to any form of child protection planning). The GP spoke to Lauren and her mother together (they did not ask to see Lauren separately which would have been good practice). The GP told the review that enquiries regarding self-harm

4

are not 'routine' but that they are sensitive to the issue and will try to establish a rapport with the child to enable them to ask probing questions if there are concerns regarding self-harm and/or suicidal thinking.

The GP suggested a referral for assessment of Lauren's mental health however, due to an administrative error, this was sent to the 16-19's service rather than to the Community Paediatrician. The GP's secretary looked at Lauren's age and decided the referral should go to 16-19 although Lauren was still only 15 at the time. It was not until the GP received a response from the 16-19's service that it became apparent that the referral had been incorrectly routed. The response suggested that Lauren could be referred to the community paediatrician or to Improving Access to Psychological Therapies (IAPT).

By October 2015, following conversations with Lauren and Child 1, arrangements were made at school for them to be taught in the same classes as each other. They were assigned specific teachers to ensure that they had safe passage throughout the school buildings and grounds. Child 2 and some of the other children involved in incidents were being taught separately to other pupils.

Both girls had been assigned to a learning coach who they saw on a daily basis. The role of the learning coach was to ensure that Lauren and Child 1 were able to benefit from their education and to prepare them for exams. The learning coach noted that both Lauren and Child 1 were somewhat rebellious, they came in on most days wearing jackets and trainers that did not comply with school uniform policy, it became routine for them to come to see the learning coach every morning, leave their jackets, trainers and other items with her and then collect them at the end of the school day.

The learning coach told the review that Lauren was happy and chatty and didn't object to coming to see her. She said that Lauren would talk about what she did outside of school however she always had the feeling that Lauren was holding something back. The extent of pastoral support offered by the learning coach appears to have been limited to conversations of this nature. Whilst there was a link between the learning coach and the school safeguarding lead, Lauren did not make any disclosures to the learning coach which would have triggered a discussion between these two professionals.

Child 2 was subject to TAF (Team around the Family)⁵ and in December a TAF meeting took place in which her mother said that she thought it was unfair that Child 2 was still being taught in a separate room as all charges against her in relation to the assault in October 2015 had been dropped. School informed the review that they were not aware that the charges against her had been dropped and were under the impression that the case would eventually go to court.

On 18th December Child 1 contacted police to say that she and Lauren had been out in the local area and had been assaulted by Child 3. She said that they had been so frightened that

⁵ <https://www.cheshirewestandchester.gov.uk/residents/health-and-social-care/children-and-young-people/team-around-the-family.aspx>

she had jumped into a stranger's car to get home. Due to an error in recording by police the incident was graded for response within 60 minutes rather than as an urgent response.

Later that evening a police constable attended the home address of Lauren and spoke to her and Child 1 about the incident.

It was 9 days and 16 days later that a constable took two statements from the girls (Child 1 on 27th December and Lauren on 12th January). Because of sickness absence no further action was taken by police until 21st March when a police constable interviewed Child 3 who denied the allegations and gave an alibi for the time the offence was alleged to have taken place.

A week later the police constable made an entry on the recording system that there was no independent evidence to support the allegation that the assault had taken place and no realistic prospect of conviction. There are no entries to say that any other party had been spoken to or any attempts had been made to trace the vehicle.

The constable updated Lauren and Child 1 to let them know the case was closed and there would be no further action by the police. Police did not inform school of the incident or of the outcome of their investigations. This is a significant oversight.

On 2nd February 2016 Lauren's step-father informed police that Lauren had been threatened whilst on school premises by a pupil associating with Child 2. Lauren was told she would be assaulted by Child 2 on leaving school premises and therefore step-father had gone to collect her. Police spoke to Lauren, Child 2 and the other child and advised them to stay away from each other.

Later in February Child 1 and Lauren were involved in an incident in school involving two other girls. The incident involved verbal abuse between the girls and threats being made, Lauren and one other student had to be restrained by a member of school staff. Child 2 and Child 3 were noted to be waiting outside of school. School informed police who attended and spoke to all parties. School also contacted the children's parents who escorted them home from school. Lauren's step-father noted that Lauren was visibly shaken by the incident and was in fear.

Following the incident school conducted a risk assessment and agreed a detailed plan that kept Child 2 and two other girls separate from all other students within the school. This involved reduced lessons, separate learning spaces, and supervised movement around the school. Lauren and Child 1 also entered and left the school through a different entrance and their school hours were altered slightly to accommodate them coming in later and leaving earlier. The risk assessment does not appear to have considered a discussion with Lauren about emotional support or to seek her views about the impact of ongoing intimidation and the proposed plan for separation.

The separation of Child 2 and the other girls continued and there were no further incidents in school, although Lauren's family told the review that there was ongoing intimidation and harassment of both girls throughout this time through text messaging, being outside the home and harassing the girls outside of school hours.

Child 1 told the review that she and Lauren completely relied on each other and supported each other, they became inseparable and spent most of their spare time together. Child 1 said that although the school kept them apart from the other girls they still felt frightened and intimidated but no-one in school asked them about their feelings or what they wanted.

In April Lauren was found in possession of a phone during a public examination. This was reported to the exam board who ruled that she would receive 0 marks for the exam in question. Lauren and her mother went into school to discuss the decision as Lauren was particularly upset about the incident and that she would automatically fail one of her exams. *Child 1 told the review that she and Lauren kept their phones with them when they could so that if anything happened they could contact someone to help.* School told the review that Lauren had been asked a number of times why she wanted to retain her phone but that she would not provide any reason.

Until the day of Lauren's death there were no other recorded incidents or contacts with any agency.

On the day of her death Lauren had completed a biology exam and had walked home from school. She had given no indication to anyone on that day that she was troubled or intended to harm herself.

When Lauren was found she had written a note saying that she felt like a failure. She did not make any reference to bullying or intimidation.

3. ANALYSIS OF PROFESSIONAL PRACTICE

3.1 Agency Responses

3.1.1. General Practitioner

Following Lauren's death the GP conducted their own internal investigation and learning review which demonstrates a willingness to be open and learn lessons.

When Lauren was first seen in 2010 with behavioural difficulties the GP made a referral to CAMHS although they were not entirely sure that this was the most appropriate service. However in reflective conversation for this review the GP noted that at that time, and subsequently, there is a general lack of services for children with behavioural and emotional difficulties. When CAMHS referred back and suggested school nurse it was unclear who should contact, the GP therefore advised Lauren's mother to make the contact. It would have been good practice for the GP to clarify with CAMHS to support mother in contacting the school nurse.

On the second visit 8 months later there is no clear outcome from the consultation, this is possibly a recording issue that has been noted by the practice.

Between 2010 and 2015 Lauren presented with 'minor' complaints such as abdominal pain, these presentations were not frequent although these may have been indicators of anxiety and depression. The GP responded appropriately to treating physical illness however they did not exercise professional curiosity as to potential cause.

When the GP saw Lauren in 2015 mother remained present at the consultation (it may have been useful to see Lauren alone). The GP observed that mother was more concerned about ADHD at that presentation and reflected that perhaps ADHD had been missed in earlier years. However, there is no indication that there was a missed diagnosis.

When the GP saw Lauren in 2015 they decided to make a referral to CAMHS. The change of referral to 16-19 services was made by an administrative member of staff. This has been the subject of internal review and safeguards are now in place to ensure that GPs are consulted before any such changes are made.

The GP showed good insight into self-harm and suicidal ideation and observed that Lauren had not given any indication of either in any of her presentations (although as noted earlier in this report GP's do not make 'routine' enquiry in relation to self-harm).

3.1.2. Police

The first contact with police was in January 2013 when Lauren's father reported to them that he was concerned about Lauren being bullied by Child 2. Police spoke to Child 2 about the concerns and raised the matter with high school. This was appropriate action however there is no indication that there was a detailed assessment of the nature and frequency of the bullying and no joint plan with the school in relation to safeguarding Lauren in the

future. Both police and school should have investigated whether this was an isolated incident or ongoing harassment and intimidation.

When Lauren and Child 1 were assaulted by Child 2 at a local leisure centre in October 2015 police acted appropriately and arrested Child 2. However, after initial telephone contact, police did not communicate with school regarding Child 2's arrest or that she had been charged and bailed with conditions not to approach Lauren and Child 1, nor did they raise this with the school to identify Lauren and Child 1 as vulnerable pupils. This was a significant omission on the part of police.

It was not until Lauren's step-father went into school the following day to inform them of the incident that school were aware of the bail conditions. It was good practice on the part of school to contact police and a joint meeting was held. However, the focus of the meeting was the enforcement of Child 2's conditions of bail rather than how best to safeguard Lauren. There was no consideration that Lauren and Child 1 may be at risk of significant harm; advice and guidance was not sought from the Integrated Access and Referral Team (i-Art)⁶ and therefore no consideration was given to whether need or risk should have been addressed via Integrated Early Support (IES) or Children's Social Care. This was a significant missed opportunity.

Some days' later police were again called to school in relation to an altercation between Lauren and a male pupil who had called her 'a grass'. Police spoke to both pupils (who were excluded, see below). They did not recognise this verbal abuse as further intimidation of Lauren.

Allegations in relation to the assault in October 2015 were retracted by Lauren and Child 1 in November and no further enquiry was made. Police did not inform school that charges had been dropped and bail lifted. This was a significant missed opportunity to both inform school of developments and to hold a multi-agency meeting to discuss the potential impact on Lauren.

On 11th December police responded to a call that Lauren and Child 1 had stolen an item from a local pharmacy. No further action was taken however a vulnerable person referral was recorded as having been made by police. There is no record of this having been received by the school.

In response to the incident that occurred on 18th December (where Child 3 jumped out of a car and assaulted Child 1 and Lauren), police did not interview either child until some-time after the event, and there was a significant gap in between the two interviews.

The incident that took place in school in February resulted in police attending school to deal with a serious altercation involving Lauren, however there is no evidence that police linked this incident to the ongoing harassment of Lauren.

6

<http://www.westcheshirelocaloffer.co.uk/kb5/cheshirewestandchester/directory/service.page?id=J9NtZ5h4MqA>

The police officer was on sickness leave and the case from December appeared to sit on file until Child 3 was interviewed at the end of March when she denied the allegation. No further action taken.

The police response to this incident was slow and ineffective. The allegations should have been investigated to ensure safeguarding of Lauren and prevent further risk of intimidation. There is no indication of liaison with school and no documented consideration of whether a referral to i-Art would have been appropriate. (This assault investigation was voluntarily referred by Cheshire Police to the IPCC).

3.1.3. School

When Lauren's step-father reported bullying in 2013 and expressed his concerns there appears to have been no specific action taken.

Child 1's mother reported her concerns about cyber-bullying to school in September 2015, she brought evidence of threats that had been made to Child 1 and Lauren by Child 2 and Child 3. School advised Child 1's mother that she should contact police. There is no indication that school demonstrated an understanding of the insidious nature of cyber-bullying and that it may continue and impact the wellbeing of Child 1 and Lauren.

Following the report made by Lauren's step-father of the incident that took place in October 2015 where Lauren was assaulted school proactively contacted police to discuss the incident and were informed that Child 2 was subject to bail conditions. This was good practice.

School took action to manage the practicalities of enforcing Lauren's bail conditions and liaised with parents in this respect. However there is no indication that Lauren's wishes and feelings were considered in responding to this matter. There was no assessment of the emotional impact of the assault on Lauren nor any apparent consideration that she may require emotional support in addition to support to maintain her education.

Shortly after this incident Lauren was verbally abused in the school grounds by a boy who called her 'a grass'; Lauren retaliated and an altercation took place. This resulted in Lauren (and the boy who had verbally abused her) receiving a 5 day exclusion. It appears that no consideration was given to Lauren's vulnerability in relation to this incident. In order to treat children with parity both were excluded, however school were aware that Lauren had been assaulted only days earlier and was experiencing ongoing intimidation from the group of girls. There is no evidence that this incident led to a discussion regarding Lauren's ongoing safety and emotional needs or acknowledgement she was being subjected to further intimidation by another pupil at the school.

School were not informed by police that charges in relation to the incident in October 2015 had been dropped nor did they know that Child 2's bail conditions had ceased (although Lauren's parents did inform school about the incident). This is an indication of a lack of ongoing dialogue between police and school which relied on contact being linked to incidents rather than a joint oversight of an ongoing safeguarding issue.

School were not informed by police of the incident that took place in December 2015 when Lauren and Child 1 were assaulted by Child 3. Although Child 3 had left the school by this time the victims of the assault were still pupils at the school. Police should therefore have informed school and discussed with them an ongoing safety plan for Lauren, including the recognition of the potential for significant harm. School were totally unsighted on this issue and therefore unable to consider the safeguarding needs of Lauren.

When an altercation took place between Lauren, Child 1, and two other girls in February 2016 school responded by conducting a risk assessment which resulted in Child 2 and other girls receiving a detailed plan to keep the girls apart in school. The risk assessment does not appear to have included a discussion with Lauren about her wishes and feelings, nor does it acknowledge the ongoing impact of intimidation and abuse upon Lauren and Child 1. There is no consideration given to raising the matter as a safeguarding referral nor to the potential for significant harm for Lauren and Child 1.

In April 2016 when Lauren was found in possession of a mobile phone during an exam . School contacted Lauren's mother to inform her of the incident. Lauren was asked why she had her phone with her but would not give a reason.

3.2 Responses to the Terms of Reference

(i) Is there a clear definition of bullying that is shared by all agencies (i.e. as set out in DfE guidance)?

It is not evident from this review that all agencies work to the DfE guidance and have a shared understanding and response in relation to bullying. The high school attended by Lauren is an Academy and part of a larger organisation which has organisational policies relating to bullying. The review found the school's policy to be heavily focused on management of incidents and maintaining academic achievement (which is understandable) however the policy could be strengthened by setting out how the school meets the pastoral and safeguarding needs of children who are being bullied and when the school should escalate matters (e.g. section 47 referral).

The multi-agency partnership would benefit from clear definition and shared understanding.

It is important to note that several incidents in this case constituted criminal acts of harassment and assault which should have left agencies in no doubt as to their significance. In plain terms the actions of Child 2 and other members of the group warranted immediate and ongoing action to safeguard Lauren.

(ii) Do local schools have clear guidance/policies and procedures in relation to the management of bullying and policies adhered to in this case?

The case illustrates a need for a consistent approach and a focus on processes for managing high level incidents. (NB this review has only looked at the policies and guidance for the school directly involved in the review).

- (iii) Do police have clear guidance/policies and procedures in relation to the management of bullying (guidance contained in Protection from Harassment Act 1997, Malicious Communications Act 1988, Communications Act 2003 and Public Order Act 1986) and were policies adhered to in this case?**

Police have policies in place, although these were not applied consistently in this case. Police failed to communicate and share information with school (or other agencies) in relation to a number of incidents. Police did not recognise the potential for significant harm being caused to Lauren nor did they consider taking action as a consequence..

- (iv) Are links between schools and police robust in relation to the management of school based incidents of bullying and harassment?**

This case illustrates that the links between schools and police are not robust. Further work needs to take place to ensure that police and schools not only share an understanding of the impact of bullying behaviour (including harassment and criminal behaviour) on victims but that they take the same approach to managing incidents and have an agreed pathway for referral and escalation of concerns.

- (v) What role do parents, families, peers play in constructive interventions in relation to bullying and are there clear protocols within agencies for involving families and peers?**

Parents in this case were engaged and concerned however this seemed to have had little impact on how incidents were managed. Child 1's mother notified the school about the split in friendship group which could have offered an opportunity to safety plan and tackle the issues at source. Mother provided evidence of cyber-bullying which was not fully acted upon by the school.

Lauren's parents were proactive in their contact with school and also responded to invitations from school in relation to behaviour support and re-integration meetings (when Lauren received temporary exclusions). However, due to a lack of recognition of the potential significant harm being caused to Lauren there was no multi-agency forum established (e.g. a TAF) where parents and Lauren could engage and access co-ordinated support. This would also have provided an opportunity to evidence the impact of interventions that school had put in place.

- (vi) What is the role of social media in bullying and intimidation?**

In this case both police and school failed to recognise the significance and impact of cyber-bullying in addition to face to face intimidation and assault. There is little evidence that either agency has robust policies or levels of understanding of cyber-bullying and its impact on victims.

(vii) Are all agencies working in an integrated way to manage bullying and self-harm?

The practitioner event brought agencies together to look at these issues. It is apparent that the case has raised important issues for practice. Participants at the event demonstrated a willingness to work together to achieve a more integrated response.

(viii) Are there sufficient/accessible and appropriate services for victims of bullying and their families in the statutory and non-statutory sectors including mediation services?

The review identified the need for a directory of services or similar resource that can be used by professionals and families. The Board will wish to consider what form such a resource should take, this is therefore not included as a recommendation and appears in the wider learning section.

(ix) Did agencies attempt to understand Lauren's daily lived experience and act on her wishes and feelings?

There is little evidence to suggest that agencies sought Lauren's views about her situation and what would be most appropriate for her as a response. There is no record of attempts to understand Lauren's daily lived experience or the emotional impact that being subjected to intimidation on a daily basis had upon her wellbeing. The voice of the child (children) is largely absent in this case.

(x) Are schools (and other agencies) unduly influenced by individuals or groups within communities who exercise negative control (e.g. known offenders, anti-social individuals or groups, local people with negative community capital)?

This question was discussed at the learning event where participants said they are conscious of the potential influence on practice when dealing with families who are known for criminal and anti-social behaviour, although the subtle impact is difficult to evidence. The review suggests that that further work be undertaken to understand these issues and support agencies in developing responses.

(xi) What learning can be drawn from other serious case reviews/research in relation to the links between bullying and suicide in adolescents?

The NSPCC repository for the three years 2014-2017 contains no cases in which bullying was a key feature. There are several cases of adolescent suicide in the repository however the variables in these cases are wide ranging and would not add to the learning in this case.

There is evidence in the literature on child suicide that there is a relationship between child suicide and bullying however the links in this case are not strong enough to draw robust conclusions.

(xii) Were other events in Lauren’s life sufficiently recognised as troubling her and were these acted upon by agencies?

Agencies were largely unsighted on other events in Lauren’s life as she did not disclose aspects of her life to professionals or family members. Lauren’s GP was aware that she had experienced behavioural difficulties and had made referrals to support her, however Lauren did not disclose self-harm or suicidal thinking to her GP.

Opportunities to understand Lauren’s daily lived experience were not taken despite her receiving additional support at school. The coaching support she received focused only on school work and academic achievement and did not have a pastoral component.

Lauren did not discuss all aspects of her life with her parents although they were proactive in raising their concerns regarding bullying and intimidation at school

(xiii) Do GPs have a clear pathway in place to respond to concerns about low mood/emotional wellbeing?

The GP highlighted this is a significant issue. The ‘default’ position appears to be to refer to CAMHS because of the absence of other services or lack of knowledge of services available, including third sector and self-help services.

(xiv) Was information about self-harm sought and did this influence responses to Lauren’s low mood.

The GP enquired about self-harm although there was no disclosure from Lauren. Only after Lauren’s death did it become known that Lauren and Child 1 self-harmed together. A stronger focus on Lauren’s self-esteem and emotional well-being may have encouraged disclosure.

4. SUMMARY - WHAT DO WE LEARN FROM THE REVIEW

The review concludes that Lauren's tragic death could not have been predicted or prevented.

The review is in no doubt that from September 2015 until her death Lauren was subjected to ongoing bullying, intimidation and harassment by Child 2, Child 3 and others. The review has seen evidence of the intensity and frequency of this behaviour from September 2015 to February 2016 and has seen evidence that there was bullying behaviour before and after these dates.

The nature of the bullying and harassment took the form of cyber-bullying⁷ (threats and intimidation via technology); verbal and physical abuse and assault both in school and outside and criminal acts of assault and witness intimidation. The impact of the trauma associated with persistent bullying, harassment and intimidation on Lauren and Child 1's emotional well-being and mental health was never fully assessed or responded to.

Lauren had experienced emotional and behavioural difficulties before she transitioned to high school and, whilst she settled well following transition, she experienced some behavioural difficulties in her first year at high school which were picked up by her mother and reported to her GP who took action to have Lauren's emotional needs assessed. A referral to the school nurse was suggested by CAMHS although this never seems to have materialised into any form of emotional support service being made available to Lauren.

When Lauren's step-father first raised the issue of bullying with police and school in 2013 little concrete action appears to have been taken to understand what was taking place and the traumatic impact that this might have on Lauren's emotional wellbeing. A meeting with school at this point would have provided an opportunity to discuss the seriousness of the concerns and formulate a joint plan, which may have included assessment, to understand and address parental concerns and the views of Lauren.

From September 2015 until Lauren's tragic death police and school were aware of a number of serious incidents involving intimidation, harassment and assault on Lauren. Neither agency appeared to appreciate the significant impact that these events were bound to have on the emotional wellbeing of Lauren and neither agency took sufficient action to safeguard her.

As set out in Section 3 of this report there were a number of missed opportunities for police and school to share information in a timely manner and with a purpose that would have put the events in the context of Lauren's daily lived experience, there was a lack of professional curiosity as to how it would feel to be subjected on a daily basis to threats, harassment, intimidation and to live in fear of being further victimised and the impact that this may have on Lauren's resilience.

School commented that Lauren sometimes initiated disputes; that she was volatile and that she reacted to provocation. It is the view of the review panel that Lauren's disruptive

⁷ <http://www.bullying.co.uk/cyberbullying/>

behaviour may have been a way to draw attention to her situation and that it would not be unusual to see such behaviour in a young person who was vulnerable and at risk. This behaviour in itself should have warranted a review of Lauren's needs.

The review acknowledges that school were not informed on every occasion by police when significant events occurred outside of school, this is particularly the case in relation to the incident that took place in December 2015 which ultimately led to no further action because of police errors and a failure to fully investigate the allegations.

Lauren's family told the review that they felt powerless to stop the bullying behaviour and that they had little help or support from school or police in preventing the behaviour. They tried to keep Lauren safe in the best way that they could by talking to her and taking up her concerns with school and police. However this did not result in a robust safety plan for Lauren.

The review found that links between police and school were inconsistent and that neither agency had a clear plan for information sharing. The existing police protocol was not followed in this case which would have included proactive safety planning, involving parents in a planned way, listening to the voice of the child, establishing multi-agency meetings or raising a safeguarding concern.

The review has noted that the group of girls who intimidated and harassed Lauren and Child 1 were children at the time of these events. Despite the nature of their actions their vulnerabilities and risks should also have been recognised and addressed.

5. FINDINGS AND RECOMMENDATIONS

5.1 Finding 1 – Police and School placed insufficient focus (in relation to bullying and intimidation) on the safeguarding needs of Lauren

Action taken by school to address the bullying and harassment of Lauren did not fully safeguard her. Lauren continued to be subjected to harassment and intimidation whilst on the school premises both via cyber-bullying, the attitudes and actions of other pupils, the creation of a power imbalance and by not asking her what she wanted or what she thought the school could do to keep her safe.

When Lauren reported assaults that had taken place outside of school in October and December 2015 police did not give full consideration to Lauren's safeguarding needs and on the second occasion did not inform school of the incident.

The trauma and emotional impact of sustained intimidation was not recognised or explored by the school or police.

Despite efforts being made to ensure that Lauren was able to attend lessons and maintain her academic school life, there is little evidence of pastoral support or attempts to explore what she wanted and what might help her. There is no indication that Lauren was offered referral to counselling or mental health services or any other form of pastoral support.

Lauren's disruptive and rebellious behaviour was perceived as being assertive rather than exercising professional curiosity as to whether this behaviour could have been a demonstration of Lauren's distress.

When Lauren (and Child 1's) parents reported ongoing concerns regarding cyber-bullying and assaults outside of school, the school missed opportunities to recognise the potential for significant harm and to convene a multi-agency meeting with a view to making a referral to Children's Social Care.

School were proactive in liaising with police regarding Child 2's bail conditions and ensuring that these were not breached.

Child 1 told the review that the bullying and intimidation stopped when Child 2 was on bail. This is important learning.

5.1.1. Recommendation 1 – National

The Chair of the LSCB should seek assurance from the Department for Education that all schools, not only those in the public sector, are clear about their responsibilities to ensure that children are safe and are safeguarded in relation to bullying and intimidation. Current guidance is ambiguous in relation to the role of state schools, private schools and academies in this regard.

5.1.2. Recommendation 2 – Local

The LSCB should be assured that all schools, irrespective of their status, have clear policies and guidance in relation to bullying. Policy and guidance should make explicit reference to

reviewing individual incidents of bullying and intimidation to assess the potential for significant harm. They should set out clearly the process for consideration of raising concerns and under what circumstances safeguarding referrals will be made. They should also include a clear statement regarding when and under what circumstances multi-agency meetings will be called to discuss individual cases.

5.1.3. Recommendation 3 – Local

The LSCB should be assured that all schools have clear policies and take appropriate action in relation to cyber-bullying; this should include the use of powers to remove property and report criminal behaviour.

5.1.4. Recommendation 4 – Local

The LSCB should hold schools to account, via the Emotional Health and Wellbeing Board in relation to maintaining a culture of care and concern for the emotional and physical well-being of the child, in line with the Healthy Schools programme. Schools should ensure that a culture of care is balanced with and of equal importance to the achievement of academic results.

5.2 Finding 2 – Police action to investigate allegations of assault (December 2015) lacked rigour and did not comply with standards. Furthermore police failed to notify school of the assault thereby further compromising Lauren’s safety and schools ability to respond appropriately.

Police failed to recognise the traumatic impact of the intimidation and harassment on Lauren and Child 1. Their responses to incidents that took place both on and off school premises did not safeguard either child in relation to bullying.

The length of time that police took to investigate the incident reported by Child 1 and Lauren in December 2015 was unacceptable and contributed to both children feeling that they had no protection from their aggressors.

5.2.1. Recommendation 5

The LSCB should be assured that police action in relation to allegations of assaults on children (irrespective of the age of the alleged perpetrator) should always be investigated immediately and should pay due regard to the potential intimidation of victims.

5.2.2. Recommendation 6

The LSCB should be assured that, when a child is subject to police bail and continuing to attend school the conditions of bail enable all children to function effectively in the school environment. Schools and police should develop a specific policy that sets out the joint management of children who are on bail and in school and any positive or negative impacts on all the children involved.

5.2.3. Recommendation 7

The LSCB should be assured that any alleged assault on a child should result in a VPA being generated to appropriate agencies.

5.2.4. Recommendation 8

The LSCB should be assured that schools understand and act on their responsibilities to safeguard children at risk of significant harm by seeking multi-agency meetings to discuss concerns and, where necessary contacting the local authority to discuss whether a multi-agency response is appropriate, whether via early help and intervention or statutory Social Work intervention.

5.3 Finding 3 – Absence of the voice of the child

There is little evidence that attempts were made by any agency to seek and listen to the voice of Lauren throughout the period in which she was the victim of harassment and intimidation.

Parental concerns were listened to however they did not feel that either police or school made sufficient effort to act on their concerns. Parents were frustrated and felt a sense of helplessness.

The voice of Lauren was not sought, there is no sense in the case of her being asked what she wanted and what might have worked for her. No-one explored whether anything else was happening with Lauren that may have contributed to her feelings of hopelessness.

Opportunities were not taken to understand Lauren's life in the wider context and to discuss any concerns she may have had about other aspects of her life including thoughts of self-harm.

5.3.1. Recommendation 9

The LSCB should be assured that schools give primacy to seeking and listening to the views of children, understanding their daily lived experience and where appropriate and warranted acting on the child's voice.

5.4 Wider Learning

5.4.1. The subtle influence that may be brought to bear on professionals who are working with anti-social and criminal families was recognised by practitioners participating in the review. It was suggested that a workshop/learning event be established to explore the issues of potential pressures, bias and intimidation that practitioners can experience and ways to address this.

5.4.2. The definition of bullying contained in national and local guidance requires further discussion. Distinctions are made between bullying and criminal acts however the dynamic and interaction associated with bullying requires ongoing professional conversations and the involvement of other agencies to 'check out' professional judgment. A forum in which issues can be discussed before raising concerns would be useful. Practitioners in all agencies should have clear guidance on the difference between bullying and criminal

behaviour and the actions they should take to deal with both taking into account the potential for significant harm.

5.4.3. The case highlights the importance of the role of the school nurse. In this case the school nurse made initial contact however did not follow up when there was no response. The Board should satisfy itself that all professionals are aware of the role of the school nurse, particularly in relation to liaison and follow up with families.

5.4.4. The availability and range of services to vulnerable young people with emotional and mental health concerns needs clarification. If not already available an up to date service directory or similar resource would be a useful addition to the information available to professionals working with young people.

6 RESOURCES, GUIDANCE AND TOOLKITS

The following resources and guidance have been used in research for this review, these resources will be useful in constructing an action plan to accompany the review report and recommendations.

1. Theme: Child Self Harm and suicidal thinking in the context of safeguarding

<https://www.nice.org.uk/guidance/CG16>

<https://www.nice.org.uk/guidance/cg133/chapter/guidance/RCGP-NSPCC-Safeguarding-Children-Toolkit.pdf>

Papyrus: National Charity Working to prevent young suicide – a range of resources available

<https://www.papyrus-uk.org/about>

<https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/self-harm/>

<http://www.themix.org.uk/mental-health/self-harm>

<https://youngminds.org.uk/find-help/for-parents/parents-helpline/>

http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf

2. Theme: Bullying, Intimidation and Harassment in Schools and Social Settings

<https://www.gov.uk/government/publications/governance-handbook>

<https://www.anti-bullyingalliance.org.uk/>

<https://www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/bullying-and-law/what-does-law-say-about-bullying>

<https://www.papyrus-uk.org/news/item/papyrus-reports-rise-in-students-seeking-help-with-exam-stress>

<https://www.papyrus-uk.org/>

<https://www.childnet.com/ufiles/Cyberbullying-guidance2.pdf>

<https://www.childline.org.uk/info-advice/bullying-abuse-safety/types-bullying/>

<http://www.bullying.co.uk/>

<https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/bullying-and-cyberbullying/>

<http://www.nhs.uk/Livewell/Bullying/Pages/Antibullyinghelp.aspx>

www.saferinternet.org.uk/about/helpline

<http://ies-news.info/wp-content/uploads/2017/05/i-Art-A6-Flyer-FINAL.pdf>