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Anonymisation

In order to protect the privacy of the family, this report has been anonymised for publication.

At the suggestion of her mother, the young woman who is the subject of the review is referred to by the pseudonym ‘Alex.’

Other family members are referred to in terms of their relationship to Alex, with that name capitalised– Mother, Step-Father, Step Grand Uncle etc.

The school Alex attended is not named, in order to protect Alex’s identity. Staff at the school are referred to by a non-specific description of their role e.g. ‘Senior Teacher B.’

References to towns or other locations that could identify Alex or her family have been avoided.

Specific dates, such as the date of her death, which could have allowed Alex to be identified have been avoided and instead more approximate dates are used – ‘spring 2014.’
1 Background to the Serious Case Review.

1.1 Events leading to this review

Alex, who was 15 years old at the time of her death, lived with her mother and step-father. Prior to her death there was no involvement with services other than universal services. At 8.15 am in spring 2014 she was found dead in her bedroom by her step-father with a scarf tied around her neck. According to parents, the previous evening had been unremarkable and Alex had last been seen by her parents at 9pm when she retired to her room.

On examination of her body at the Emergency Department, Police reported 5 faint linear marks on Alex’s left forearm. It subsequently emerged that three of Alex’s friends had approached school staff in October 2013 to report that she had been self-harming.

Police investigations commenced and a notebook was found in her bedroom with a note in it which suggested she may have been a victim of abuse. Further forensic work with mobile telephones and laptops indicated Alex had been receiving numerous messages from a man subsequently identified as her Step Grand Uncle, a relative who lived in the south of England. As a result, this man was arrested by Kent Police and indecent images of children, including images of Alex were recovered from his laptop. The man took his own life whilst on Police bail.

A subsequent inquest into her death gave a narrative verdict and ruled that ‘Alex took her own life by hanging.’ The Coroner was not able to determine what her intention was at the time she took this action.

Since Alex’s death her school have developed excellent policies and guidance on ‘self-harm’ which will be used to improve practice across Nottinghamshire.
1.2 Decision making process

This case was first considered by the Serious Incident Review sub group on 7th October 2015, when a decision was made to recommend a serious case review (SCR) be carried out. A summary of the recommendation was passed to the independent chair of Nottinghamshire Safeguarding Children Board on 13th October 2015 and following a request for additional information on 5th November the Chair confirmed his decision to carry out an SCR. It was judged that the criteria for undertaking a SCR were met – ‘abuse or neglect of a child is known or suspected and the child has died – including where a child has died through suspected suicide.’ On 17th November 2015 Ofsted and the National Panel of Independent Experts were notified of this decision.

There was a delay of 20 months between Alex’s death and the decision to conduct a serious case review in November 2015. This issue is discussed later in the report.

The review has been conducted in line with the principles set out in Working Together 2015 and Nottinghamshire Safeguarding Children Board Interagency Procedures to Safeguard Children. The purpose of reviews is to identify improvements that are needed and to consolidate good practice. Reviews look at what happened in a case and why, and what action will be taken to learn from the review findings.

1.3 The Independent Author.

The author of this overview report is Dr John Bradley, a consultant educational psychologist with over 35 years experience. He began his career as a teacher, in both mainstream and special schools. He is a former Principal Psychologist who worked for local authorities and the Ministry of Defence. He is now an independent consultant psychologist for The Educational Guidance Service (Halifax.) He has been the author of individual agency reports in six previous serious case reviews and three domestic homicide reviews. He is the author of an investigation undertaken at the request of the Secretary of State for Education into contact by Jimmy Savile with
The author is mindful of the advice of the National Panel of Independent Experts on Serious Case Reviews that the aim is:

‘…to produce a clear and succinct account of what happened and why, and what needs to change to prevent it from happening again.’

2 Terms of Reference.

The following terms of reference were determined by Nottinghamshire Children’s Safeguarding Board.

The initial work carried out by the Serious Incident Review Sub-Group to gather information and subsequent follow up enquiries revealed that there had been very little contact with the family by agencies. Two key practice episodes were identified that require further examination.

1) Examine the effectiveness of the management of Step Grand Uncle as a registered sexual offender following his conviction in 2003,
   a) in particular,
      • the assessment of the risk he posed,
      • compliance with Kent Police Policy and MAPPA guidelines in place at the time
   b) Were those responsible for his offender management aware of any potential risks to Alex, or could have reasonably expected to be aware?
2) Examine the actions of Alex’s school following the disclosure made to them by her friends that Alex was self-harming.

   a) Consider any learning which the school has put in place as a result of this incident.

   b) Examine this response and best practice from other areas to make recommendations as to how responses to this type of disclosure can be improved across the Education sector.

   c) What provision did the school have in place for covering e-safety and keeping safe more generally with students, have they reviewed their processes and is there best practice which can be shared across the Education sector?

In addition:

3) Was there anything which could have been done to support the parents when they became aware of Step Grand Uncle’s offending which would have helped them to protect Alex?

3 Subjects of the review - Anonymity chart

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Relationship</th>
</tr>
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<tbody>
<tr>
<td>Alex</td>
<td>The subject of the review</td>
</tr>
<tr>
<td>Mother</td>
<td>Mother of Alex</td>
</tr>
<tr>
<td>Step Father</td>
<td>Mother’s partner, Step-Father of Alex</td>
</tr>
<tr>
<td>Father</td>
<td>Father of Alex</td>
</tr>
<tr>
<td>Step Grand Uncle</td>
<td>Paternal Step Grand Uncle of Alex and Uncle of Step Father</td>
</tr>
<tr>
<td>Step Grandmother</td>
<td>Step Grandmother of Alex and Mother of Step Father</td>
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</tbody>
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4 Methodology

The overview author worked closely with the Development Manager of the Nottinghamshire Safeguarding Children Board (NSCB.) His specialist knowledge as a former senior police officer was particularly useful in considering the role of Police in this case.

4.1 Contributing Agencies and the SCR Panel

The following local agencies were asked to provide an information report of their contact with Alex and her family:

- School 1
- Nottinghamshire Children’s Social Care
- Local NHS Foundation Trust
- Nottingham University NHS Trust
- Nottinghamshire Healthcare Foundation Trust
- Alex’s GP Primary Care Centre
- Nottinghamshire Police
- Kent Police

The author was also provided with detailed minutes of the Initial Case Discussion and Final Case Discussion meetings held to respond to the unexpected death of a child.

Three agencies were found to have had a significant involvement in the case: School 1 (Alex’s school); Nottinghamshire Police (who dealt with the local investigation following her death) and Kent Police (who had been responsible for the offender management of Step Grand Uncle and the subsequent investigation into his contact with Alex.) These agencies were asked to conduct an individual management review (IMR) and provide a report signed off for accuracy by a senior responsible officer.
A briefing event was held for the agencies asked to provide Individual Management Reviews. This was also attended by the Acting Director Education Standards and Inclusion. A panel was established to oversee the review. This comprised:

Manager, Nottinghamshire Safeguarding Children Board (Chair)
Development Manager, Nottinghamshire Safeguarding Children Board
The overview author
Acting Director Education Standards and Inclusion Nottinghamshire County Council
The Principal of School 1
The author of the Education IMR
The author of the Nottinghamshire Police IMR
The author of the Kent Police IMR
A representative of the commissioner of Kent Police IMR

The Chair of Nottinghamshire Safeguarding Children Board also liaised with the Chair of Kent Safeguarding Children Board.

4.2 Parental involvement

Alex's mother met with the overview author and the NSCB Development Manager on two occasions – at the start and towards the end of the review process. Her views are reported in the body of the report.

Alex’s father was invited to meet with the overview author and the NSCB Development Manager but declined.

4.3 Limitations in the investigation

The period of 20 months between Alex’s death in 2014 and the decision to conduct a serious case review in November 2015 may mean that some participants’ memories of events are not as clear as they would have been if spoken to sooner. More significantly, a key member of staff at School 1 has now left the school and is no longer in the country. He could therefore not be interviewed.
5 Facts of the case

5.1 Culture, ethnicity and disability

Alex is described as being of White British heritage. She attended a school where most pupils are also White British\(^1\). She had a mild specific learning difficulty that was well managed by her school. It is not known whether religion was a feature in Alex’s life but Police records describe her as ‘Christian.’

5.2 The period prior to Alex’s death

Alex lived with her mother and step-father. Her parents had separated when she was young but she had contact with her father. Alex only had contact with universal services prior to her death.

Alex joined Year 7 of School 1, her local secondary school, in September 2009. Her attendance averaged around 94%. Alex’s absences were a mixture of odd days of illness and a family holiday in term time.

In November 2012 her mother raised concerns about Alex’s reading. She was struggling to read black text on a white background\(^2\). An in-school assessment identified mild dyslexia and Alex was provided with her work on coloured paper (to reduce contrast) and granted exam dispensations – extra time and the services of a reader and scribe in exams, if requested. Her teachers were provided with advice on supporting Alex’s specific learning difficulty. Alex passed 2 GCSEs at grade C in Year 10 and was posthumously awarded a further 5 GCSEs at grade C or better in Year 11 on the basis of work already submitted.

Alex was a Girl Guide and helped at the local Brownie pack. She occasionally played for the school netball team and was working for her Duke of Edinburgh Award.

Alex had some limited contact with her GP where she usually attended with her mother. Her GPs have reported that there were no indicators of concern during these

\(^1\) Ofsted (2014) Inspection report on The School 1
\(^2\) Difficulty reading high contrast text is sometimes associated with Irlen syndrome or ‘visual stress,’ a condition often associated with dyslexia.
appointments and no concerns about safeguarding or other issues possibly connected with her death.

In School 1’s IMR Alex’s form tutor for Years 10 and 11 is quoted as describing her as follows:

‘I was Alex’s Form Tutor since Alex was in year 10. At the start of year 10 Alex was a popular member of the tutor group, who was always happy and quiet; which was her manner. She was in a relationship with a popular year 10 boy and Alex had grown in confidence due to this, in my opinion. Alex was always well turned out doing her hair and makeup each day.

I [did not have contact with her] from Easter 2013 until January 2014. [After] January 2014 I did notice some changes to Alex. She was no longer in a relationship, but was still happy and looking forward to school events that were coming up for her. This included the [school trip] and the school prom. However, Alex did not take as much pride in her appearance as she did in Year 10, as she was wearing less make-up and her hair was not as made up as she had been, when she was in year 10. However she was still the same happy girl, always talking about the prom dress she was going to wear. I had no safeguarding concerns about Alex. I had no knowledge of any self-harm concerns raised about Alex. I felt Alex’s death was completely out of the blue.’

A key event occurred in October 2013. Staff Member 1, a senior non-teaching support member of staff, was approached by three of Alex’s friends who reported that she was self-harming. He sent an email to Senior Teacher B saying:

‘Hi, 3 students have come to me at the end of the day today to report that Alex is self-harming. I will pick it up tomorrow and contact home.’

Senior Teacher B reports that he later met with Staff Member A and advised him of the appropriate next steps - to speak to the Alex’s parents and to Alex herself to see if support was required. There is no record of that discussion and no record or memory of the nature of the self-harm that was reported, or which pupils reported it.
Staff Member A is no longer in the country and therefore could not be interviewed about these events.

It appears that Staff Member A tried to phone parents but did not get through to them. He appears not to have contacted them later, either by phone or letter. There is no record of any contact with Alex’s parents and School 1 IMR notes:

‘…record keeping of the phone call home was not made at the time of Alex’s reported incident of self-harm. Staff Member A did not record whether he had made actual contact with Alex’s parents, and this information was not placed on the communications log on SIMS (School Information Management System). For if it had been recorded accurately on the day of the self-harm incident Staff member 1 would have known whether he needed to attempt to contact parents again.’

The School 1 IMR goes on to report that at an earlier interview, following Alex’s death:

‘Staff Member A recalled he did speak with Alex and asked her if she needed support with regards to self-harming, Alex was offered both CASY\(^3\) counselling and to speak with the School Nurse, but Alex declined having any support in school.’

Again there is no record of this conversation and apart from the very brief email to Senior Teacher B, information about this concern does not appear to have been shared with anyone. The information report from Nottinghamshire Healthcare Trust found no record of school nurses being informed of Alex’s self-harm and her form tutor was not informed.

\(^3\) CASY is an independent counselling service commissioned by the School 1
There is no record of any further follow up of this disclosure either with Alex or the friends who reported their concern. Senior Teacher B did not follow up the matter with Staff Member 1.

When interviewed by Nottinghamshire Police following Alex’s death Staff member 1 was not able to recall which students had reported their concerns to him. Police inquiries identified a student who had reported the self-harm. This student said ‘she had asked Alex about it and she had just said she was ‘not getting on with her family.’ Another student told Police that ‘Alex had cut herself in Year 10 and the student had said to her ‘You can talk to me about anything’ to which Alex replied ‘Yeah I know I can’ but nothing further was said or disclosed.’ Another student told Police that Alex had received abusive comments from some students after a rumour had circulated that she had an alleged sexual encounter with a boy.

Nottinghamshire Police went on to interview eight of Alex’s close friends, including an ex-boyfriend by way of a standardised questionnaire and Nottinghamshire Police IMR reports:

‘They all generally described her as happy and outgoing. There is a suggestion that she was subject to some bullying but no specific details. The boys apparently teased her about her weight but this was behind her back and it isn’t known if she ever knew about it. None of her friends had been asked by Alex to keep secrets for her and she hadn’t disclosed any abuse by anyone. There were rumours that she had had sex with an older boy in a caravan during the summer holidays in 2013 but nothing was confirmed and Alex didn’t disclose any details about it to her friends.’

‘Generally she was described as confident, outgoing and happy. Some said she could sometimes be moody but those that remember speaking to her the day before she died said she appeared happy.’

Shortly before she died, Alex had been on a school trip. The member of staff looking after the girls on the trip reported:
‘Alex never raised any concerns to me during the trip. She progressed slower than others, with [the activities], but Alex was not alone, as she was with another student of a similar ability… and she had a ‘give it a go’ spirit. In the evening she always got involved with evening activities, socialising with her friends. She was never isolated from the group. She was always well turned out, applying make-up. I had no concerns about Alex during or after the trip.’

5.3 The period following Alex’s death

In spring 2014 at around 8.15 am Alex was found dead in her bedroom by her step-father with a scarf tied around her neck. Nottinghamshire Police and East Midlands Ambulance Service were called to the family’s home. Alex’s parents told police that the previous evening had been unremarkable and Alex had last been seen by her parents at 9pm when she retired to her room.

Police report that on examination of her body at the Emergency Department, five faint linear marks on Alex’s left forearm were noted. ‘One looked like it had broken the skin at some point and possibly bled – possibly self-harm marks.’ In my meeting with Mother she told me that she had not seen any signs of self-injury and no signs that Alex was covering up her arms to conceal anything.

When Police examined Alex’s room they found handwritten notes suggesting that she was very unhappy about something that was happening to her and wanted to get away from the situation.

Nottinghamshire Police examined Alex’s iPhone and found that it had been used extensively to view internet websites on depression. These searches started around 8th February 2014.

The police discovered that Alex had posted quotes on her Twitter account suggesting that she was feeling a pain that others could not see.

Further examination of Alex’s phone showed repeated contacts from Step Grand Uncle.
His messages to Alex included:

‘Think hard Alex. You don’t have to do anything! Just being pleasant and talking to me could get you so much. I already have euros for your trip.’

‘[Name] says you want money for the weekend. If you text me your bank details I would send you some. No strings. I love you that’s all there is to it xx.’

Nottinghamshire Police concluded:

‘Paternal step-grand uncle may have been grooming her in the form of giving Alex money and buying her presents. All phone contact from him, generally in the form of text messages had been unreciprocated by Alex. The last message was dated [the day she died].’

Enquiries revealed that Step Grand Uncle had previous convictions for distributing indecent images of children and indecency with children. It was also established that although he lived some distance away in another part of the country, he had regular contact with the family and had been on holiday with them.

Nottinghamshire Police liaised with Kent Police to pursue enquiries about Step Grand Uncle.

5.4 Step Grand Uncle – his criminal record, offender management and contact with Alex

Step Grand Uncle was Step Father’s uncle and so was Alex’s paternal step-grand uncle.
Step Grand Uncle lived in Kent but his mother, Step Great Grandmother, lived in Nottinghamshire.

5.5 Step Grand Uncle’s criminal record
In June 2003 Step Grand Uncle pleaded guilty to charges of indecent assault on a girl under 16; gross indecency to a child and making indecent images of children. Other offences were left to ‘lie on file.’ The victim was a child known to him who was between 12 and 14 at the time of the offences. He had apparently induced the victim by buying CDs and clothes for her. After committing the offences he made threats to the victim that if she told anyone about it he would post the pictures on the internet. He did later post the pictures on the internet.

Step Grand Uncle was sentenced to six months imprisonment and released in September 2003 and was required to sign on the Sex Offenders Register for a period of 7 years.

5.6 The management of Step Grand Uncle as a registered sex offender

Shortly before his release in September 2003 Step Grand Uncle was risk assessed by Kent Police using the Violent and Sex Offender Register (ViSOR) matrix. He was assessed as ‘low risk’ – meaning he was judged to show no significant current indicators of risk of harm. The fact that his convictions related to an acquaintance and did not involve physical violence were factors in him being judged ‘low risk.’

As a ‘low risk’ subject he was required to register with the police annually, notify them of any changes of address and other addresses he was likely to visit for more than 7 days in any year and also undergo an annual home visit.

Step Grand Uncle was next risk assessed using the Matrix 2000 risk assessment in December 2009. He was again identified as low risk. The Kent Police IMR comments that:

‘There is no record of additional formal risk assessments being carried out between these dates (2003 and 2009) although, no doubt, risk was in the mind of the visiting officers throughout that period but was not recorded as a ‘Risk Assessment’.
In February 2008 Step Grand Uncle declared Step Great Grandmother’s address in Nottinghamshire as one that he would attend for more than 7 days a year. However no questions were recorded about access he may have had to children when in Nottinghamshire. It was recorded that he told police his family ‘were aware of his situation’.

In 2008 officers became aware that Step Grand Uncle was in a sexual relationship with a married woman. He told officers that the woman’s husband knew about the affair and was not concerned. However when the relationship broke down Step Grand Uncle sent compromising photos of the woman to her husband, apparently by email. This resulted in the husband attending Step Grand Uncle’s house and, following a disturbance, being arrested.

Step Grand Uncle was removed from the Sex Offenders Register on 11 May 2010 and the record was archived.

5.7 **Step Grand Uncle’s contact with Alex’s family**

The Nottinghamshire Police IMR gives the following account of what they understand to have been Step Grand Uncle’s contact with the Alex’s family.

‘Mother believes she first met Step Grand Uncle when Alex was around six years old and her youngest daughter had recently been born in 2002… she had heard from Step Grand Uncle’s mother [Step Great Grandmother] that he had been in trouble with the police over something to do with a girl …but believed Step Grand Uncle would not have been capable to do anything due to a heart condition.

Mother did not consider Step Grand Uncle’s offending history to be serious but it is not known exactly how much she was told about it by his family.

As a family they saw Step Grand Uncle about three times a year when he visited his mother in Nottinghamshire. Mother was aware that Step Grand
Uncle’s wife had left him due to what had happened with the girl, and that his own sons no longer spoke with him either.

They first went away as a family on holiday with Step Grand Uncle in 2012, having previously met up with him several times in Kent. They had also gone to France for the odd day and he would join them. In 2013 they had 5 days with him in Whitstable and were due to see him in Nottinghamshire again in June 2014 and later on holiday in August 2014... Step Grand Uncle would ring and speak to all the family on occasions and she knew he rang and texted Alex.

Step Father knew about Step Grand Uncle’s offending history but again did not think it was serious.’

5.8 Step Grand Uncle’s arrest and subsequent death

On 1st May 2014 Kent Police were contacted by Nottinghamshire Police following the death of Alex. Later that day Kent Police Paedophile Online Investigation Team (POLIT) officers executed a warrant at Step Grand Uncle’s address and arrested him on suspicion of sexual assault. A quantity of computer equipment was seized from the house for analysis. After interview, during which he denied any offences, he was released on bail pending analysis of the computers. He returned on bail and was further questioned about his involvement and some images that had been found on his computer. He answered ‘no comment’ to all questions put to him. He was bailed again to allow further analysis.

Under examination a number of indecent images of children were discovered. These included images judged to be levels A, B and C.

Level C is the lowest level of illegal images and it covers erotic posing by children.
Level B covers sexual activity without penetration.
Level A includes instances of penetration and also incidents involving animals or humiliation or torture.
Within these images were a large number of personal photographs which on examination included some images of a young girl who appeared between 7 and 10 years old apparently taken in a bedroom. These images fell within the level C category. These images were identified by Alex’s family as pictures of her taken about 2007 or 2008. The bedroom was identified as Alex’s bedroom at her home in Nottinghamshire. Kent Police conclude that the images were taken on Step Grand Uncle’s camera, during the period Step Grand Uncle was subject to sex offender registration.

On the day he was due back on bail, 13 November 2014, Step Grand Uncle sent a text message to his legal advisor asking him to inform the investigating officer that he would not be attending the police station that morning. Police attended his home address and found him dead on the bed having apparently consumed a large quantity of tablets. Kent Police report that at Step Grand Uncle’s inquest the coroner returned an ‘Open’ verdict. However the coroner commented that ‘he was satisfied that Step Grand Uncle had fully intended and took the necessary steps to take his own life.’

6 Contextual information: Self-harm and suicide by young people

Before turning to the questions posed in the terms or reference it may be helpful to review briefly what is known about self-harm and suicide by young people.

It is very difficult to be sure about the number of deaths that could be described as suicide. The Department of Health\(^4\) is aware of this difficulty and recognises that incidence figures are probably an underestimate. Several writers suggest there is reluctance by coroners to label a death as suicide, particularly in the case of young people. It should be remembered that the coroner in Alex’s case did not give a verdict of suicide but rather provided a narrative verdict. With that caveat, the Department of Health reports suicide rates for 15 – 19 year old females as being

\(^4\) Department of Health ‘Statistical update on suicide’ February 2015.
around 2 per 100,000. This makes it a statistically uncommon event when compared to the most at-risk group, 40-44 year old males, where the incidence is 24 per 100,000.

The incidence of self-harm by young people presents a very different picture. Self-harm is defined by National Institute for Clinical Excellence as ‘self-poisoning or injury, irrespective of the apparent purpose of the act.’ The National Child and Adolescent Mental Health Support Service (2011)\(^5\) quotes data suggesting a prevalence of self-harm among 11-15 year olds without any diagnosed mental health issues as 1.2% (1,200 per 100,000) this rises to 9.4% (9,400 per 100,000) for young people with an anxiety disorder and 18.8% (18,800 per 100,000) for those with depression.

Hawton et al (2000)\(^6\) suggest that one in ten UK teenagers deliberately self-harm, and the average age to start self-harming is 13, with the prevalence of self-harming behaviour being three times higher in girls than in boys. The Report of the National Inquiry into Self-harm among Young People\(^7\) (Mental Health Foundation, 2006) estimated that one in 15 young people self-harm, with the average age of onset being 12 years old. Public Health England reports even higher levels of self-harm – quoting figures of one in six\(^8\).

Even when we take into account uncertainties about these statistics, and the overlapping age groups being reported, it is clear that suicide by young women is a relatively uncommon event while self-harm by young people is much more frequent. The Hawton et al figures, which are midway between the higher and lower estimates,

\(^5\) National CAMHS Support Service (2011) Self-harm in children and young people handbook


\(^8\) Public Health England gives as the source for this claim ‘Health behaviour in school-aged children: world health organization collaborative cross-national survey.’ However the overview author has not been able to find or verify this data.
would imply that in every secondary school class of thirty pupils there could be three pupils who would at some point commit self-harm.

There is no clear agreement about the links between self-harm and suicide. Some researchers\(^9\) view self-harm as being quite a different clinical issue to suicide. From this perspective self-harm is seen as a coping mechanism – a method of relieving stress. As such it is seen as a mechanism to make life bearable rather than to end it. For others however self-harm and suicide should be understood as being part of the same continuum, both being responses to distress\(^10\).

The University of Oxford Centre for Suicide Research has undertaken large scale studies of suicide by under 25s in England\(^11\)\(^12\)\(^13\). They found that just under half (44.8%) of the young people had a history of previous self-harm. 22% had carried out multiple episodes and 26% had self-harmed within the previous year. The Royal College of Psychiatrists reports that ‘The risk of suicide (by young people) in the first year after self-harm is between 60 to 100 times the risk of suicide in the general population.’\(^14\)

In Alex’s case it seems reasonable to see her self-harming as a precursor to her death by her own hand and to suspect that similar issues were behind both actions.

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\(^9\) See for example Social Care Institute for Excellence (SCIE) 2005 ‘Deliberate self-harm among children and adolescents: who is at risk and how is it recognised?’

\(^10\) NSPCC (2009) Young people who self-harm: Implications for public health practitioners


\(^13\) Fortune, S., Stewart, A., Yadav, V., Hawton, K. Suicide in adolescents: using life charts to understand the suicidal process. (2007) *Journal of Affective Disorders*, 100, 199-210

Research\textsuperscript{15} suggests an overlapping list of risk factors for both self-harm and suicide. These include:

- mental health problems including depression
- family issues (criminality, poverty)
- disrupted upbringing
- physical or sexual abuse
- having worries about sexual orientation
- family relationship problems
- self-harm in a family member
- drug use
- low self-image and low self-esteem.

Other research\textsuperscript{16} has highlighted the strong links between childhood abuse and self-harm.

\section{Analysis}

This report now considers the questions raised by the safeguarding board in their terms of reference for the review.

\subsection{Examine the effectiveness of the management of Step Grand Uncle as a registered sexual offender following his conviction in 2003}

\subsection{The assessment of risk Step Grand Uncle posed and his management}

On release, Step Grand Uncle was managed as a Registered Sex Offender by Kent Police under the terms of the Multi-Agency Public Protection Arrangements

\textsuperscript{15} The child and adolescent self-harm in Europe seven year study (2005). National Children’s Bureau

(MAPPA). The Kent Police IMR author commissioned an evaluation of Step Grand Uncle’s management which concluded ‘that there was an appropriate level of visits and the subject matter discussed at the visits was reasonable.’ However the IMR author also identifies weaknesses in Step Grand Uncle’s management and concludes that ‘records appear to indicate that officers were recording the welfare of the subject and his feelings and wellbeing but could have been more intrusive in their visits.’

The Kent Police IMR author makes some important observations about the episode involving Step Grand Uncle, a married woman with whom he had an affair and her husband. When the relationship broke down Step Grand Uncle sent compromising photos of the woman to her husband, apparently by email. This resulted in the husband going to Step Grand Uncle’s house and, following a disturbance, being arrested.

The Kent Police IMR points out that this episode revealed some similarities to his previous method of offending against his previous child victim – the taking of intimate images, then threatening to share them, and then doing so. The report notes that ‘This may be part of his controlling nature and is certainly similar to his actions in 2008.’ This interpretation also raises questions about the nature of his contact and offending with Alex. We know that Step Grand Uncle took indecent images of Alex and it remains a possibility that he used them, as he had done on these earlier occasions, to threaten and exert control over her.

The 2008 episode also revealed that Step Grand Uncle had access to the internet at a time when the visit notes by Kent Police officers report that he had no internet access.

The Kent Police IMR goes on to identify another weakness in Step Grand Uncle’s management at this time:

‘It was recorded that the woman friend had children and although some questions were asked around access to the children no consideration was made regarding child protection referrals for those children. It is unclear to the Reviewing Officer what level of knowledge the woman friend had with regard
to Step Grand Uncle’s convictions. It was recorded on records that ‘she knew of his situation’ - this should have been explored further.’

It is worthwhile examining the nature of ‘risk assessment’ in this context. Step Grand Uncle was categorised as ‘low risk’ on the basis of standard assessment tools. The Risk Matrix 2000 (RM2000), used in 2009, is a statistically-derived risk classification process for men who have been convicted of a sex offence. It is an approved tool for use in the MAPPA process. It is what is termed a ‘static’ assessment tool – it uses simple factual information about offenders’ past history to divide them into categories that differ substantially in their rates of reconviction for sexual or other violent offences. The validity and reliability of the tool was tested using a large national sample of offenders who were followed for nearly 20 years after assessment\textsuperscript{17}.

Thornton (2007)\textsuperscript{18} examined re-offending rates for sexual offenders assessed using Risk Matrix 2000 with the following results:

<table>
<thead>
<tr>
<th>RM 2000</th>
<th>5 years re-offending rate</th>
<th>15 years re-offending rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offenders assessed as ‘Low risk’.</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Offenders assessed as ‘Medium risk’.</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Offenders assessed as ‘High risk’.</td>
<td>49%</td>
<td>55%</td>
</tr>
<tr>
<td>Offenders assessed as ‘Very high risk’.</td>
<td>85%</td>
<td>91%</td>
</tr>
</tbody>
</table>


This and other research suggests that while static, statistically derived, risk assessment tools such as RM2000 are very effective in distinguishing between groups with different likelihoods of re-offending, ‘low risk’ should not be misunderstood as meaning ‘no risk.’ More than 1 in 10 low risk offenders are likely to re-offend within 15 years.

Given that ‘low risk’ does not mean ‘no risk’, it is important that those managing sex offenders are alert to the significance of continuing sexually coercive and threatening behaviour, such as that shown by Step Grand Uncle in 2008. This event should, at the least, have led to more intrusive enquiries about his contact with children and young people. As more recent MAPPA guidance\textsuperscript{19} notes:


\textsuperscript{19} Ministry of Justice 2012 MAPPA Guidance Version 4
Risk assessment is a dynamic process which requires ongoing re-evaluation in the context of the offender’s changing circumstances. It should be reviewed regularly.

7.1.2 Compliance with Kent Police policy and MAPPA guidelines in place at the time

Kent Police report that they have been unable to locate copies of the earliest MAPPA guidance, issued around 2003. However local Kent Police policies from between 2001 – June 2009 were reviewed and found not to provide any guidance regarding the need to repeat risk assessments.

Kent Police go on to report that

‘MAPPA guidance issued in 2007 under Good Practice Standards includes the requirement that all level 1 cases20 are reviewed at least once every four months. This Level 1 review must identify any new information relating to the case which has an effect upon the risk assessment.’

Kent Police go on to note that their local policy was updated in September 2009 to make clear that:

‘…there is a requirement to monitor the risk of the particular offender, identify changes and risk factors and ensure that appropriate action is taken to manage and where necessary review the risk.’

The context in which Kent officers were working was that they had no local guidance on the need to review risk assessments prior to September 2009. However from at least 2007 national MAPPA guidance made clear the need to review their risk assessments in the light of new information.

Against this context, the Kent Police IMR identifies some explicit shortcomings in Step Grand Uncle’s management.

- Officers did not consider the potential significance of Step Grand Uncle’s use of intimate photographs (and possibly threats as to their use) as part of a sexual relationship

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20 Such as Step Grand Uncle
- his access to email, as evidenced by the 2008 episode, suggests that he misled officers in saying that he had no internet access. It should have been apparent from the facts of this episode that he did have internet access.
- his potential contact with children in Kent was known but not pursued through child protection procedures
- his visits to Nottinghamshire and possible contact with children there were not explored in more detail
- information about his extended visits to Nottinghamshire were not shared with Nottinghamshire Police.

As the Kent Police IMR concludes such issues ‘should have resulted in a revisiting of the Risk Assessment on each occasion. If this was done it is not recorded.’

7.1.3 Were those responsible for his offender management aware of any potential risks to Alex, or could have reasonably expected to be aware?

In February 2008 Step Grand Uncle declared Step Great Grandmother’s address in Nottinghamshire as one that he would be at for more than 7 days a year. Given that he had been on the sex offenders register since 2003 and Mother believes the family first met him in 2002, it raises the question of whether Step Grand Uncle declared his visits to his mother in Nottinghamshire as soon as he should have.

The Kent Police IMR reports that there is no record of any questions to Step Grand Uncle about the access he had to children when in Nottinghamshire. It was recorded that Step Grand Uncle told officers that his family ‘were aware of his situation’. It is unclear to the Kent IMR author whether that meant the family knew he had been to prison or the detail of what he had been to prison for. He concludes that ‘This was not recorded as having been probed in sufficient detail. The officers should have explored the subject’s access to children and any details shared with the relevant forces.’

There is no record by either Kent or Nottinghamshire Police of information about Step Grand Uncle’s visits being passed to Nottinghamshire Police. This was a
mistake. Nottinghamshire Police should have been informed about his visits so that they could take appropriate steps.

The Nottinghamshire Police IMR sets out what would have happened if that notification had taken place.

If Nottinghamshire Police had been informed in 2008 when Step Grand Uncle first registered the Nottinghamshire address the following action would have been taken:

- The address would have been visited for a risk assessment of Step Grand Uncle’s surroundings by the Management of Sexual and Violent Offenders department.
- Any reference to a child having access to that address/familial access would have been referred to Children’s Social Care who would then also have conducted an assessment.
- An intelligence record of his temporary residence at that address would have been created.
- A place of interest marker may have been placed on the address if Step Grand Uncle was felt to be high risk of re-offending.

7.1.4 Developments in Kent Police’s management of registered sex offenders

Kent Police IMR reports that working practices have improved and more detailed information is now collected from offenders and there is more thorough recording of this information. Kent Police training now focuses on the need to corroborate accounts and reminds officers to be aware that subjects may be controlling in their nature and wish to appear compliant. The Kent Police IMR author concludes that he is assured that if the same circumstances occurred today a revision of the risk assessment would take place.

All relevant officers undertake the Management of Sexual Offenders and Violent Offenders course. Local training makes particular emphasis on the grooming of officers by offenders.

Kent Police now use the Active Risk Management System (ARMS) to assess risk. This is a dynamic assessment tool and includes an explicit assessment of the extent to which offenders have access to children.
If any children are identified as at risk through this process they would be identified in the risk management plan and a child protection referral to the Central Referral Unit for onward dissemination to Social Services would be made.

The Kent Police IMR author is content that current training covers any inadequacies that may have been identified in this case.

Improvements have clearly been made in Kent Police’s management of registered sex offenders. In the light of the learning from this review, Kent Police will be conducting an audit of how effectively these new arrangements are being implemented.

### 7.2 Examine the actions of Alex’s school following the disclosure made to them by her friends that Alex was self-harming

- Consider any learning which the school has put in place as a result of this incident.
- Examine this response and best practice from other areas to make recommendations as to how responses to this type of disclosure can be improved across the education sector.
- What provision did the school have in place for covering e-safety and keeping safe more generally with students, have they reviewed their processes and is there best practice which can be shared across the education sector?

### 7.2.1 The actions of Alex’s school following the disclosure

There were failings in the way School 1 responded to the disclosure by friends that Alex was self-harming. The events show both individual mistakes by staff as well as shortcomings in School 1’s systems at the time. The record keeping relating to these events was not in line with the school’s safeguarding policy. In part this was because at the time, self-harm was not explicitly identified as a safeguarding issue within the school’s safeguarding policies.
The School 1’s safeguarding procedures in place at the time make no explicit reference to responding to self-harm but they do set out the general procedures for responding to concerns about a pupil:

- Any member of staff who has concerns about the safety or potential abuse of a child must report their concerns to Senior Teacher B without delay.

When Staff Member A became aware of a risk to Alex’s safety he did the right thing and informed the Designated Member of Staff for Child Protection - Senior Teacher B. However from this point on there was a failure of both Staff Member A and Senior Teacher B to keep any record of the concerns or their actions. This hampered the effectiveness of their work. The School 1 safeguarding policy of the time referred to the need to carefully record ‘abuse’ but did not explicitly extend this to recording other safeguarding concerns such as self-harm. It required that:

- Any member of staff receiving a disclosure of abuse from a child or young person, or noticing signs or symptoms of possible abuse in a child or young person, will make notes as soon as possible (within the hour), writing down as exactly as possible using the child’s own words, what was said or seen, putting the scene into context, and giving the time and location. Dates and times of events should be recorded as accurately as possible, together with a note of when the record was made. All records must be signed and dated clearly. Children will not be asked to make a written statement themselves or to sign any records.
- All records of a child protection nature (handwritten or typed) will be given to the designated safeguarding lead for safekeeping. This includes child protection conference minutes and written records of any concerns. Access to any records will be on a ‘need to know ‘basis. All records must be securely held, separate from the main student file, and in a secure place.

Had this been done, staff would have had a record of what they had been told and by whom and the failure to contact Alex’s parents would have been apparent.
Previous serious case reviews in Nottinghamshire have identified the impact of poor record keeping on the effectiveness of school safeguarding. As a response, Nottinghamshire produced a toolkit for governors and managers to audit their school safeguarding record keeping. This material asserted that ‘Good record keeping is not bureaucracy – it is safeguarding.’

The fact that pupils brought their concerns about Alex to a member of staff suggests that they had a raised level of concern about her but also that they had a sense of trust in staff – feeling able to take such issues to them.

When information about Alex’s self-harming was given to staff there should have been an assessment of the level of risk this represented in order to guide appropriate responses. There were no school level procedures in place to support staff in doing this but more general guidance on self-harm was available from the safeguarding board. Any assessment of risk there was appears to have been very informal and nothing was recorded.

The School 1’s new procedures for self-harm include an explicit process of risk assessment. This is good but needs to be supported by evidence-based guidance on evaluating risk.

The safeguarding board’s guidance suggests that self-harm could sometimes prompt more substantial planning:

‘As the child or young person who is self-harming is likely to be experiencing problematic issues in a number of areas in their life the professional should discuss with the child or young person the possibility of undertaking a Common Assessment Framework (CAF) and/or, having a multi-agency meeting to identify the young person’s needs.’

The actions agreed in response to the report of Alex’s self-harm were to inform her parents and speak to Alex. These would have been a reasonable first response, although an initial conversation with Alex should have only been a first step.
It appears that Staff Member A did not contact Alex’s parents as he intended to do. Without the benefit of an interview with Staff Member A it is not clear why this was the case. However in the overview author’s experience secondary schools are very busy places and staff dealing with pastoral and behavioural issues are often trying to juggle many important issues. As such it would be reasonable to conclude that a well-intentioned action became lost as other tasks emerged.

This is why systems for recording and reviewing actions are important. As School 1’s IMR comments ‘if it had been recorded accurately on the day of the self-harm incident then Staff Member A would have known whether he needed to attempt to contact parents again.’

No notes were made of the meeting between Staff Member A and Senior Teacher B. Similarly there is no record of the Staff Member A talking with Alex about the concern, although he reportedly said that he did speak with her the next day.

A conversation with Alex asking if she wanted to access support would have been a good initial response. However Alex’s initial response to decline such help should not have been left at that. Other opportunities for Alex to talk with a trusted adult and consider further the offer of support would have been helpful. The local safeguarding board guidance on self-harm advises that if a young person declines support that should be viewed as something that ‘will potentially increase the level of risk.’ Instead Alex’s refusal of support seems to have been viewed as suggesting matters were not serious.

The question of sharing the information about Alex’s self-harm with others should have been discussed. This might have included telling her form tutor or the school nurse. The safeguarding board guidance offers advice on sharing information and in Alex’s case it may have been judged that it was appropriate to share information, even without her consent, in light of the risks to her safety.

Having been made aware of the disclosure and advised on next steps, Senior Teacher B did not follow up the matter with Staff Member A to find out what had happened next. There do not appear to have been systems in place at the time to
provide a framework to help staff record concerns of this type and monitor follow up actions.

The School 1 IMR notes that ‘there was insufficient supervision in place to ensure that all staff were following the framework correctly, so areas such as record keeping were not overseen regularly.’ It also highlights that there was no specific guidance to help staff respond to self-harm – ‘A specific framework/flow chart was not in place at this time to support specific actions for self-harm.’

Research suggests that many schools have had poor systems for responding to self-harm. The Mental Health Foundation’s report ‘Truth hurts’ described the views of pupils. They told researchers that:

‘…schools have no real focus on promoting good mental health and emotional well-being – most of the PSHE sessions concentrate more narrowly on drug and alcohol issues, sexual health, peer-pressure and bullying. They expressed particular concerns about needing clear and informed information and advice specific to self-harm. Most said that they had never had any opportunity to discuss or learn about self-harm at school or in any other context.’

7.2.2 School 1’s learning from these events

Following Alex’s death School 1 reviewed and amended its procedures for responding to self-harm. Their IMR describes the new systems now in place:

- Model practice for managing self-harm flow diagram; this highlights to frontline staff involved the key procedures that need to be followed in order to ensure the safety of a child with regards to self-harm. This flow diagram takes into account both low level concerns and points of crisis. The

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procedures give a degree of accountability to staff and also provide a clear timeline for actions to be completed and checked.

- **A self-harm incident form;** to be used by staff reporting incidents of self-harm with clear follow up actions and time dependent checklists – which is collated and overseen by the Senior Designated Person.

- **Follow up letter of concern;** the letter of concern follows up the telephone call and subsequent conversation previously made to a parent. Also a letter of concern is sent to parents in the unusual situation where the member of staff has failed to make contact with a parent of a student and they have recorded this on the ‘Self-harm Incident Form’. Staff are required to continue to attempt to contact home until they are successful and manage to speak with a parent/carer.

- **Emergency contacts business card;** this is included with the letter of concern providing parents with several key phone numbers for support including; ChildLine, Women’s Aid, Samaritans and the School Principal’s personal phone number.

- **Parent and Carer fact sheet to explain self-harm;** this is a fact sheet explaining what self-harm is with clear guidance for follow up by the parent or carer.

- **‘What to do if you are aware of concerns of a student self-harming’ document;** this has been issued to all staff as part of the safeguarding training completed regularly in the School 1.

- **Safeguarding training for students;** students are made aware of the safeguarding procedures through the School 1 assembly programme and through themed PSHE days. Key issues of bullying, e-safety, self-harm, CSE are addressed through these days, as well as, assemblies and in tutor times.

This new material is of very high quality and could provide a model for other schools. It provides the clear guidance on how to respond that would have been helpful in supporting staff dealing with Alex. The only issues raised by Alex’s case that may not be fully reflected in the new guidance are:
• recognising that disclosures about self-harm will quite often come from other students. Therefore students as well as staff need training and guidance on recognising and responding to self-harm
• ensuring that the procedures are followed by staff. This will mean auditing practice, including record keeping, regularly
• when discussing the sharing of information about a pupil who is self-harming staff should weigh up the possible benefits of sharing information with others. For example the form tutor is likely to see the pupil on daily basis and the school nurse may be able to offer advice to staff
• the flow chart of actions includes a point of ‘risk assessment’. It will be important for the staff making this assessment to have an evidence based framework of self-harm risk assessment to guide them.

7.2.3 Using this learning to improve practice across the education sector.

The Nottinghamshire Safeguarding Children Board (NSCB) guidance\(^{22}\) on self-harm was published in 2011 and updated in March 2014. It provides clear simple multi-agency guidance on self-harm. However it refers to structures that are no longer in place (Joint Access Teams, Multi-Agency Locality Teams) and frameworks that have changed (Common Assessment Framework.) This guidance is available as a printed document and as a pdf on the NSCB website. The NSCB also provides other information on self-harm and suicide on their website\(^{23}\) and while this advice is broadly similar to the 2014 self-harm guidance document, it follows a different format. The additional website information offers more detailed advice, which would be helpful to staff. NSCB should consider if both pieces of guidance are needed in their current format. It might be appropriate to amalgamate them.

While this guidance is clear and helpful it would not be sufficient in itself to provide guidance to schools on how they should respond to self-harm. Schools would need


more detailed guidance that reflects their own internal structures and the pattern of provision in their area.

The Self-Harm Awareness and Resource Project (SHARP) has recently published guidance for secondary schools in Nottingham City\(^24\). This provides the more detailed guidance on self-harm that schools in Nottinghamshire would also find helpful if it were adapted to reflect their local circumstances.

In 2011 Nottinghamshire Educational Psychology Service produced ‘Self-harm: Guidance Notes’ for schools in collaboration with colleagues from Child and Adolescent Mental Health Services. The service is currently revising and updating that guidance.

Other examples of national best practice have been highlighted in the Public Health England report ‘Promoting children and young people’s emotional health and wellbeing. A whole school and college approach.’\(^25\) This provides examples of best practice in relation to mental health and self-harm as well as examples of teaching materials.

There is an opportunity to use

- the learning from this SCR
- the school level material developed by School 1
- the material developed by SHARP for Nottingham City secondary schools
- the emerging revised EPS guidance
- an updating of the safeguarding board guidance
- examples of national good practice

to develop new guidance for Nottinghamshire schools.

\(^24\) *Nottingham City Secondary School Self-Harm Guidance May 2015*

When providing safeguarding guidance of this type Nottinghamshire typically develops a ‘model policy’ for schools, which schools are then asked to adapt to reflect their internal structures and local provision.

It is recommended that Nottinghamshire commission work to develop such a ‘model policy’ which is then supported with training events for schools. It will be important that this model policy is developed with representatives of schools, health services, children’s social care and the independent and voluntary sector. The views of young people should also be reflected, either by local consultation or by reference to other recent projects that have given expression to their views.

7.2.4 What provision did the school have in place for covering e-safety and keeping safe more generally with students, have they reviewed their processes and is there best practice which can be shared across the Education sector?

‘E-safety is defined as ensuring children and young people are safe whilst using all fixed and mobile technologies that children and young people may encounter, now and in the future, which allows them access to content and communications that could raise e-safety issues or pose risks to their wellbeing and safety’ (British Educational Communications and Technology Agency).

When the terms of reference for this review were established it seemed possible that issues of e-safety might emerge from Alex’s case. As such additional questions about e-safety at School 1 and Nottinghamshire schools were posed.

In practice electronic communication did play a role in this case, but Step Grand Uncle’s contact with, and access to, Alex was established by non-electronic means. He did however use telephone calls and texts, to her mobile, to maintain his contact with Alex. Alex also used Twitter to express her thoughts, including some that might have given rise to concerns.

7.2.4.1 E-safety and keeping safe at School 1

The School 1 IMR reports that
‘Prior to Alex’s death no audit was in place of how students were kept informed of e-safety and keeping themselves safe. It was planned for and delivered in assemblies, PSHE lessons, tutor time and throughout subject lessons, such as ICT. The Pint Sized Theatre Company also delivered a performance to students based on e-safety and Challenge Days (themed days of focus such as safeguarding) took place.’

The report goes on to say that School 1’s approach to e-safety and keeping safe is now more systematic:

- ‘the topic of covering e-safety and keeping safe more generally with students is now shared with students in themed assemblies which are clearly set and calendared throughout the year, in addition to the above.
- Display boards now show students key information to keep safe and also sign post students to places and agencies who can help them.
- Specific students also receive additional guidance, based on records and referrals.’

The Nottinghamshire lead officer for e-safety has a record showing she provided training to some parents of School 1. The School reports that staff are now trained and made aware of e-safety as part of their safeguarding training. The School keeps records of all staff safeguarding training.

**7.2.4.2 Best practice**

In 2010 26 and 2012 27 Ofsted published reports that described the characteristics of excellent e-safety practice in schools. These features were:

- having an active approach
- a close relationship between provision and pupils’ knowledge and understanding

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• well established staff training which was monitored and evaluated
• well planned and coordinated curriculum
• using 'managed' rather than 'locked down' systems
• systematic reviewing and evaluation of e-safety policies
• shared responsibility for provision
• leaders, governors, staff and families working together to develop a clear strategy
• excellent relationships with families
• systematic training of staff.

The local safeguarding board produced guidance in November 2011 for all agencies working with young people – ‘E-safety: Inter-agency practice guidance.’

Nottinghamshire’s Anti-bullying Co-ordinator is a qualified e-safety trainer and Child Exploitation and Online Protection (CEOP) Ambassador. She provides training to schools and parents on e-safety. Nottinghamshire has published guidance for schools on how to develop an e-safety policy and acceptable use policy. This is available on the Schools’ Portal.

Nottinghamshire recently commissioned a large scale survey by ‘Youthworks,’ a specialist consultancy in the field of e-safety. Nearly 3,000 Nottinghamshire pupils took part in the survey in the Autumn term 2015. 75% of pupils said they had received teaching about e-safety and those who had, said they were likely to follow it. The anonymous survey revealed disclosures by young people of potentially risky on-line behaviour. For example over 200 12-15 year olds said they had met up in real life with someone they met online and fewer than three-quarters of those told anyone they were going to do it.

This new data is being used to inform a new Nottinghamshire programme ‘Tacking Emerging Threats to Children,’ which it is hoped will begin in late 2016. This will share best practice across the education sector.

28 Nottinghamshire County Council (2015) E-safety policies: Advice & guidance to schools
Alex was posting worrying material on Twitter prior to her death. It will be important to ensure that e-safety training for parents points out the need to monitor young people’s postings on public spaces such as Facebook and Twitter.

**7.3 Was there anything which could have been done to support the parents when they became aware of Step Grand Uncle’s offending which would have helped them to protect Alex?**

It is not the purpose of this review to consider the actions of Alex’s family. However it is appropriate to consider what might have helped them protect Alex when they became aware of Step Grand Uncle’s history of sexual offending.

There is discussion earlier in this report of what information should have been provided by Kent Police to Nottinghamshire Police when it became known in 2008 that Step Grand Uncle was regularly visiting his family in Nottinghamshire.

Without that information Alex’s family were reliant on what they had been told informally by Step Grand Uncle’s relatives about his offending. This account apparently minimised his offending and the risk he posed.

Nottinghamshire Police provide information about child sex offenders under the terms of the Child Sex Offender Disclosure Scheme, often known as Sarah's Law. The Nottinghamshire Police website has well-presented information on this scheme which the author was able to find quickly with a Google search. The website explains:

*Child Sex Offender Disclosure Scheme (Sarah's Law.)*

_We operate a scheme that allows anyone concerned about others working, living or in contact with children to raise their concerns with the police. This may include a parent concerned about their new partner or a friend of the family._
Once a concern is raised, we will carry out background checks and, where appropriate, inform the person best placed to protect the child or children concerned from harm. Please see the link at the bottom of this page for more information about the scheme.

The website takes readers to well written leaflets about the scheme. The first of these explains:

*The aim of the scheme is to:*

- To reduce sexual offending against children
- To provide parents, carers and guardians with information that will enable them to better safeguard their children
- To improve public confidence.

*If police checks show that the individual has a record for child sexual offences, or other offences that might put the child at risk, the police will consider sharing this information with the person(s) best placed to protect the child, usually the parent, carer or guardian.*

The leaflet goes on to explain how to request information about a person of concern and how the Police will respond.

Nottinghamshire Police, then, have a mechanism for applying Sarah’s Law locally and it is well explained on their public website. This only leaves the question of how well known it is within the local community. Given that the law was introduced in 2011 it may now be an opportune time to refresh the public’s awareness of the law and how it operates in Nottinghamshire. This would remind other parents of the resources available when they are concerned about the possible sexual offending history of someone who has contact with their children.
8 Parallel processes

The coroner has issued her findings in regard to Alex’s death. Kent police have closed their investigation of Step Grand Uncle. Nottinghamshire Children’s Social Care has closed their involvement with Alex’s family. An inquest into Step Grand Uncle’s death has been completed.

9 Good practice identified

School 1’s work to develop systems and guidance for responding to self-harm is excellent. It should be used as one of the resources for developing a model policy on self-harm for Nottinghamshire schools.

The Nottinghamshire Police public website provides excellent, easily understood, guidance on the use of ‘Sarah’s Law.’

10 Conclusions

Alex was 15 years old when she took her own life by hanging. She was a bright girl, doing well at school and was ready to progress to the next stage of her education. Her diary tells us that she had positive hopes and dreams of a life with marriage and children. She was seen by teachers as generally positive and happy. Her friends had a more nuanced picture of her. They knew she could appear cheerful and happy much of the time but some of them also knew that she could be unhappy. They did not know what caused this unhappiness but some of them knew that she harmed herself, probably by cutting herself.

We now know that there were good reasons for Alex to be unhappy. In addition to whatever normal adolescent turmoil Alex had to navigate, she was the victim of abuse by Step Grand Uncle, someone trusted by her family. Step Grand Uncle continued to groom and pursue her up until the day of her death. He had taken indecent photographs of her when she was younger. He had previously used indecent images he had taken of women to threaten and control them. It is possible that he was doing the same with Alex.
It is not clear how long Alex had been self-harming but one pupil told Police that Alex had been self-harming in Year 10. In Year 11 a group of her friends became sufficiently concerned to disclose the matter to a member of staff. When Alex’s self-harm became known to staff they set out to do the right things – talk with Alex and inform her parents so that they could seek support. Although they clearly intended to do so, staff did not contact Alex’s parents. They were therefore left unaware of the concerns. The school lacked systems for recording and monitoring important actions such as this. This was a missed opportunity to alert Alex’s family to herself harm and direct them to appropriate support.

A member of staff has said that he spoke to Alex and offered her access to support in school. When Alex reportedly declined this support staff should have seen this as something that potentially increased her level of risk. School systems at the time did not provide staff with guidance on managing self-harm or assessing risk. Staff did not keep any records of information and actions as was required by the school safeguarding policy. This hampered the effectiveness of their response.

Since Alex’s death School 1 have developed and implemented excellent materials to help staff respond to self-harm by pupils. These materials, together with other material in development locally and material published nationally should be used by Nottinghamshire County Council to develop model guidance on self-harm for all Nottinghamshire schools [Recommendation 1.] Alongside this, Nottinghamshire Safeguarding Children Board should update their guidance on self-harm to reflect the organisational and procedural changes that have taken place since it was last revised. They should amalgamate the two slightly different sets of guidance on self-harm they currently make available. [Recommendation 2.] School 1 should audit the implementation and effectiveness of their new arrangements for responding to self-harm. [Recommendation 3.]

Evidence from Alex’s computer suggests that by early 2014 she was seeking out web sites on depression. Step Grand Uncle seems to have been in continuous contact with Alex with messages that have a sinister implication when we know of Step Grand Uncle’s history - ‘Just being pleasant and talking to me could get you so much.’
Step Grand Uncle had access to Alex from around 2002. He was a convicted child sex offender who was jailed after he abused and threatened a teenage girl in 2003. Step Grand Uncle visited Alex’s family and went on holiday with them. They knew something of his conviction for sexual offending but did not believe he was a risk.

From 2003 until 2009 Step Grand Uncle was managed by Kent Police as a registered sex offender. They visited him annually, as required by MAPPA guidance but do not appear to have re-visited and updated their risk assessment of him between 2003 and 2009. They kept track of his welfare and his feelings but should have been more intrusive - particularly questioning his access to children.

In 2008 Kent Police became aware that Step Grand Uncle had access to the internet, contrary to what he had told them. They also learned that he had taken intimate images of a married woman with whom he had a relationship and then shared them when the relationship came to an end. This was reminiscent of the how he had tried to control his previous child victim when he abused her – taking indecent images of her, threatening to share them as a means of control and then sharing them when she resisted him. This should have led to a re-assessment of the level of risk Step Grand Uncle posed.

Kent Police knew that the woman with whom Step Grand Uncle had a relationship had children but did not investigate further what contact he had with them or what risk he might pose.

In 2008 Step Grand Uncle declared that he made extended visits to Nottinghamshire to visit Step Great Grandmother. Kent Police did not inform Nottinghamshire Police of this. Had they done so Nottinghamshire Police could have made enquiries to establish what opportunities Step Grand Uncle had for contact with children in Nottinghamshire. Mother told Police that they saw Step Grand Uncle about three times a year when he visited his mother. It appears that it was during his visits to Nottinghamshire that Step Grand Uncle took indecent images of Alex in her bedroom. Kent Police believe the photographs were taken in 2007 or 2008, so these offences took place at a time when Step Grand Uncle was being managed as a...
registered sex offender. Kent Police’s management of Step Grand Uncle as a registered sex offender had some shortcomings.

Kent Police IMR reports that working practices have improved and that current training covers the inadequacies identified in this case. However, it would be appropriate to review the effectiveness of current practices in the light of learning from this case. [Recommendation 4.]

It is unclear what information Alex’s parents had about Step Grand Uncle. Nottinghamshire Police implement the Child Sex Offender Disclosure Scheme, (Sarah’s Law.) This provides a mechanism for parents and carers to request information about the criminal record of offenders who may have contact with their children. It is five years since this law came in to force and it would be appropriate for Nottinghamshire Safeguarding Children Board to refresh the public’s knowledge of the law and how it can be used to protect children and young people. [Recommendation 5.]

This report discussed earlier the factors known to be associated with young suicide. We now know that Alex was probably exposed to three of these risk factors:

- previous self-harm
- abuse
- depression

Prior to her death however, only one of these risk factors was known – her self-harm. Her abuse was not known, other than to Alex and her abuser, prior to her death. The possibility that she was experiencing depression is only inferred from the later analysis of her internet history. It does not appear to have been apparent to those who knew her.

Risk factors in suicide are not simple indications of an impending suicide. If we take self-harm as a ‘risk factor,’ we know from research discussed earlier that self-harm is a high frequency event among young women at school. By comparison, suicide by
young women is statistically quite uncommon. The overwhelming majority of those young people who self-harm at school do not go on to commit suicide.

As such, Alex’s self-harm did not predict that she would go on to kill herself. What it did do, however, was to suggest that she had a higher level of risk and that appropriate protective action should be taken:

- Informing her parents so that they could play a part in keeping her safe
- Encouraging them to seek medical advice
- When Alex declined support, seeing that as a matter to raise concern levels.

When School 1 did not take these actions effectively an opportunity was missed to reduce Alex’s risk of suicide.

The other risk factor that was potentially under the control of agencies was Step Grand Uncle’s abuse of Alex. When he declared to Kent Police that he was making extended visits to Nottinghamshire, Kent Police should have informed Nottinghamshire Police. This would have triggered child protection procedures in Nottinghamshire to establish what opportunity for contact he had with children and what risk he posed. Evidence from Kent Police suggests that Step Grand Uncle took indecent photographs of Alex, in her Nottinghamshire home, at a time when he was a registered sex offender, supervised by Kent Police. We know from his previous behaviour that Step Grand Uncle had used indecent images to put pressure on women. If he was doing that with Alex it may have been a contributing factor to her depression and death. When Kent Police failed to inform Nottinghamshire Police of Step Grand Uncle’s visits an opportunity was missed to protect Alex from abuse and so reduce her risk of self-harm and death.

Alex’s mother and step-father do not appear to have been aware of the seriousness of Step Grand Uncle’s previous conviction when they allowed him access to their family. The provisions of ‘Sarah’s Law’ could have given them a way to find out more about the risk Step Grand Uncle posed to their family. If they had that information they might have reached a different judgement about allowing him contact with their family.
In judging whether Alex’s death could have been predicted or prevented the author is mindful of the conclusion of Marion Brandon\textsuperscript{29} at the Centre for Research on the Child and Family, who has examined the evidence from serious case reviews. She concludes that ‘Not all young suicide can be predicted or prevented.’ We should also remind ourselves that even with the benefit of hindsight and a police investigation, we may not be aware of all the factors that led to Alex taking her own life.

In the light of what we now know it would be reasonable to conclude that opportunities were missed to identify that Alex was being sexually abused and thereby to reduce the risk that Alex would take her own life.

\textbf{10.1 The delay in instigating a serious case review}

Nottinghamshire Police had suspicions in May 2014 that Step Grand Uncle was a factor in Alex’s death. They liaised with Kent Police and a search warrant was executed at his home address on the same day. Step Grand Uncle was questioned further on 2\textsuperscript{nd} October 14 and was due to answer bail on 13\textsuperscript{th} November 2014 (presumably for charging purposes). Nottinghamshire Children’s Social Care was kept updated by Nottinghamshire Police regarding their concerns in relation to Step Grand Uncle. At some point between May 2014 and November 2014 Nottinghamshire Police had sufficient information to suggest that Step Grand Uncle had abused Alex. At this point Nottinghamshire Police or Nottinghamshire CSC could have made a referral for consideration of a serious case review. The referral eventually came when the case later reached the Nottinghamshire Safeguarding Children Board (NSCB) Child Death Overview Panel (CDOP) for review. This review normally takes place when all investigations into the deaths, including the inquest, have been completed. CDOP reviewed the death at their monthly meeting on 24\textsuperscript{th} April 2015 and the view of the meeting was a referral should be made for SCR

\textsuperscript{29}Marian Brandon (2012) ‘Young Suicide and Serious Case Reviews’ paper presented at 8\textsuperscript{th} BASPCAN International Congress April 2012, Queen’s University Belfast, accessed from http://www.baspcan.org.uk/files/Brandon%20Marian%20S7.4%20Tues%2010.45.pdf
consideration. This referral to the SIR Sub Group was made by the CDOP chair on 11th May 2015.

In line with all other NSCB partner agencies, Nottinghamshire Police and Nottinghamshire Children’s Social Care have an obligation to refer cases for consideration of a SCR where they believe the criteria for SCR may have been met. This should be done in a timely manner.

Since these events Working Together 2015 included content intended to clarify the Serious Incident Notification process. The guidance requires Local Authorities to notify Ofsted and local safeguarding children boards of any serious incident involving a child within five working days of them becoming aware of it. As a result Nottinghamshire Children’s Social Care has introduced processes for submitting Serious Incident Notifications (SINs) which should lead to both Ofsted and NSCB being notified of serious incidents in a timely manner. It has been reinforced within members of the responsible NSCB sub group that all agencies have a responsibility to identify cases for consideration of reviews at an early stage.
11 Recommendations

The following recommendations have been discussed and agreed by agencies through the SCR Panel process.

Recommendation 1. Nottinghamshire County Council should develop model guidance on self-harm for Nottinghamshire schools. This should draw on:

- the learning from this SCR
- the school level material developed by School 1
- the material developed by SHARP for Nottingham City secondary schools
- the emerging revised EPS guidance
- an updating of the safeguarding board guidance
- examples of national good practice

This work should be developed with representatives of schools, health services, children’s social care and the independent and voluntary sector. The views of young people should also be reflected, either by local consultation or by reference to other recent projects that have given expression to their views. When developed, this material should be disseminated to schools and schools should be advised on how to customise the model policy to reflect their own internal structures and local provision.

Action: Nottinghamshire County Council Education.

Recommendation 2. Nottinghamshire Safeguarding Children Board should update their guidance on self-harm to reflect the organisational and procedural changes that have taken place since it was issued in 2014. They should amalgamate their two slightly different sets of guidance in to one.

Action: Nottinghamshire Safeguarding Children Board.

Recommendation 3. School 1 should audit the implementation and effectiveness of their new arrangements for responding to self-harm. They should consider if their new arrangements could be further strengthened by:

- providing students as well as staff with training and guidance on recognising and responding to self-harm
- undertaking a regular audit of compliance with practice
• reviewing their policies on sharing of information about a pupil who is self-harming

Action: School 1

Recommendation 4. Kent Police should review the effectiveness of their management of registered sex offenders in the light of learning from this case. This should consider:
  • do officers always thoroughly investigate the offender’s opportunities for contact with children?
  • do officers use risk assessment in a dynamic way – regularly updating their assessment and using new information to review their judgements about risk?
  • do officers routinely inform other forces or agencies when a RSO has contacts outside of Kent?

Action: Kent Police

Recommendation 5. Nottinghamshire Safeguarding Children Board and its partner agencies should review its communication and engagement with parents and carers. They should ensure that key messages around safeguarding risks are delivered effectively and help equip parents to protect children. This will include reference to the use of Sarah’s Law in Nottinghamshire and how it can be used to protect children and young people.

Action: Nottinghamshire Safeguarding Children Board.

Dr John Bradley
15.9.2016