Diogelu Gwent
Gwent Safeguarding

Concise Child Practice Review

Report

In respect of

SEWSCB 1 / 2017

Date of report: 30.08.18

Child Practice Review Report

South East Wales Safeguarding Children Board (SEWSCB)
Concise Child Practice Review

Re: SEWSCB 1/2017

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*

Legal Context

A Concise Child Practice Review was commissioned by South East Wales Safeguarding Children Board following the recommendations of the Case Review Group convened on 13th February 2017.

In accordance with the 'Working Together to Safeguard People' Guidance for Multi-Agency Child Practice Reviews, the criteria for this review are met under section 6. The Terms of Reference for the review are at **Appendix 1.**

Circumstances Resulting in the Review

This review concerns the case of a young person who died on 7th January 2017 having taken her own life by hanging.

The time period for the review was agreed as from 18th November 2014 to 7th January 2017.

Prior to the agreed timeline, the historical information recorded that this young person's parents separated when she was quite young. She experienced physical and emotional abuse as a young child and following social services involvement went to live with her father from the age of 9 years until her death. She struggled in school with the transition from Year 8 to 9 when she began self-harming and expressing suicidal thoughts.

Prior to the young person's death, she continued to struggle within the education environment. In October 2015, she was referred to the School Inclusion Centre where she remained until April 2016 with an attendance rate of 95%. However, she began displaying frequent anxiety attacks, reported she was being bullied and often

talked about self-harm and wanting to die.

After an incident with a blade, in April 2016, she received a three-day fixed term exclusion and then was referred for Home Tuition which began in May at her paternal grandmother's house.

In July 2016, she became part of a Nurture Group which her father reported she enjoyed. This placement ended in September 2016 due to a serious incident that led to staff feeling they would not be able to keep her safe. The young person remained out of education until the time of her death in January 2017.

The young person was referred to Child and Adolescent Mental Health Services (CAMHS) by her General Practitioner (GP), in October 2015, and was first seen by the Clinical Psychologist at the end of November 2015. She was seen regularly by this service with a number of interventions put in place for the young person and her father. At the time of her death, CAMHS were in contact with the young person on almost a daily basis.

Between May 2016 and December 2016, there were four recorded serious attempts at self-harm by the young person which resulted in hospital admissions.

In January 2017 the young person took her own life.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

As part of this Child Practice Review, a learning event was held engaging practitioners involved with the young person and her family. The death of a child in such circumstances is always distressing and the reviewers would like to thank all those who attended and for their contribution to the learning from this review. Of note, the discussions and suggested learning from the learning event reflected the thoughts and thinking of the panel.

Partnership Working with the Child and the Family

There was evidence of a lot of collaborative involvement with the young person and her family, particularly, her father and his partner.

However, when working with families, practitioners need to be mindful about how they effectively communicate. The young person and involved family members should have the reasons for the interventions, strategies and actions being implemented clearly explained to them to assist in the management being proposed.

The young person's father and his partner reported that sometimes they felt the

advice being given was unhelpful and could "put ideas into the young person's head" and could also be unachievable, for example, restricting her use of social media.

It is important that, when more than one service is involved, management and advice being given is clear and consistent to avoid confusion for the family and young person. One example given by the family was that whilst one service advised taking away her telephone in the evening to try to lessen the effect of social media issues, another service said this might be seen by the young person as a punishment.

Also, when developing collaborative plans with families, practitioners need to consider the impact that their proposed plan of actions may have upon individual family members' personal circumstances.

It was identified at the learning event that, whilst the young person's father clearly wanted to be supportive, this did become very stressful for him as he tried to work with services, manage work commitments and meet his daughter's needs. Practitioners felt they could have better explored with the family all the alternatives and help that could be considered, including the involvement of social services.

Educational Involvement

Up until Year 8, the young person attended school in Local Authority area 1 and appeared to be settled and was seen as coping well.

Due to the young person's difficulties and increasing need, she received various methods of education which the family reported she engaged with and enjoyed, particularly her time spent in the Nurture group.

When her placement ended at this group in September 2016, the young person's father was informed that, as she was now living in Local Authority area 2, he would have to make a new application for an educational placement to that Local Education Authority department. Although there was communication between the two Local Authority areas, these cross border processes which include the need for a formal written application to be made can be unhelpful to families already struggling and in crisis. In this case, the young person failed to return to an educational placement.

Children begin to "fall out" of education for a variety of reasons. It may be due to bullying, being given an exclusion period, presenting as unmanageable or moving to another Local Authority area. In this review, a common feature was educational practitioners' difficulties in coping with the young person's increasing behaviours of potential and actual self-harm and expressions of suicidal thoughts. Practitioners reported that, at times, they felt they could not keep the young person "safe" and spoke of their responsibility to consider the impact of her behaviour on other students and her teachers.

At this time, both CAMHS and the education services were engaging well with the family and regularly communicating and sharing information with each other.

CAMHS services were delivering a range of interventions and strategies to help the young person to deal with her issues.

When education professionals found it increasingly difficult to maintain the young person in education, it may have been helpful to have convened a multi-agency meeting to consider all the support, advice and help available to help her manage her educational placement.

In one Local Education Authority in Gwent, a series of mental health and wellbeing workshops have been delivered in order to support young people by raising awareness and reducing stigma associated with mental health issues. This is an identified area of good practice.

LEARNING POINT 1

When working with complex cases and trying to keep young people in education there should be consideration by education of holding a multi agency meeting to assist with the maintenance of the placement and management of any particular difficulties such as cross border issues.

CAMHS Involvement

A report has already been undertaken for the purposes of a Serious Incident Investigation by Aneurin Bevan University Health Board (ABUHB) and several of its recommendations have been incorporated into this report

This young person became involved with CAMHS services in November 2015 and a Welsh Applied Risk Research Network (WARRN) clinical risk assessment and management tool was commenced. This is a recognised mental health assessment tool used throughout Wales and is a live assessment which is updated as need indicates.

During the period of this review, there is evidence of the provision of an extensive CAMHS service ranging from out-patient care to intensive crisis outreach work, with a range of evidence-based psychological interventions and behavioural strategies being applied. This included involving the young person in a Music Group, Anxiety Management Group and a Dialectical Behaviour Therapy Skills group. The latter being a specific type of cognitive behavioural psychotherapy to help individuals in extreme emotional crisis.

There was regular contact with the family through home visits and telephone contacts. However, as previously discussed, it appears that the family were not always understanding of the strategies being used to assist the young person and, when interviewed, said they felt that she should have been hospitalised in order to keep her “safe.”

At the learning event, this issue of when a young person would meet the threshold for hospital admission and the benefits and contra indications of this course of action was discussed. In their internal review, CAMHS have reflected on this and, although the Crisis Outreach Team (COT) believe in this case the young person

would not have met the criteria for in-patient admission, a second opinion from the Tier 4 in-patient service may have been useful in terms of supporting the therapeutic approach and aims that the COT were delivering. This has resulted in the health review making the following recommendation.

LEARNING POINT 2

The CAMHS COT service to review with Tier 4 CAMHS in-patient service and agree protocol for second opinions

The young person was regularly discussed at Multi Disciplinary Meetings (MDTs) although these meetings would usually only consist of health professionals.

In this case, it is clear that both the education service and CAMHS were struggling to meet all the needs of this family and each service made several child protection referrals mainly as a result of her self-harming behaviours and suicide attempts. None of the referrals were assessed as meeting the threshold to convene a statutory case conference. As a result, there was no multi-agency meeting held until eight weeks before her death when the young person made an allegation of historical rape.

The Suicide and Self Harm Prevention Strategy for Wales 2015-2017 Talk to Me 2 notes that “there is no single reason why someone may take their own life or harm themselves. It is usually in response to a complex series of factors that are both personal and relate to wider social and community factors."

Thus, when developing safety plans and strategies there is a need to include a range of agencies to enable full information sharing to secure the best support for the child or young person, the family and the professionals involved. It may have been helpful for such a meeting to have been held earlier in her care. Having multiple stress factors would have contributed to her suicidal intent and, for this reason, it is important that there are processes in place to promote shared responsibilities across all agencies, in order to promote the protection of such vulnerable young people.

LEARNING POINT 3

To consider the development of a multi-agency locally agreed policy/protocol for the management of high risk cases of self-harm and potential suicide

The life history of this young person shows she had a number of adverse childhood experiences (ACEs) that made her particularly vulnerable. She had a history in early childhood of physical abuse and neglect and possible sexual abuse, a parent with mental health issues, parental separation, loss of a family member, bullying and social isolation.

Managing social media and social networking appeared to be a particular trigger for this young person’s often low mood and need to self-harm or act on suicidal urges.

LEARNING POINT 4

In light of this review the SEWSCB should signpost and make accessible information and guidance for young people and their families / carers experiencing difficulties in managing social media and the internet

During the period of the review, the young person was admitted to the local Children's Assessment Unit four times following incidents of self-harm and suicide attempts. All admissions resulted in a review to update the current WARRN assessment and subsequent safety plan. A key element of the safety planning would have been advising and getting agreement from the young person's father on how he would monitor and protect her at home.

When interviewed, the young person's father and his partner felt that sometimes there were unreasonable expectations placed upon them to undertake this supervisory role. As previously discussed, they felt there was sometimes a lack understanding of the difficulties felt by the young person's father to have to constantly "watch" his daughter, e.g. whilst in the shower or in her bedroom.

Whilst he wanted to be supportive, he reported that he often felt overwhelmed by her needs and what was expected of him. This was brought out at the learning event and is also reflected in the health internal review of the case.

LEARNING POINT 5

The CAMHS Service to review how they communicate with families about the outcomes of their psychiatric assessments and on-going formulation of the young person's mental health

In the final few months before the young person's death, the use of texting between the CAMHS Outreach Team and the young person increased significantly, with multiple usages on a daily basis. She actively used this method of communication as a means of reporting her distress and thoughts about, and intention to, self-harm. This form of communication, whilst socially appropriate and acceptable to young people, does raise some important governance issues for professionals, from how to record the conversations to how to evidence that the advice and strategies being offered are being implemented and having an impact. This also has been highlighted within the health review with the following recommendation being made.

LEARNING POINT 6

The CAMHS service to review its use of "texting" contact and develop guidance on use to ensure it meets required governance standards.

Local Authority Child Care Services Involvement

There had been some historical involvement with child care services in the Local Authority area 1 due to an allegation of physical abuse and neglect with a history of

her moving to live between her parents until July 2012 when she moved to live permanently with her father. She did, however, continue to have some sporadic contact with her mother.

Between 2015 and 2016, several referrals were made to childcare services in Local Authority area 2 by several different agencies. The reasoning for making these referrals and the expectation of action from childcare services was discussed at the learning event. As previously noted, none of these referrals met the threshold for child protection intervention i.e. that the young person was suffering from, or likely to suffer from "significant harm," which is the threshold which justifies compulsory intervention into family life (All Wales Child Protection Procedures, 2008). There does appear to be some confusion and uncertainty amongst professionals from differing agencies as to what would constitute a child being "at risk of significant harm" in these circumstances.

When discussed at the learning event, it was felt that based on the information provided, the assessment of the referrals would be that whilst the young person was indeed at risk from herself, there were comprehensive services in place, there did not appear to be any third party abuser, and father was being offered support if requested. Thus, the appropriate child protection response would be of no further action. There were referrals made to Families First services but, because of suicidal attempts and CAMHS involvement, it was not felt that the threshold was met for Families First involvement. As a result, the family did not receive services from prevention services either. However, as evidenced by the timeline, agencies were often working and making decisions without the full information and knowledge of all the dimensions and extent of issues facing this family.

The All Wales Child Protection Procedures (2008) state that whilst a single serious event of abuse might cause significant harm "more frequently significant harm occurs as a result of a long-standing compilation of events, which interrupt, change or damage a child's physical and psychological development".

It was not until the young person made an allegation of historical sexual abuse (i.e. a serious event) in late 2016 that a multi-agency case conference was arranged. This facilitated the first opportunity for all agencies to get together to share information, analyse and debate the presenting issues and risks and to then agree how best to support the young person and her family to achieve maximum impact.

Suicide and Self-Harm

Suicide is the second leading cause of death among 15-29 year olds worldwide accounting for 8% of all deaths. In the UK, suicide is the leading cause of death in young people accounting for 14% of deaths in 10-19 year olds (Office for National Statistics).

A recent report "Suicide by Children and Young People: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Manchester: University of Manchester 2017 "reinforces the message that suicide is rarely caused by one thing and it usually follows a combination of previous vulnerability and recent events. It cited ten common themes;

- Family factors such as mental illness
- Abuse and neglect
- Bereavement and experience of loss
- Bullying
- Suicide-related internet use
- Social isolation or withdrawal
- Academic pressures, especially related to exams
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas

The report concludes that these experiences may combine over time to increase risk until suicide occurs often triggered by a crisis event e.g. relationship or examination problems. It indicates that the best way for health, social care, and other agencies working with young people as well as families to contribute to suicide prevention is through a workforce with a greater awareness of the range of factors that may add to risk and of the final straw "stresses" that can lead to suicide.

LEARNING POINT 7

The SEWSCB to explore opportunities for practitioners to gain broader experience and knowledge to promote and deliver collaborative and multi-agency approaches to the prevention of suicide and self-harm

Good Practice / Improvements already made

- Frequent communication between agencies and with the family.

- Intensive, consistent support from CAMHS.

- Several alternative educational placements tried.

- Staff worked within Wales Ambulance Service Trust's (WAST) procedural guidance on Children who Self-harm. Therefore, during one incident where WAST were advised by Police that their assistance was not required, a vehicle continued to be deployed. This ensures that the child/young person can receive a health assessment and a child protection referral can be made.

- As a result of an internal review undertaken by ABUHB, several practice recommendations have been made e.g. development of Tier 4 inpatient protocol.

- Torfaen Children Services have now introduced a new management structure to cover both Child Protection and Family First services to ensure cases are not lost between child protection and prevention services.

- Newport Children Services have developed 'Step up Step down' arrangements whereby the Prevention Service and Children's Duty and

Assessment Team, through collaboration, work together to find the right solution for families.

- Prior to the young person taking her own life, she rang Childline who assessed the seriousness of the situation and quickly started to give information to the police to assist in the search for her.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB and its member agencies and anticipated improvement outcomes:-

LEARNING POINT 1

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LEARNING POINT 2

The CAMHS COT service to review with Tier 4 CAMHS In-patient service and agree protocol for second opinions.

LEARNING POINT 3

To consider the development of a multi-agency locally agreed policy/protocol for the management of high risk cases of self-harm and potential suicide.

LEARNING POINT 4

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LEARNING POINT 5

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LEARNING POINT 6

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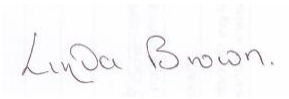
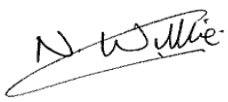
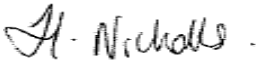
Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Linda Brown	**Name** *(Print)*	Nick Wilkie
Date	4th April 2018	**Date**	4th April 2018

Chair of Review Panel (Signature)	
Name *(Print)*	Heather Nicholls
Date	4th April 2018

Appendix 1: Terms of reference

Child Practice Review process
To include here in brief: • *The process followed by the SCB and the services represented on the Review Panel* • *A learning event was held and the services that attended* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Child Practice Review Process

The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government in June 2017 that it was commissioning a Concise Child Practice Review in respect of a young person.

Reviewer: Linda Brown, Designated Nurse, Public Health Wales

Reviewer: DCI Nicholas Wilkie, Gwent Police

Reviewer: Kelly Richards, Development Officer, Gwent Safeguarding Business Unit (A substitute Reviewer was required prior to the Learning Event so Kelly Richards replaced DCI Nicholas Wilkie on this occasion)

Chair of Panel: Heather Nicholls, Deputy Local Delivery Unit Head, National Probation Service

The services represented on the panel consisted of:

- Gwent Police
- Children's Services (Local Authority Areas 1 and 2)
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust
- Education
- NSPCC (were not represented at Panel but provided information as part of the review process)

The Panel met regularly from June 2017 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

A Learning Event took place in December 2017 and was attended by the following agencies:

- Aneurin Bevan University Health Board

- CAMHS
- Education
- Gwent Police
- Children's Services
- Welsh Ambulance Service Trust

Family Members informed

Relevant family members were informed that the review was taking place and meetings were held with Reviewers where requested.

☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Appendix 1

Terms of Reference
Concise Child Practice Review
in respect of SEWSCB 1 / 2017

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of the following parallel processes related to the case and how they will contribute to the findings*:*
    - Coroner Inquest
    - Health Serious Incident Review
    - Ongoing Police Investigation (Historical Rape)
- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.
- Agree the time frame for the review from 18th November 2014 to 7th January 2017.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review Pane*l complete the report and action plan.

- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on Board website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.