Derbyshire Safeguarding Children Board
Child Practice Review Report

Derbyshire
Safeguarding Children
Board

Re: Child Practice Review SILR15A

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Concise Review √ [redacted]

Review Process

This serious incident learning review was commissioned by the Independent Chair of Derbyshire Safeguarding Children Board on 15TH September 2015, in agreement with the recommendation of the Serious Case Review Sub Committee (SCR panel) that the circumstances surrounding the death of the young person did not indicate a need or meet the criteria for a Serious Case Review (Section 4 of Working Together to Safeguard Children Department of Education March 2015).

It was agreed by the SCR panel that there was no evidence that abuse or neglect contributed to the young person's death. However the panel felt that a serious incident learning review should be undertaken to explore the learning from the case. The Welsh Child Practice review model will be used to undertake this review.

The Derbyshire Safeguarding Children Board (DSCB) acknowledges that the death of a child / young person is a tragic loss and questions are always asked if the death could have been prevented or avoidable in any way. The SCR panel therefore take every step to scrutinise agency and Professional involvement to explore if there is any learning that can be identified with the overall aim of preventing any future deaths.

As an Independent Reviewer I would like to assure the DSCB and the parents and the family of the young person that all agencies who were involved with the young person have taken an active part in the learning review process. All agencies fully engaged in the process sharing information in an open and transparent manner with regards to their involvement and assessment of the young person.

From undertaking this review a number of learning points have being identified and recommendations have been made for the DSCB and individual agencies to address the issues being raised.

Subject of the review:

Young person (YP): Aged 16 years (deceased) [redacted]

Circumstances resulting in the review:

In the summer [redacted] East Midlands Ambulance Service (EMAS) received a call from Derbyshire Police requesting assistance. The Police had received a call from the young person's mother reporting that her child

had been found hanging at the home address. EMAS contacted the mother to offer assistance and dispatched the ambulance crew to the home address. Following a period of advanced life support taking place within the home the young person was taken to hospital but later that evening was pronounced dead. The circumstances resulting in the death of the young person in this case will be established by the Coroner.

[redacted] *the Coroner's inquest took place. The conclusion of the Coroner as to the death of the young person was Suicide.*

Family composition.
The young person lived at home with both parents [redacted]. The Family are of white British origin, both parents were in employment and the family lived in a semi-rural area of Derbyshire. Prior to the Young person taking an overdose in January 2015 when a referral was made to the Local Authority Children Services by the Emergency Department the family were not previously known to Children and Younger Adults Services or the Police.

Circumstances leading to the event:

Prior to year 10 of secondary school there had been no previous concerns raised by the young person, their parents or school. It was reported that the young person enjoyed school and had a good circle of friends and social network within the community that they resided in. In year 10 (January 2014) a friend of the young person informed the school nurse that the young person had self-harmed. The school nurse saw the young person twice to discuss the reported self-harm with them and to assess their wellbeing and to offer support. But on both of these occasions the young person denied that self-harm was a problem. The young person confirmed that they had self-harmed by cutting on one occasion and this had been a "one off" incident. The young person declined a referral to the Child and Adolescent Mental Health Service (CAMHS).

The young person commenced 6th Form at the same school in September 2014 but soon into the year the young person expressed difficulties in coping with the academic workload and spoke to the school about dropping one of the A level subjects. This plan was also agreed with parents.

In January 2015 both parents attended the Emergency Department with the young person following a disclosure that the young person had taken an overdose [redacted]. The young person was admitted into hospital overnight and was assessed by CAMHS the following morning, it was agreed that the young person was medically fit for discharge with a plan to be reviewed by CAMHS in a weeks' time in the Community.

A referral was made to Local Authority Children Services (CS) by the Emergency Department and the GP was notified of the hospital attendance and discharge. Prior to this referral the Young person was not known to the Local Authority Children Services. School were notified by mother that the young person had taken an overdose and that the young person would not be attending school for a few days. The mother informed the school the young person made no disclosure why they had taken an overdose other than saying it was a "combination of everything".

As planned one week following the overdose, a CAMHS professional saw the young person for an assessment of the young person mental health The young person was seen alone and then with their mother. It was reported by the young person that their mood was low (scoring 2 out of 10 on a mood score) and was still experiencing some negative thoughts but expressed no plans to act upon them. The young person expressed difficulties with school work and disturbed sleep. An open appointment of one month was offered by the CAMHS Service, who were not contacted during this period by the young person or by parents therefore the case was closed in March 2015.

Mood score: This is a simple method of trying to ascertain how the young person is feeling, the lower the score the lower the mood).

During the month of February 2015 school offered support to the young person in returning to 6th form and advice on how to try and catch up with course work. A Family Support Worker (FSW) who was employed

directly by the school was also allocated to work with the young person; this intervention was brief and it is unclear how many times the young person was seen by the FSW or if any concerns were shared by the young person with the FSW. During this month a letter from Local Authority Children Service was sent to the family notifying them that a Multi-agency Team Worker (MAT) was now allocated to work with the young person and parents and that contact would be made by the MAT worker. Unfortunately due to a systems failure the MAT worker did not contact the young person, parents or school.

In April 2015 the young person and their mother attended a GP appointment; this was following the young person's partner noticing that the young person was searching suicide websites. This had caused the partner concern because of a recent suspected suicide of a close relative of the partner who the young person knew. It has become apparent that the partner had shared their concerns with a family member and others about what the young person was viewing online and that appropriate action was taken by the young person's mother when they were notified of these concerns. At the GP appointment the young person was seen alone, it is reported that the young person was low in mood, stressed about their 'A' levels and upset about the death of their partner's relative. The young person denied current suicidal intent but stated that the overdose in January was taken with the intent to kill themself; the young person stated regret for what had happened because of the impact it had on their family. It was agreed that a re-referral was to be made to the CAMHS service. The mother did not speak to the GP regarding what was discussed during the young person/GP consultation but knew that a referral to CAMHS Service was going to be made.

During the month of April 2015 there were a number of contacts between school and the young person's mother regarding school attendance, how the young person was coping with their school work and plans for their future in school for example repeating the 6th form year. The mother shared information with the school that the young person had been looking at suicide sites and that the young person was struggling with anxiety.

Whilst waiting to see the CAMHS professional, the parents explored other support services for their child; for example two appointments were made to see an Independent Practitioner

[redacted]

During this period the family moved back to an area that was well outside of the school catchment area and the young person's social network/social hub.

In April 2015 school at mothers request made a referral for the young person to see the school nurse. In May 2015 the school nurse made contact with and saw the young person but very little information was shared or disclosed about how the young person was feeling. The young person did inform the school nurse that a CAMHS appointment was pending. The school nurse offered a follow up appointment in July 2015 but the young person did not attend this appointment.

In April 2015 CAMHS Service received a new referral from the GP and following screening of the referral a decision was made to offer a routine Tier 3 CAMHS appointment. An appointment was made for mid- July 2015 which was approximately twelve weeks post initial referral made by the GP. The GP and school nurse were not notified that this appointment had been arranged.

Tier 3 services are usually multidisciplinary teams or services working within the community mental health setting providing a service for children and young people with more severe, complex and persistent disorders.

The Derbyshire CAMHS Service aims to see young people within 7 weeks for routine appointments but due to increased demand and reduced capacity during this period this timeframe was not met.

During the month of May 2015 ongoing support was offered to the young person by the school encouraging the young person to attend school and focus on getting through their exams.

In June 2015 a number of meetings between the school and the young person took place to explore academic and career options. The young person was exploring the possibility of repeating the first 6th form year, changing their A level subjects and exploring a career in Health. School were willing to accommodate the young person's decision and support their future plans.

In July 2015 the CAMHS appointment took place as planned and the young person was seen alone for their mental health assessment by an experienced CAMHS professional. During the appointment the CAMHS professional spent time building and gaining a rapport with the young person. The young person was initially quiet and not opening up much but then began to talk freely. A risk assessment was undertaken which explored self-harm, suicidal ideation and intent. There was no indication during this assessment that the young person had any intent to take their own life and was speaking positively about their future, reason for living, enjoying school and considering their future career options. The young person saw school as a positive environment and did not want to leave the 6th form.

Subsequent to seeing the young person alone the CAMHS professional spoke with the young person and mother together. A follow up appointment was not offered by the CAMHS professional as it was not deemed necessary but discussion took place with both the young person and the mother regarding the benefit of Cognitive Behaviour Therapy (CBT). As the young person lived out of area they were advised to re-register with a GP in the area where they lived to facilitate a referral to this service if required.

CBT is a talking therapy that can help manage problems by changing the way one thinks and behaves. It is mostly used to treat anxiety and depression.

The following day the young person had taken a day off school and it is known that both the partner and the mother had received correspondence via text messaging from the young person that day. Mother returned to the family home to find their child hanging from the staircase. Emergency Services were called by the mother and the young person was taken to Hospital where sadly the young person was pronounced dead.

Legal Context:

A Serious Incident Learning Review was commissioned by Derbyshire Safeguarding Children Board, following agreement at Derbyshire Safeguarding Children Board Serious Case Review Panel in accordance with Working Together to Safeguard Children (Department of Education 2015).

Regulation 5 of the Local Safeguarding Children Boards Regulation 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
   (2) For the purposes of paragraph (1)(e) a serious case is one where:
   (a) Abuse or neglect of a child is known or suspected; and
   (b) Either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Working Together to Safeguard Children (Department of Education 2015) also stipulates that LSCBs should consider conducting reviews on cases which do not meet the SCR criteria.

Whilst this case was deemed not to meet the threshold for a Serious Case review it was agreed that a Serious Incident Learning Review should take place in line with the principles of learning and improvement set out in Chapter 4 of Working Together to Safeguard Children (Department of Education, March 2015). The methodology used was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an

effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final child practice report or in the action plan as appropriate.

Methodology:

Following notification of the death of the young person this case was discussed at the SCR panel meeting. It was agreed by the Chair of the Derbyshire Safeguarding Children Board to undertake a child practice review; a review panel was established in accordance with guidance. This was Chaired by Amanda Clarke, Board Manager for Derbyshire Safeguarding Children Board and included representation from relevant organisations within Health, Education, Police and Children Services. Michelina Racioppi, Designated Nurse for Southern Derbyshire Clinical Commissioning Group was commissioned to work with the panel and to undertake the review. The time period to be reviewed was between [redacted]

All relevant agencies reviewed their records and provided timelines of significant events with a brief analysis of their involvement. These were considered by the panel and provided opportunity for panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged to produce an interagency timeline. This was analysed by the reviewing officer and the panel. Areas requiring further exploration and consideration were highlighted. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case. [redacted]

The Chair of the panel and reviewing officer had the opportunity to meet with both parents [redacted] The visit enabled the Chair and reviewing officer the opportunity to gain an understanding of the parents' views and experiences of the services offered and received. This valuable insight into their experiences was shared with the panel and with practitioners attending the learning event. Account was taken of the views of the parents when writing this report and recommendations.

The learning event was held on [redacted] and was attended by 8 professionals who had had involvement with the young person in addition to the reviewer who facilitated the session, the Chair of the panel, two observers (Consultant/ Designated Nurse and Local Authority children centre manager) and the minute taker. The learning event was organised in line with Welsh Government Guidance (Child Practice Reviews Organising and Facilitating Learning Events, December 2012) and the event was recorded by the minute taker.

- *The Independent practitioner who saw the young person on two occasions did not attend the learning event but was contacted post meeting to ascertain if the young person gave her any cause for concern or had highlighted any indication of self-harm or suicidal ideation. The Independent practitioner reported that she had no concerns regarding the young person's mental health or emotional wellbeing and was completely shocked to hear that the young person had taken their own life. A discussion took place regarding a questionnaire that had been completed by the young person prior to the appointment and shared with the parent. The view of the Independent practitioner is that the young person had misinterpreted the format of the questionnaire and had interpreted it as requiring a yes or no response (relating to questions about previous experiences) rather than leaving sections blank. The importance of reviewing questionnaires used with clients was stressed in order to ensure that no possible concerns are missed.*

- *Unfortunately the GP was unable to attend the Learning event [redacted] but liaison took place with the GP panel representative following the learning event.*

Following the learning event, the reviewer collated and synthesised the learning to date for discussion with the panel. Practice issues originally identified by the panel were re-examined in the light of the findings of the review. This provided opportunity to identify issues requiring further clarification with practitioners or their

managers'. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice. [redacted].

The reviewing officer will meet again with the family to provide them with a copy of the review when it is completed and agreed by the Derbyshire Safeguarding Children Board. Learning from the full report may be made publically available after consideration by the Serious Case Review Sub Committee, the Safeguarding Children Board and the young person's parents.

ANALYSIS: Practice & Organisational Issues Identified

Current research findings:

The death of a child, whatever the circumstances, is a tragic loss. It has devastating impact on their family members, friends, school community and the community at large. It also has a significant impact upon professionals who knew and worked closely with the young person and the family.

Over the last few years there are increasing concerns regarding the mental health and wellbeing of young people. Suicides have become the second most common cause of death in young people worldwide and the most common cause of death in [redacted] aged 15 -19 years. **(Patton et al 2009 and RCPsych 2014).**

It is recognised that school plays an important role in promoting children and young people's mental health alongside early intervention services for those experiencing difficulties and CAMHS services for those that are unwell. It has also been recognised in a recent survey that there has been an increase in the number of young people experiencing anxiety or stress (90% reported increase), low mood or depression (84% reported increase) and self-harm or suicidal ideation (79 % reported increase) (**National Children Bureau/ Association for School and College Leaders 2016).** These findings are significant and services working with young people and in particular schools' need to re-think how young people are best supported and by whom.

Also it is important to highlight that findings from the Talking Taboos Campaign **(Cello and Young Minds 2012)** identified a gap in professional's knowledge and the need for a more in-depth understanding of how to support young people who self-harm is required. It is therefore important that as a Safeguarding Children Board we take a more proactive and collaborative approach in finding ways of supporting young people, families and front line professionals when there are concerns about self-harm and emotional instability. It is essential that the Board invests in ways of increasing the multiagency workforce skills and knowledge in relation to identifying early vulnerability by developing a self-harm/suicide prevention strategy which incorporates, training packages, assessment tool-kits and pathways so that young people are supported by those who know them and by those who are working closely with them.

The following is an analysis of the issues identified:

The review process has been unable to shed any light or reach any conclusions as to why the young person took their own life or whether this was intentional, this will be determined at the Coroners' inquest. It is unlikely that additional action by professionals involved would have prevented the death of the young person as they did not share how they were really feeling with professionals or their parents. The young person had a number of opportunities to talk to trusted adults in school, the GP and within the CAMHS service on a one to one basis. During these contacts the young person made no disclosure that that they had any intent to commit suicide. The death of the young person came as a total shock to the parents and all professionals who knew them.

The following points are areas that could have improved information sharing, multiagency working and support for the young person and parents.

1. **The completion of Early Help Assessment (EHA) and team around the family (TAF) meeting to facilitate effective interagency working and information sharing.**

Following the young person taking an overdose a referral was made by the Emergency Department to the

Local Authority Children Service. A MAT (multiagency team) worker was allocated to undertake an early help assessment and a standard format letter was sent to the parents informing them that a worker was now allocated and that they would be in contact soon. The letter did not indicate what support would be offered which led to the parents not pursuing this offer of support from the Children Service. Unfortunately due to a system error/failure within the Children Service the MAT worker who had been allocated the case was not prompted to commence working the family. The system errors/failure also led to the manager of the MAT worker not being alerted that the work with the family had not commenced. An internal review has now been undertaken within the Children Service and the SCR panel have been assured that systems and processes have been fully reviewed and improvements made so that this error does not occur again. It has been reported that there is now tighter management oversight of all cases allocated and the supervision arrangements with professionals have also been strengthened within the Children Service.

Not withstanding this system error it is the view of the panel that the young person and the parents would have benefited from a co-ordinated support package. It is not evident that professionals who knew and were working with the young person had considered undertaking an early help assessment following taking the overdose. An early help assessment (EHA) may have been helpful in gathering and understanding information about the needs of the young person and family. A holistic assessment such as an EHA may have assisted to identify the most appropriate way to meet the needs of the young person and helped in co-ordinating a team around the family (TAF) plan of support.

Learning:

- *To review the format and information within the letter that is sent to young people and parents regarding the service being offered by Children Service and highlighting the importance of the family contacting the service if they have not been contacted within a set timeframe.*
- *The importance of professionals working with the young person completing an EHA when there are signs of early vulnerability in order to ascertain the needs of the child and co-ordinate an interagency package of support for the young person and family.*

2. Access to pastoral support within school/education for young people who are experiencing difficulties or showing early signs of vulnerability.

Schools are ideally placed to identify children who might be at risk of harm or self-harm, monitor their progress and take action when necessary.

It would appear that the young person enjoyed school life had a close good circle of friends and a relationship with a partner who was 19/20 years of age. The young person made it clear that they wanted to continue with 6th form education and explore alternative options that would enable them to follow their chosen career path.

It was during the first year of 6th form that the young person began to struggle with the academic pressure of taking 'A' levels. It is evident that school made many good attempts to support the young person when it came to light and that they were struggling to cope. A number of options were explored with both the young person and with the parents. Additional support within school was also explored and offered such as a referral to the school nurse, changing the young person's form tutor and for a short period of time support from a Family Support Worker (FSW) who was directly employed by the school. Unfortunately the FSW left the school abruptly due to unconnected personal issues; therefore it is unknown what level of intervention was offered and if any concerns were shared with the FSW as this was not shared with the school. There were no records made of this intervention. Although school offered support to the young person an EHA was not considered and there was no consideration to arrange a team around the family meeting.

It was the view of the parents that although school did offer support to the young person they felt that this support focused mainly around supporting the young person with their academic difficulties/pressures and that more pastoral support may have been beneficial for the young person. It was also the view of the parents that they did not feel that the young person had been fully prepared for the differences of 6th form life and the work pressure/demands of 'A' levels. It is not known if the young person and parents attended the 6th form open evening which took place.

Learning:

- *Although the school provide 6th form preparation sessions for both pupils and parents a record of who has attended may allow the school an opportunity to follow up on families who do not attend as appropriate.*
- *School staff to receive additional guidance and training on how to support young people who are experiencing mental/emotional ill health.*
- *Within the 6th form setting there is a suitably trained member of staff made available and this role is promoted to students, particularly those that are showing early signs of vulnerability and possibly requiring pastoral support.*
- *When FSW's or similar roles are employed directly by a school robust governance arrangements are necessary including supervision arrangements, record keeping, management oversight and information sharing arrangements in accordance with DSCB requirements.*

3. Access to Child and Adolescent Mental Health Service (CAMHS) and signposting to other services.

Appropriate referrals were made to the CAMHS service. The young person was seen and assessed on each occasion by the CAMHS professional on a 1:1 basis and then with their parent. The young person was given the opportunity to discuss how they were feeling and explore what were the factors/triggers for them taking an overdose, experiencing low mood/anxiety and stress. Following the overdose the young person was seen and assessed; using a recognised mental health assessment called FACE in a timely manner prior to hospital discharge and was then seen again for a follow up appointment a week later in the community.

The FACE (Functional Analysis of Care Environments) assessment is a nationally accredited mental health assessment tool.

At the follow up appointment although scoring 2 in their mood score and continuing to experience feelings of low self-esteem, low mood and poor sleep it was agreed that an open appointment for a month would be made available should the young person or parents require an appointment. This offer was not taken up by the young person or parent.

Prior to closing the case in March 2015, the CAMHS professional did not contact the young person or parents to review how they were doing in relation to their mood and if further support was required prior to making the decision to discharge they young person from the CAMHS service. This may have provided an opportunity to review how the young person was feeling and if their mood had improved. Also there is no indication that the GP, parents or School Nurse received a discharge letter from the CAMHS service. A discharge letter may have provided the young person, parents, the GP and the school nurse information that they were now discharged from the CAMHS service and how the young person or parents could access services if required in the future.

It is important to note that in April 2015 the parents reported that when they were concerned about their child viewing suicide sites they did contact the CAMHS service to seek advice and they recall being advised that they needed to see the GP in order to be re-referred to the CAMHS service. It is not clear who the parent spoke to on this occasion but it is possible that if they had spoken to a CAMHS professional advice and support could have been provided in addressing and helping to manage this concern until the young person was seen again by a CAMHS professional.

It is not evident that when the GP made a re-referral to the CAMHS service in April 2015 the referral was deemed as an urgent referral. When CAMHS received the referral it was screened and scored appropriately in a timely manner but due to increased demand on the CAMHS service an appointment was made approximately 12 weeks later; the target time for a CAMHS assessment is 7 weeks from the date of referral.

It would appear that the GP and school nurse were not informed of the confirmed appointment date; it is possible that if the GP and school nurse were made aware of the 12 week time frame to see the CAMHS professional they may have requested that the appointment was brought forward.

When the young person was seen in July 2015 by an experienced CAMHS professional a good rapport was

developed, a risk assessment was undertaken where a significant amount of information was ascertained about the young person. The young person informed the CAMHS professional about the "on and off" relationship with their partner, spoke positively about 6th form and despite struggling with 'A' levels they stated that they wanted to retake the year. The young person talked positively about their future plans and options available to them, they scored 7 in their mood score and expressed no thoughts of self-harm, suicidal ideation or intent. The young person reported to feeling low when they were without their friends.

The conclusion from this assessment was that the young person did not need another appointment but discussed the possible benefits of Cognitive Behaviour Therapy (CBT). Both the young person and the mother agreed that they would register with a local GP and if required in the future ask to be re-referred to the CAMHS service for CBT.

It is important to note that the CAMHS service have undertaken an untoward incident internal investigation and the report and findings have been shared with both parents and the author of this review. The panel acknowledges the recommendations made from the internal CAMHS review and that the actions will be progressed within the CAMHS management service and shared with their commissioners.

It is also important to note that the CAMHS professional who last saw the young person has an appointment to see the parents and the parents have welcomed this opportunity to meet with them.

Learning:

- *The importance of discharge letters and appointment confirmation being copied to the GP and the School Nurse for their information.*
- *Prior to the CAMHS service closing a case to ensure that the young person and parent has been spoken to by the CAMHS professionals and provided advice on where to access support if required in the future.*
- *If a parent or young person contacts the CAMHS service for advice on a clinical matter administrative staff will ideally have a named clinician available to offer support and or advice as appropriate. (It has been reported that this is now in place).*
- *CAMHS service to develop a referral tool which will help prompt the referrer to indicate the urgency of their referral. (It has been reported that this is now in place).*
- *Should a CAMHS appointment be over the expected 7 week time frame then this needs to be highlighted to senior management and the referrer also needs to be notified of the delay.*

4. Access to school health support and signposting.

It was evident at the learning event that the school nurse has a very good working relationship with the school and referrals are made to the school health service when additional support is required. It is also known to the young people within the school that 'open door/drop in' sessions are available to access if required.

The school nurse first made contact with the young person when they were in Year 10. The school nurse made contact because another student had disclosed that the young person had self-harmed. At the learning event the school nurse shared that they knew the young person because of a friendship between the young person and the school nurses own child. It is possible that the young person may not have wanted to disclose any personal information because of the connection with the young person's friend. The view of the school nurse from this contact in year 10 was that the young person did not pose a further risk of self-harm and did not feel they met the threshold that required the school nurse to break confidentiality and contact the parents.

When the school nurse saw the young person again in May 2015 there was a student nurse shadowing the drop in session and although the young person agreed for the student nurse to be present, the young person was quiet and shared very little information. A follow up appointment was arranged but the young person did not attend.

It is possible that the young person may not have felt comfortable to talk as openly with the school nurse because of the connection with their school friend and they may have felt uncomfortable having another professional present during the consultation.

Learning:

- *If a young person is known to the professional outside the work environment then ideally an alternative member of the team should be offered.*
- *It is good practice to check and record client consent for third parties such as student nurses to be present during consultations; this should continue.*

5. Raising awareness regarding the dangers of accessing self-harm and suicide sites.

There is a growing concern that the use of the internet is playing an increasing role in self-harm and suicide. There is evidence that young people who self-harm or are suicidal are making use of the internet. **(Daine et al 2013)** For some young people the internet is used for constructive purposes for example exploring coping strategies but for some it may have negative influence including potentially discouraging disclosure or not seeking help from professionals. There is also a link to exposure to the internet and violent methods of self-harm **(Daine et al 2013)**. What is of great concern to professionals is that this type of information is readily available on the internet. More young people and adults are relying and referring to internet sites and chat rooms etc. to seek information, advice, guidance and support. It is proving to be an impossible task for the Police to monitor and shut down these sites that provide people of all age's advice on how to self-harm or commit suicide.

Government intervention is required to put pressure on search engine companies to develop robust mechanisms to monitor sites that may be linked to significant harm to children, young people and adults. Locally the Safeguarding Children Board and Safeguarding Adults Board should work together in sending clear, consistent and regular messages that suicide sites are dangerous and to signpost individuals who are experiencing feelings of suicidal ideation or intent to where they can go to access urgent advice/support and therapeutic intervention.

Learning:

- *When children are self-harming there should be proactive and detailed enquires made about their internet use including sites they are accessing as it may be likely that access to these sites is more than a 'one off' incident or exploration.*
- *Safeguarding Children and Adults Boards need to work together in providing clear, consistent and regular messages to professionals, young people and families that suicide sites are dangerous and can lead to very serious consequences.*

6. Obtaining the voice of the child

From undertaking this learning review and speaking to the professionals that knew and worked with the young person it is evident that a number of attempts were made to explore with the young person what was leading to their low mood, anxiety and stress. For reasons that will not be known the young person did not feel able to fully open up and disclose to professionals their true feelings and the extent of their low mood and depression which led them to taking an overdose and then later making a decision to end their own life.

When parents were asked what their child shared with them about how they were feeling and why they had self-harmed the response their child gave to them was **"it's just everything, bit of school, [redacted], bit of growing up"**

What is now evident is that this could have been the basis of factors that led to the young person making the decision to end their own life.

Learning:

- *Professionals should continue to be professionally curious in their interactions with young people and continue to provide young people opportunities to feel able to talk about how they are feeling and coping.*

Practice issues

A number of practice issues were highlighted by individual organisations as a result of the learning review. These will need to be monitored through the governance arrangements of those Organisations.

- Children Services to ensure that the system error/failure to prompt professionals to commence an assessment and work with a family once a case has been allocated has been resolved.
- Children Services to audit that new systems that have been implemented in relation to allocation of cases have been implemented and that there no further evidence of system error/ failure.
- CAMHS service prior to closing a case should always make contact with the young person and parent(s) to ascertain if any further appointments and intervention is required.
- CAMHS service to notify the GP and school nurse of their plan to see the young person and also ensure that they are sent a discharge letter.
- CAMHS service to monitor their waiting list times and notify their managers and commissioners regarding any concerns in meeting agreed time frames to see clients.

Good Practice Identified

A number of areas of good practice were identified during the review, by the panel and by professionals at the learning event.

- The young person was admitted overnight onto a paediatric ward. Evidence shows that overnight admission allows for a period of "emotional cooling off" and enables a more accurate assessment and care planning to take place. **(RCPsych 2014)**
- An open door/drop in service in the school setting was available by the school nurse for young people to access.
- The Head of 6th Form on a number of occasions explored with the young person and parent(s) alternative options regarding 'A' level choices, other academic courses and career options. The Head of 6th Form endeavored to be open and honest with the young person's academic capability, progress and encouraged the young person to continue to attend and engage with school.
- The CAMHS professionals developed a good rapport with the young person and managed to obtain a significant amount of information from the young person in order to undertake a risk assessment.
- The young person was seen on a number of occasions on their own providing opportunities for them to talk openly to professionals which demonstrates a focus on listening and obtaining the child's voice.

Conclusion

The findings of this serious incident learning review do not indicate that inter-agency practice or the practice of any individual or organisation could have altered the outcome of this case or that the death of the young person could have been predicted or prevented.

Areas of good practice were noted. Scrutiny of practice, however, always provides an opportunity to consider ways in which services may be improved and therefore the following recommendations, based on the learning from this case, have been made:

Recommendations

In order to promote the learning from this case the review identified the following actions for Derbyshire Safeguarding Children Board and its member agencies to address:

1. **Derbyshire LSCB should ensure that this report is made available to local practitioners to inform practice and widen learning.**

   Intended outcome: To share the learning obtained from undertaking this review with the overall aim to improve service delivery and service development.

2. **It is good practice that professionals who are working with young people who are presenting with early signs of vulnerability complete an early help assessment and that team around the family (TAF) meetings take place. The DSCB should undertake an audit of early help processes/ arrangements to ensure the use of early help intervention is making a positive difference to children, young people and families.**

   Intended outcome: To ascertain that front line staff are aware of the early help assessment and team around the family processes and that these arrangements are being utilised to help meet the needs of young people showing early signs of vulnerability.

3. **CAMHS service should produce and share widely guidance for other professionals that highlights:**
   - **Referral criteria and proforma which includes threshold guidance and response times for urgent, soon and routine referrals.**
   - **Guidance for parents, young people and professionals on how to access advice from CAMHS service.**
   - **Alternative sources of mental health support for young people and parents to access.**

   Intended outcome: To guide professionals in their decision making, help them to determine the levelof urgency when making a referral to CAMHS service and having a recognised/reputable signposting service for young people and parents to refer to whist waiting to be seen by the CAMHS service.

4. **The GP and school nurse should receive a copy of the appointment confirmation and discharge letter from the CAMHS service.**

   Intended outcome: If required the GP or school nurse can contact the CAMHS service to raise any issues regarding the appointment date and the discharge plan.

5. **When a professional knowns a young person and /or family outside their professional role then an alternative worker should be explored in order to offer the service to the young person.**

   Intended outcome: This will avoid any possibility of the young person not feeling able to engage with a professional known to them and the professional experiencing a possible conflict of interest.

6. **The Derbyshire Safeguarding Children Board should ensure a child focused training programme/tool kit is developed to help equip professionals to respond appropriately to young people who self-harm or have suicidal ideation. This training should be made available to all front line staff.**

   Intended outcome: For front line staff to feel more confident, better equipped and skilled to support young people who are self-harming or having suicidal thoughts.

7. **As part of the assessment of the young person all professionals should ascertain the young person's internet use and clarify with them the types of sites being accessed and the frequency of use especially when there are concerns around self-harm and suicidal ideation.**

   Intended outcome: For professionals to be aware that suicide sites have a very negative influence and can increase the young person vulnerability to self-harm or act upon the information made available to them. If suicide sites are being accessed this information needs to be shared and requires an urgent assessment to determine the level of intervention and support required for the young person.

8. **For both the Derbyshire Children and Adults Boards to work proactively and collaboratively with Public Health in developing a consistent and regular awareness raising campaign highlighting the dangers of young people and adults accessing suicide sites and advising who people can turn to if they are feeling depressed and need advice or support.**

   Intended outcome: To raise awareness to young people and adults that there are safe and reputable services available for them to access to obtain advice and support during periods of emotional instability and mental ill health and that these suicide sites are extremely dangerous to refer to.

9. **Organisations that directly employ family support workers/ pastoral support workers should ensure that they have robust governance arrangements in place, such as supervision arrangements, management oversight, record keeping and information sharing processes.**

Intended Outcome: That all staff are clear about their safeguarding children role and responsibility and are clear on who they can go to for advice, support and guidance when they have concerns about children and young people.

10. **The DSCB to consider working together with Public Health and partners in developing a self-harm and suicide prevention strategy and action plan.**

Intended outcome: To develop an action plan to demonstrate the commitment of the DSCB to address the concerns being raised regarding the prevalence of self-harm and suicide cases of young people in the area with the overall aim to reduce future incidents occurring.

References

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- NICE Guidance on self-harm (NICE 2004 and 2011)
- Cello, Young minds (2012) Talking Taboos: Talking self-harm, Cello Group.

Statement by Reviewer

Independent Reviewer

Michelina Racioppi
Designated Nurse
Southern Derbyshire Clinical Commissioning Group

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 involved 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.