Child Safeguarding Practice Review Seven Minute Guide

Date agreed by the partnership: 09/03/21

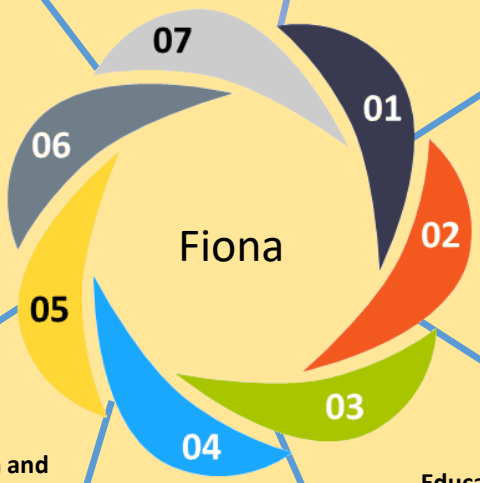
Fiona

Our Seven Minute guides provide information on key topics useful for managers to use to support reflective discussion with practitioners.

https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/NSCC-7-Minute-Guide-How-to-use-seven-minute-briefings.pdf

This Seven minute guide is longer than usual as when developing its contents we did not want to lose Fiona and her lived experiences which are set out on page two.

Page three offers the key learning and recommendations agreed by the partnership in March 2021



1

Fiona's Presentation

Fiona was 17 yrs old when she died due to suspected self harm in May 2020, whilst living in supported accommodation.
In April 2018 Fiona's mother took her to the GP, concerned about self harm (cutting), anxiety and low mood.

In May 2018 Fiona was admitted to hospital following an overdose of painkillers and alcohol. Over the next 2 yrs she attended Accident and Emergency 52 times, with 12 of these requiring hospital admission.
Her self harm behaviour included overdose, head-banging, burning, cutting and tying ligatures around her neck. She was compulsorily detained in hospital 3 times under the Mental Health Act.

2

Diagnosis and Treatment

Fiona was initially diagnosed with anxiety and an eating disorder. She received extensive input from community mental health teams and specialist in-patient units.
In October 2019 she was diagnosed with Emerging Emotionally Unstable Personality Disorder (EUPD) and was referred to the Personality Disorder Services Hub for care-planning in preparation for transfer to adult services at 18 yrs.

3

Education and Training

The extent of Fiona's illness and her periods in hospital meant that she missed most of her GCSE programme in school.

March – May 2019: she accessed small group tuition from Education Other Than At School (EOTAS)

Sept – Dec 2019: she enrolled at a Further Education college but found the volume of students and long bus journey overwhelming, despite a reduced timetable.

March2020: Fiona started to attend a training centre close to her home just before the Covid lockdown led to closure of the centre.

4

Impact of Covid

At the time of lockdown, Fiona was living in supported accommodation, accessing a number of activity groups, most of which had to cease (her 1:1 support continued face to face) She did not have any education work supplied by the training provider.

Fiona missed socialising with friends and felt isolated from family. Some residents in the supported accommodation had returned to their family home for lockdown but Fiona felt this was not an option for her.

Although some contact with key professionals was face to face, much of Fiona's support and treatment had to be delivered using virtually via phone and video links

5

Accommodation and Services for 16 & 17 Yr Olds

By June 2019, Fiona's parents were struggling with her self harming behaviour and the demands of close supervision.

In August 2019 Fiona moved into a 2-person flat in local supported accommodation for 16+ yr olds with complex mental health needs, for a short-term stay.
In January 2020 Fiona became a Looked After Child when she and her mother felt a return home from supported accommodation was no longer wanted.

There were conflicting approaches by health and social care about involving Fiona's parents in her care plans and treatment because of her age.

6

What worked well:
There was considerable evidence of good practice identified eg:

- Strength of relationships professionals had with Fiona and with each other
- Shared identification of high risk and manager support
- Use of strengths-based practice and identification of protective factors
- Attendance at multi-agency meetings
- Amount of time and commitment to Fiona
- Fiona was seen as a person, not a diagnosis
- Level of support from staff in supported accommodation, particularly during the night, showing compassion, staying calm and following plans.
- Fiona was happy where she lived and felt supported

7

Key Issues and Recommendations for Multi Agency Working
The importance of:

- Shared understanding among practitioners of diagnosis, roles/responsibilities, service remit and legislation
- Streamlining processes eg risk assessments and meetings
- Parents' involvement with risk assessments relating to serious self harm
- Involving ALL health professionals (including A&E and GPs) in strategy meetings for mentally ill young people at risk of serious self harm
- Education as a protective factor – suitable education provision to be pursued with pace
- Rapport and relationship building with young people to establish trust
- Potential benefits of facilitating parents' and siblings' access to information, advice and support

Summary of learning; how agencies worked together to provide support, care and treatment

The complexity involved (processes) in working with mentally ill young people who are at serious risk from self-harm and who are "looked after" by the local authority

The importance of a shared understanding amongst practitioners; diagnoses, concepts, roles and responsibilities, service remits, legislation

The potential benefits of streamlining processes, especially risk assessments and meetings

The importance of devising written risk assessments with parents caring for young people at serious risk from self-harm and ensuring they have a copy

It is important to involve and/or share information with all relevant health professionals in strategy meetings for mentally ill young people who are at serious risk from self-harm; especially Emergency Department and GP representatives

Being in education is a protective factor and where young people are not receiving suitable education this needs to be pro-actively considered with pace

The importance of establishing rapport and relationship building with young people to establish trust

The potential benefits of facilitating parents' and siblings' access to information advice and support from an independent source

Summary of learning: services for young people aged 16 & 17 years old

Annual assurance visits for new provision under contract to adult services should commence soon after the first placement is made, rather than up to 12 months, especially when being used for children

The importance of explicit discussion with young people about the benefits of S20 versus S17 support

The benefits of practitioners, as a team around the individual young person, explicitly identifying the challenges of working with young people aged 16 and 17 years old

Practitioners who are not mental health specialists benefit from access to consultation and supervision from qualified specialist staff and training about mental illnesses and their treatment.

Summary of learning: the impact of Covid

The adverse impact of social isolation and lack of meaningful activity on a young person's mental health

The potential value of convening a strategy meeting when there is a significant change in circumstances and/or multiple service disruption

The potential benefits of ensuring Business Continuity plans including consideration of convening/requesting strategy meetings where service disruption includes more than one agency

To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations for NSSCP:

1) That NSSCP review the self-harm pathways for young people with a view to integrating processes, especially risk assessment and meetings.

2) That the NSSCP considers how best to ensure consistently good awareness amongst all practitioners of Section 117 aftercare (Mental Health Act 1983) and the self-harm pathways

https://www.proceduresonline.com/nesubregion/files/manag_self_harm_suicid_behv.pdf

3) That the NSSCP considers how best to ensure that practitioners who work with mentally ill children but who are not mental health specialists have;

a) sufficient knowledge relevant to their role to understand diagnoses, treatment, pathways, roles and responsibilities, service remits, and legislation according to their roles

b) sufficient access to consultation and supervision from practitioners who are mental health specialists.

4) That the NSSCP considers how best to ensure assessments of, and care plans, for mentally ill young people consider the need for support for parents and siblings, including support from the third sector.

5) That the NSSCP ensures a baseline audit is conducted to establish;

a) how well agencies individually and collectively are meeting the needs of vulnerable 16 year and 17 year olds and

b) the most significant challenges which undermine agencies' efforts to meet the needs of vulnerable 16 and 17 year olds

6) That NSSCP seeks assurances from all agencies delivering services to children that, when significant service disruption includes more than one agency, their Business Continuity plans include a requirement to consider convening multi-agency meetings for individual children who are at risk of significant harm to jointly assess risks and plan a joined-up response.

7) That NSSCP seeks assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them.

As part of your team meeting please reflect and consider how your team and you as an individual worker will embed these recommendations and key learning points in your practice.