CHILD SAFEGUARDING PRACTICE REVIEW

Fiona

Date agreed by the partnership: 09/03/21

Lead Reviewer: Karen Perry

Publication date – 4 June 2021

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INTRODUCTION

1.1. This Child Safeguarding Practice Review (CSPR) is in respect of Fiona, (who died at the age of 17 years in hospital on the 3rd May 2020). She had been found just over a week previously, unconscious in her room in supported accommodation, due to suspected self harm.

1.2. All learning points are listed in section 4, at the end of each theme. What follows is a summary of the most significant learning from this review. Streamlining local arrangements for risk assessments and meetings would support practitioners better in managing the considerable complexity involved in working with mentally ill "looked after" young people who are at serious risk from self-harm. It would also be helpful to identify the local challenges for multi-agency/multi-disciplinary teams around the child of working with 16- and 17-year olds; the involvement of services whose users are predominantly adults, with different culture and expectations to those that usually apply to children. 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. 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; this might include a representative from the Emergency Department. There is also potential value in convening a strategy meeting when there is a significant change in circumstances and/or multiple service disruption.

1.3. The Northumberland Strategic Safeguarding Children Partnership (NSSCP) will ensure that learning is widely disseminated locally and publish this report on their website. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning. The CSPR takes into account multi-agency involvement from June 2019 (when her Mother and Stepfather were expressing concerns that they could no longer care for her safely) until April 22nd 2020 when she was found with a ligature round her neck.

1.4. The NSSCP agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time.[1] Mother and Stepfather agreed to speak to the lead reviewer and their views are included at appropriate points in the report.

2. DETAILS OF THE FAMILY AND CASE CONTEXT

2.1. Fiona had one older sibling. Family members are referred to in terms of their relationship to her e.g. as Mother and Stepfather. Fiona has been described as a clever, likeable, "sassy", and independent minded girl, who had a sense of humour and who liked getting her hair, makeup and nails done. She was good at art and maths and aspired to be a maths lecturer.

[1] Due to Covid 19, meetings with practitioners and parents and quality assurance and approval panel meetings were achieved by video conference rather than face to face

2.2. Some contextual information is relevant. On 21st May 2018 Fiona was admitted to the local hospital following taking an overdose of painkillers and alcohol. The hospital made a referral to Children's Services which stated that she was still expressing suicidal intent. The referral progressed to a Child and Family Assessment; a social worker remained involved throughout the period covered by the review. The Child and Young People (mental health) Services (CYPS) also become involved. This was less than a month after Fiona's mother first took her to the GP expressing concerns about increased self-harm (cutting) and that her personality had completely changed to being withdrawn, anxious with low mood. Fiona had not previously had any services other than those provided to all children.

2.3. Since 2018 Fiona had extensive input from mental health services. This included involvement from: CYPS; the Intensive Community Treatment Service (ICTS);[2] Eating Disorder Intensive Community Treatment Service (EDICT); Psychiatric Liaison team (PLT); and in-patient admissions at local specialist hospitals for children's mental health and for eating disorders. Fiona was given access to several sets of DBT therapy[3]: as an inpatient in hospital, between June and August 2019 and from February 2020. Practitioners told this review that it was difficult for her to engage meaningfully with the support and skills she needed to use.

2.4. Fiona's risk history between 2018 and 2020 includes several overdoses, often requiring treatment/observation, self-harm in the form of banging her head against hard surfaces, burning herself, tying ligatures around her neck and cutting herself with various implements. Records show that Fiona had had 52 visits to the Emergency Department in the two years before her death and 23 visits since January 2020. Many of these involved potentially life-threatening incidents. 12 of these occasions required admission to the local hospital.

2.5. Fiona was compulsorily detained in hospital three times under the Mental Health Act,[4] and received treatment at the local specialist hospital for mentally ill young people: from 12th June 2018 until 3rd January 2019 (mostly in an eating disorder unit); from 19th January to the 27th March 2019; and from 16th – 20th December 2019.

2.6. Whilst risk levels varied throughout the period under review, they were always high at best, and a measure of the lack of stability was the virtually continuous involvement of the Intensive Community Treatment Service (ICTS).

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[2] ICTS provides intensive home-based treatment for children and young people with complex mental health needs. This includes urgent assessments for self-harm and acute mental health presentations and a role in pre-admission and discharge for all young people admitted to the specialist mental health local children's hospital

[3] DBT is a type of talking therapy, a type of Cognitive Behaviour therapy adapted for people who feel emotions very intensely. The aim of DBT is to enable people to understand and accept difficult feelings, learn skills to manage them and make positive changes in their lives

[4] The Mental Health Act 1983 , including amendments, is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

3. KEY EPISODES

Key Episode 1: from June 2019 until August 2019 (Mother and Stepfather caring for her whilst alternative placement was found)

3.1. After discharge from hospital in March 2019, the Education Other Than At School team (EOTAS)[5] arranged for Fiona to receive tuition in a small group of students until May 2019.

3.2. By June 2019, Mother and Stepfather were finding it difficult to cope with Fiona's incidents of self-harming and expressed frustration with what they saw as lack of support from Children's Social Care, especially now her education had finished. Mother and Stepfather told this review that the social worker attempted to address the subsequent lack of meaningful activity by having a Barnardo's worker take Fiona out 5 weekdays a fortnight; the other days Fiona were supervised by extended family members.

3.3. In early August 2019 Fiona moved into a two-person flat in supported accommodation in her hometown for people aged 16 years and over with complex mental health and/or learning disabilities. The original plan was for a short term stay with a view to returning home.

Key Episode 2: from August 2019 until January 2020 (from admission to the specialist supported accommodation until becoming a Looked After child)

3.4. In September 2019 Fiona enrolled at a Further Education college. Fiona told practitioners she felt overwhelmed by the volume of students and the long bus journey to and from college; this was not sufficiently eased by the implementation of a reduced timetable and Fiona ceased attendance in December 2019.

3.5. The frequency of self-harm incidents reduced a little in the first few weeks after she moved into the supported accommodation, but by October 2019 the frequency began to increase again, with supported accommodation staff expressing concern about new trends of head banging and of self- harm when night duty staff were on duty. At an appointment with the psychiatrist at the end of October 2019, he concluded that the most appropriate diagnosis was one of Emerging Emotionally Unstable Personality Disorder (EUPD).[6]

3.6. In mid-January 2020, because becoming "Looked After" [7] entitled Fiona to support post 18, as a care leaver[8] and a return home was no longer wanted by Fiona or her Mother,

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[5] The EOTAS Health Needs team provides for learners who are of statutory school age but who are unable to attend school full time due to health and medical needs. Tuition is provided on a one to one basis or in small groups depending on the needs of each individual pupil.

[6] Emotionally Unstable Personality Disorder (EUPD) is sometimes referred to as Borderline Personality disorder. EUPD/BPD involves feelings of intense negative emotions, and severe mood swings which can change quickly and unpredictably from despair to euphoria. It can involve hallucinations. Impulsive behaviour including self-harm and involvement in reckless activities e.g. binge drinking, drug use, unprotected sex with strangers. Personal relationships tend to be unstable either because of fear of abandonment or fear and anger at being smothered or controlled. https://www.nhs.uk/conditions/borderline-personality-disorder/

[7] A "looked after" child is one who has been in the care of their local authority for more than 24 hours or who is subject to a care order.

both consented to Fiona becoming "Looked After". Mother told this review that this was due to the social worker explaining the benefits to her and that Fiona had agreed to this.

3.7. **Key Episode 3: from February 2020 (when risks began escalating further) until April 2020 (Fiona's death)**

3.8. During February 2020, apparently partly triggered by suicide of a friend, the risks from self-harming escalated due to Fiona using ligatures more frequently and not always directly seeking help and occasionally self-harming in the bathroom, where she knew staff could not enter if she locked the door. The support plan and risk assessments were reviewed and, for a short while, Fiona was a little more settled. A careers advisor supported her to enrol, at a training centre for 16-19 year olds only 10 minutes' walk away. Fiona began to attend at the beginning of March 2020 and engaged well.

3.9. The impact of Covid and the lockdown in March 2020 had a big impact on Fiona's access to education and activities. From mid-April 2020 onwards the rate of self-harm incidents increased, and Fiona expressed a concerning level of suicidal thoughts in conversations with an ICTS worker and the care-co-ordinator. During a phone conversation with Fiona on 22nd April 2020, after her return from the local hospital due to a ligature incident, the ICTS practitioner found it sufficiently difficult to redirect Fiona's thoughts from plans to kill herself that they alerted staff at the supported accommodation and requested an immediate welfare check. As staff at the supported accommodation were unable to gain entry to her room, they called the police, who found Fiona with a ligature round her neck. Fiona died in hospital on 3rd May 2020.

4. THEMATIC ANALYSIS

4.1. The learning from this review will be discussed via three themes:

- How agencies worked together to provide treatment support, care and education
- Services for young people aged 16 & 17 years
- Impact of Covid and the "lockdown"

Theme: how agencies worked together to provide support, care, treatment and education

4.2. Fiona's initial diagnosis was social anxiety and anorexia. By the time of her admission to supported accommodation in August 2019, it had become apparent that her food restriction did not represent a classic form of eating disorder but was in fact another form of self-harming. During October 2019, not long after her 17th birthday, Fiona was reviewed within the CYPS multidisciplinary team. This resulted in a diagnosis of Emerging Emotionally Unstable Personality Disorder and a referral to the Personality Disorder Services Hub (PDHub) for advice regarding care planning, including the appropriate care pathway when reaching aged eighteen years and planning for transfer to adult services. This diagnosis was confirmed in a review by the psychiatrist at the end of the month.

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[8] A Care Leaver is someone who has been in the care of the Local Authority for a total period of 13 weeks or more since their 14th birthday including after their 16th birthday.

4.3. Caution is applied to diagnoses of personality disorders before the age of 25 years as personalities are still developing; it is very unusual to have a diagnosis before the age of 18 years, although a diagnosis is needed to offer continuing treatment with adult services. However mental health practitioners thought that Fiona's diagnosis of Emerging Emotionally Unstable Personality Disorder was clear. Being given a diagnosis of a personality disorder can be upsetting if it makes people feel as if they are being told there's something wrong with who they are. On the other hand, some people find that getting a diagnosis helps them to name and understand their experiences, to explain themselves to other people, and sometimes get treatment and support they otherwise might not. Practitioners told this review that Fiona had felt insulted initially, she did not like the label "emotionally unstable" preferring alternative terminology of Borderline Personality Disorder. However, she recognised herself in the traits described to her and was reassured that change was possible.

4.4. The diagnosis of emerging EUPD was shared and discussed at a multi-agency strategy meeting in November 2019. However, managers at the supported accommodation told this review that they were not formally told of the change in diagnosis until the discharge planning meeting in December 2019. Fiona's mother told this review that she was aware of the change in diagnosis because it was mentioned in meetings, but to understand it better she relied on information taken from the internet. She told this review she never received a detailed description of what it was, partly she thought because she was no longer accompanying Fiona to attend appointments with the psychiatrist because supported accommodation staff were doing that.

4.5. In June 2019 Mother and Stepfather were worried they could not keep Fiona safe at home and records show they requested either admission to hospital for psychiatric treatment or for Fiona to be "looked after" by the local authority. Mental health clinicians thought admission to hospital in June 2019 was not appropriate as Fiona's previous lengthy stay had not stopped her self-harming. Since her discharge in March 2019, and throughout the period under review they consistently felt anything other than short-term admission in life threatening circumstances was likely to be counterproductive, and that care and support needed to be provided which would enable her to live in the community.[9] Mother and Stepfather told this review that they did not understand or share that view; they thought the priority was to keep her safe and that this was very difficult to do in the community.

4.6. All practitioners recognised that Mother and Stepfather were struggling to manage Fiona's self-harm appropriately but thought that a move (to a placement) should be done in a planned way rather than in a crisis. Accordingly, a referral was made to a specialist supported accommodation provider via the Local Authority Complex Housing Panel on 2nd July 2019. Fiona's move into the supported accommodation involved a planned transition, which included a professionals meeting, contact between supported accommodation staff and ICTS for advice on how best to support her and a visit by Fiona and her mother. A place wasn't immediately available so the time from referral to

[9] Whether or not Fiona would benefit from admission to hospital for psychiatric treatment was considered frequently including at each attendance at the Emergency Room and in discussion at multi-agency meetings.

admission was 4 weeks; towards the end of that time practitioners were concerned that the lack of a firm date was increasing Fiona's anxiety and self-harm.

4.7. Mother and Stepfather told this review that Fiona liked living in the supported accommodation, she enjoyed feeling more independent and having her friends to visit and that she had immediately become friendly with her female flatmate who was of a similar age. Records show that Fiona felt rejected by her parents although practitioners attempted to reframe the move in terms of the benefits of having some time apart.

4.8. The aim for Fiona was to try to find a safe way of living within the community near her established social networks. The purpose of most supported accommodation for 16 and 17 year olds is to promote independent living skills, and whilst staff might have training in the range of typical needs of vulnerable young people who have left care, or where family relationships have broken down, this would be insufficient to manage the level of need and risk involved in caring for Fiona, even with the intended continued involvement of specialist mental health services. Finding local placements for young people with Fiona's type and level of needs is challenging.

4.9. The placement was commissioned by the council. As there was nothing suitable within the normal approved children's provider arrangements for 16- and 17-year olds, an alternative provider was required. Practitioners told this review that the aim was to find a local placement that could manage Fiona's mental health and assist in developing strategies for safe living in the community. The supported accommodation chosen via the adult social care contractual framework has 39 places for people aged 16 years and over with complex mental health problems or learning difficulties or dual diagnosis, with a focus on promoting independence and recovery. Numbers of young people are small (two other young people at the time of Fiona's placement) and matching issues about sharing with a (young) adult were discussed at the meeting in July 2019. Customers are housed in small groups and provided with focused one to one support from a named support co-ordinator whose role is to provide support, not therapy or treatment, and who is supervised by a practice lead who is a registered mental health nurse.

4.10. Support staff would accompany Fiona to appointments, otherwise the main focus of the 6 hours daily support was to offer distraction at high-risk times. These tended to be in the evenings, although Fiona's risk would increase as soon as support ended at the agreed times and often incidents of self-harm occurred during the night. Supported accommodation staff contacted the relevant agency in a crisis; they were commissioned to provide care and support rather than therapeutic intervention or treatment to Fiona.

4.11. Due to Fiona's age, uncertainty about her independent living skills, and her challenging behaviour at night-time, she was housed in the main building, where staff are always available day and night. Supported accommodation managers told this review that the factors they always consider for matching the customers in individual properties include: age and age appropriateness; gender; level of support required; current stability of the other customer in the property. The supported accommodation has since learned more about matching, including the impact of the proposed admission on existing service users,

and recognising patterns of behaviours that can require further assessment for sharing flats.

4.12. During the period under review there were three different risk assessment processes and documents generated by the social worker, the care-co-ordinator and the supported accommodation, respectively. These each appear to have been updated regularly, and in response to changing risks, and practitioners told this review that all three would be considered at meetings led by the social worker and include information from different agencies. However having three was potentially confusing and some practitioners who would have benefitted from knowing the multi-agency risk arrangements did not have copies; the Emergency Department records only had a copy of the social workers risk assessment which was out of date. The GP did not have a copy of any risk assessments.

4.13. As Fiona's risk level and behaviours could quickly escalate the complexity of the risk management arrangements was particularly difficult for supported accommodation support workers. This was because, although they had had relevant training for their roles, they were unqualified staff, yet had the most immediate responsibilities for dealing with any incidents. This was particularly the case in February 2020 when staff at the supported accommodation were seriously concerned that they could no longer manage the level of risk; one of the ligature incidents had been a "close call" requiring the use of a ligature cutter. Supported accommodation staff told this review that they were surprised that their role was not always captured in other agencies risk assessments and that, while comments on their risk assessments from health and social care practitioners were helpful, this was not the same as having all agencies fully "signed up" to the approach they were taking. There was an example during the period of the review where different agency risk assessment documents had been joined up for one young person. The initial barriers on a case-by-case basis are persuading each agency that it is possible to incorporate all the necessary elements, and there are further challenges in keeping the document up to date and accessible. The practitioners involved in this review could see the benefits to young people, their families and agencies of developing multi-agency policies and procedures to achieve a consistent streamlined approach.

4.14. Supported accommodation managers told this review that Fiona had copies of her safety plan and that she was always consulted on any changes. The care co-ordinator told this review that she considered risk and asked Fiona's views at every contact; Fiona did not want others to take actions needed to reduce risk so was not supportive of the plan. The social worker told this review seeking Fiona's views before Care Team Meetings included asking about the content of risk assessments; she did not want any changes.

4.15. The arrangements for risk assessments did not always capture all the necessary elements and would have benefitted from streamlining. For example, in July 2019 Fiona took an overdose of prescription medication. This was opportunistic (she had taken it from Mother's handbag which Mother told this review was usually locked away in her car boot along with anything else in the she might use to harm herself). This revealed that her mother did not have a lockbox, which also suggests that practitioner's discussions with parents regarding minimising the risk of overdoses of prescription medication were not fully effective; the parents do not recall receiving a copy of any written risk assessment given

to parents when Fiona was living at home, although ICTS records show that a copy was offered a number of times during the period under review. Mother told this review that she was aware that the local authority had a risk assessment while Fiona was in the supported accommodation; that the social worker had showed it to her, and that the supported accommodation sent weekly updates regarding events by email.

4.16. During the period under review there were a range of multi-agency/multi-disciplinary meetings held. These included Care Team meetings when Fiona was a Child in Need,[10] and then as a looked after child, which incorporated S117 responsibilities[11], and a statutory review as a looked after child. Fiona and her mother were invited to attend these, Mother usually attended, Fiona usually chose not to, and her views were fed in by attendees. There were some meetings which did not involve Fiona or her parents: 8 strategy meetings convened by Children Social Care under the safeguarding procedures, and a health strategy meeting convened by the NHS (mental health) Trust on 03/02/20. This latter meeting was the only meeting that involved representatives from the local hospital including the psychiatric liaison team. The care co-ordinator used multi-agency meetings as an additional opportunity to compete care co-ordination reviews to fulfil the requirements of the Care Programme Approach (CPA)[12]

4.17. Strategy meetings called under the safeguarding procedures were usually chaired by a manager, as they should have been. They were convened mostly due to an escalation in the frequency or type of self-harming behaviour. Under the multi-agency safeguarding Managing Self-Harm and Suicidal Behaviour procedures[13] child protection procedures (which include strategy meetings) should be considered for moderate risk incidents and used for those which are high risk.

4.18. Key practitioners were usually present at strategy meetings but there were gaps in invitation/attendance. A representative from the community and hospital trust, should have been involved, not least due to the frequency of Fiona's attendances at the Emergency Department. No consideration appears to have been given to inviting a Trust representative prior to Fiona becoming looked after. This may have been because she did not have a school nurse, although for other cases contact has been made with the Trust safeguarding team; both school nurses and safeguarding staff have access to records for all the 0-19 community service and for the Emergency Department. Practitioners told this review that anyone attending as a representative of the hospital acute and community health trust would have provided feedback to others in the trust but that this would not

[10] A Child In Need (CIN) is one who is receiving services under Section 17 Children Act 1989 to support children to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development. Looked after children are also CIN. Care Team meetings are care planning meetings which should be convened at regular intervals for CIN

[11] S117 of the Mental Health Act 1983 places an enforceable on both Health (Clinical Commissioning Group (CCG)) and Social (local authority/Council (LA)) Services to provide free aftercare services to people who have been hospital inpatients n discharge from hospital.

[12] The Care Programme Approach (CPA) describes the approach used in secondary mental health and learning disability services to; assess, plan, review and co-ordinate care, treatment and support for people with complex needs, relating to their mental health or learning disabilities. The local policy is for these to be held at minimum intervals of 12 months although the care-co-ordinator completed more frequent reviews than this

[13] https://www.proceduresonline.com/nesubregion/files/manag_self_harm_suicid_behv.pdf

normally include the Emergency Department unless there was a specific issue or something that needed doing differently. Whilst this is understandable, given the level of frequency of Fiona's attendances at the Emergency Department, specific consideration about how to engage those staff in the strategy meeting process and share information may have been helpful. Once Fiona became looked after, invitations were sent to the LAC nurse. She was only able to attend one of the four meetings to which she was invited, for reasons which are not known. The other gap in communication was with the GP. Whilst GPs are not normally invited to strategy meetings, partly because they are not easily able to attend. However, it would have been helpful if they had been made aware at the very least of their occurrence, one health manager suggested that including them on the invite list would have the benefit of them receiving a record of the decisions.

4.19. The strategy meeting on the 18th February 2020 was deliberately reconvened a week later to ensure what was a particularly good attendance, including the Community Matron from CYPS, as a result of a conversation a few days earlier with a senior manager in Children's Social Care. The meeting resulted in a more robust plan which included: ICTS to provide a formal structure for clinical supervision to the key worker at the supported accommodation (whose implementation was prevented by Covid see section below); regular appointments with Fiona (social worker fortnightly, care-coordinator weekly) ideally at times when the key worker was on duty; and DBT.

4.20. There was challenge from the police; to social care about whether secure accommodation should be considered, and to mental health specialists why hospital admission was not considered in Fiona's interests. This latter had also been questioned a few days earlier by the social care team manager. The view from mental health specialists present was that an inpatient admission for mental health treatment was not in Fiona's best interests. They felt that she had already been assessed and treatment could be provided in the community; that an admission would not beneficial to Fiona, in fact it could be detrimental by implying to her that she could not be kept safe in the community; it would expose her to other young people who self-harm; and her behaviour would likely escalate again upon discharge. They outlined that Fiona needed long term therapeutic intervention in the community.

4.21. The social worker sought legal advice about admission to a secure unit on welfare grounds. Applications require that young people are in care. No application for a care order can be made for a child who is over 16 years old, therefore an application for a secure order would depend on Fiona's co-operation as 16-year olds can sign themselves out of voluntary care. Whilst being in a secure unit might reduce her ability to self-harm in the short term, ensuring appropriate treatment for her ongoing mental health would not have been easy. Placements are in short supply and could be anywhere in the country; the strong relationships she had with her current care team would be disrupted. Secure applications should be a last resort when there is no other option; proposals for more intense support had been made. Until the adverse impact of Covid (see below) the situation stabilised for a while after the strategy meeting, the plans were reviewed in a Care Team Meeting at the beginning of March 2020, when Fiona was engaging well with the training provider.

4.22. Judgements about when to convene a strategy meeting under the safeguarding procedures for someone who self-harms as frequently as Fiona are not straightforward. However, there were two occasions during the period where more consideration should have been given to convening one. The first occasion was at the end of 2019, after Fiona had been compulsorily admitted to hospital on the 17th December 2019 because she refused treatment for an overdose of paracetamol. During attendances at the Emergency department, it was not unusual for Fiona to need persuasion to accept treatment after an initial refusal. However, this was the first time in 12 months that compulsory admission had been necessary, in a challenging context which involved likely swift discharge due to the practitioners' view that anything other than short-term admission in life threatening circumstances was likely to be counterproductive, at a time of year which can be emotive when services are not operating at full capacity. These are all risk factors. Children's Social Care told this review that no strategy meeting was convened because Fiona was in hospital; therefore, it was expected that mental health colleagues would take the lead and support planning would be done via the CPA pre-discharge meeting. The social worker prepared for this meeting with the support of her team manager to ensure that the risks were being manged and information shared. Whilst a motivation to avoid having separate meetings is laudable, consideration could have been given to holding both meetings jointly. This would have ensured a broader child safeguarding focus and given direct managerial oversight and support to the social worker through the attendance of a social care team manager.

4.23. The second occasion was in mid - April 2020, after police and paramedics had attended because Fiona was self-harming and had told staff about a suicide pact with a friend. The social worker contacted ICTS who spoke with Fiona, and the police subsequently satisfied themselves the other young person was safe. Because her own team manager was not at work the social worker had a discussion with a duty manager about convening a strategy meeting. It was agreed that no strategy meeting was necessary because Fiona was being supported appropriately by mental health services and staff at the supported accommodation had followed the risk assessment. This decision does not seem to have taken into account the reduction in protective factors due to the impact of Covid (see section below), the rejection Fiona had expressed to the social worker in March 2020 due to being unable to go home to isolate, nor that the last escalation in self-harming behaviour had been associated with the suicide of a peer. The decision not to hold a strategy meeting might have been challenged had the social workers own team manager been aware of the incident, but no alert on the electronic record about it was sent to her by the duty manager, as it should have been, for reasons which are not known. The lack of strategy meeting at this point is important because it would have enabled a multi-agency discussion about the impact of Covid and how to mitigate it and would have ensured that risk assessments were up to date. It might also have considered the significance or otherwise of Fiona very recently initiating contact with ICTS for the first time due to feeling distressed.

4.24. Practitioners told this review that Fiona's use of alcohol increased the risks, not only by making her more impulsive, but also by depressing her mood. Whilst this review was told

that both the drugs and alcohol worker and the care coordinator discussed both issues with Fiona, practitioners thought that in general young people tended to be less aware of the depressant qualities of alcohol, and how these vary according to the type of alcohol consumed.

4.25. Because of the extent of her illness and lengthy detention in hospital Fiona effectively missed two years of education in the run up to GCSEs. Whilst there is evidence of care planning before Fiona was discharged from hospital in January 2019 via a CPA meeting, the aftercare plan was not sufficiently robust to prevent a re-admission within 2 months. Fiona's Mother and Stepfather told this review that they believed the relapse was largely because Fiona had nothing to do during the day; they said she had refused to go back to her previous school due to bullying and no alternatives were put in place, they and her older sibling were out at work all day which meant Fiona was supervised by members of the extended family which was stressful for all concerned due to a need to monitor her food intake. A referral was submitted to the Education Other Than At School team (EOTAS)[14] in December 2018 prior to discharge. EOTAS needed a letter of support from mental health services, which had not previously been recognised, and it was not possible to put arrangements in place before Fiona was readmitted to hospital in mid-January.

4.26. After discharge from hospital in March 2019, EOTAS arranged for Fiona to receive tuition in a small group of students who were undertaking GCSEs; she was enthusiastic and within four weeks was participating full-time. Fiona's Mother told this review that Fiona had deferred GCSE entry; whilst she had had some tuition in hospital there was not much work and it was too easy for her (perhaps, Mother thought, because the staff did not want to put too much pressure on her). Therefore, she left the tuition group in May 2020 with a view to attending college in September.

4.27. EOTAS provided support for Mother to get a place at college and supported accommodation staff assisted Fiona to be up on time, dressed and get to the bus stop for college, as well as providing emotional telephone support throughout the day when Fiona required it. The Education Service for Looked After Children (ESLAC) supported Fiona to make enquiries to attend a local training centre for 16-19 year olds. Fiona began to attend and received positive feedback; however, this was not until early March i.e. two months after the beginning of term. Within a short period the training provider closed due to Covid 19 restrictions and advised that work could not be sent to her due to Fiona not completing her induction. Social worker and ESLAC considered what other options were available to ensure that Fiona had access to education during Covid restrictions. One barrier was lack of a laptop; and the request was not put in for a month after this was identified, because of a decision to wait for the government loan scheme.

4.28. Fiona (and her family) was supported by many practitioners. The care co-ordinator and social worker co-ordinated their visits to ensure these happened weekly and so that Fiona would know who was visiting and when. Practitioners described arrangements in several

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[14] The EOTAS Health Needs team provides for learners who are of statutory school age but who are unable to attend school full time due to health and medical needs. Tuition is provided on a one to one basis or in small groups depending on the needs of each individual pupil.

agencies for assessing young people's understanding and ability to engage and strategies to support those less able than Fiona. They also stated that, for those young people who want fewer practitioners, a worker could be identified to provide information/resources to the social worker on their behalf. Practitioners believed Fiona did understand their roles; she approached professionals with issues that related to their role. Who to contact, when and about what was also contained in the supported accommodation safety plan. Initially Stepfather was confused about assessment and decision-making for admission to hospital; that this was the role of the mental health specialists not social workers.

4.29. Mother and Stepfather told this review that Fiona responded best to practitioners who tried to build a rapport with her and put her at her ease by talking about her interests and making her laugh. In contrast they said she did not respond well to people whose contact was very incident driven, with questions about what had happened, which Fiona did not want to answer. A recent Office of the Children's Commissioner for England[15] found that duration of the relationship was a key component of trust for the study participants alongside the personal qualities of kindness, empathy competence and being non-judgemental. In terms of the support offered to Mother and Stepfather they recognised the primary focus of practitioners was with Fiona, especially given her age, but were appreciative of those who treated them with respect and courtesy, and spent some time talking with them even when the main purpose of a visit was to see Fiona. On the other hand they told this review that some practitioners used jargon which they did not understand and that expressions of empathy couched as "we know what you are going through" were not helpful in making them feel their situation was really understood.

4.30. They also told this review that Fiona's older sibling found it difficult to understand her illness. They thought that siblings would benefit, and be more empathetic, if practitioners had direct contact with them. In this case they told this review that a police officer did check once that the sibling was ok after being affected by a particular incident, but otherwise no-support was offered. There are a few voluntary organisations which can provide support for families of mentally ill people. As well as being an additional resource, they can provide an objective perspective which may support the goals that practitioners are trying to achieve or enable parents to challenge in an informed and constructive way. Mother told this review that she had been given contact details for MIND but her phone call was not returned. There are benefits of providing information about voluntary organisations more than once and at key stages in the progression of illness: diagnosis, treatment, prognosis hospital admission and discharge etc.

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

[15] Cossar J et al(2013) 'It takes a lot to build trust' Recognition and Telling: Developing earlier routes to help for children and young people Office of the Children's Commissioner for England

- 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

See recommendations 1,2,3,4 and 7

Theme: services for young people aged 16 & 17 years old

4.31. The supported accommodation is regulated by the Regulator of Social Housing (RSH)[16] and the Care Quality Commission (CQC)[17] for customers in receipt of personal care (which did not apply to Fiona). This meant that the placement was not regulated (by Ofsted) specifically for children. There has been a lot of controversy about unregulated provision for children and young people, especially 16- and 17-year olds, due to the poor quality of some of it. However, as Directors of Children's Services have pointed out[18] the crucial issue is that placements are "suitable" for the individual child (as not all young people placed in unregulated settings are badly placed and without support), and that the overall quality of the provision is monitored. The provision was registered but not yet inspected by the CQC nor had there been a first adult annual social care assurance visit before Fiona was placed due to the newness of the provision, which was established in April 2019. This is not to suggest that the placement was not suitable, more that the quality assurance arrangements for young people need strengthening.

4.32. National guidance in place since 2010[19] specifies that all children aged 16 and 17 years who present as potentially in need of accommodation because of family breakdown should be offered an assessment of their needs under the Children Act 1989. The assessment should include consideration of the legal basis under which support should be provided; the child should be accommodated ("looked after") under section 20

[16] The Regulator of Social Housing regulates registered providers of social housing to promote a viable, efficient and well-governed social housing sector able to deliver homes that meet a range of needs, by gathering data from providers and investigating concerns and complaints

[17] CQC registers monitors and inspects the following service provision; treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services; treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care); services for people whose rights are restricted under the Mental Health Act. Settings are inspected against 5 key criteria, whether the service is; safe: effective; caring; responsive and well-led. Some settings include services for children

[18] https://www.cypnow.co.uk/blogs/article/what-s-in-a-name-1

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/8260/Provision_20of_20accommodation.pdf

arrangements if their welfare would be seriously threatened if accommodation is not provided. Being "looked after" offers more support and protection; for example, the involvement of an Independent Reviewing Officer who has a legal duty to monitor the case. Part of the way this is done is by them chairing statutory review meetings.[20] Had Fiona had the status of a looked after child on admission to the placement, these would have been held earlier, in September and December 2019, rather than commencing in February 2020. These would have included consideration of how well her educational needs were being met, with the support of the involvement of the Virtual School team, who did not become involved until February 2020. This might have enabled earlier recognition of the unsuitability of the college placement and prompter engagement with the training provider. Apart from having a right to an education, being in college/training is usually a protective factor for young people providing opportunities for: social contact with peers; trustworthy adults to turn to (who will also notice changes in behaviour); and stimulation and occupation. This later benefit was particularly important for Fiona as structure within her day and meaningful activity were important tactics for improving her emotional wellbeing and reducing her self-harm. Another benefit of being looked after is an entitlement to a holistic health assessment conducted by a paediatrician and/or a specialist nurse within a month of becoming looked after, which did not happen until February 2020.

4.33. Practitioners told this review that Fiona did not become looked-after when admitted to the supported accommodation because the placement was only intended to be short-term. Prior to January 2020 there is no evidence of a specific conversation with Fiona and her mother, as there should have been, about the pros and cons of becoming "looked after".

4.34. One of the challenges of working with children as they get older is being sensitive to their ability to form their own views and have them taken increasingly seriously. Seeking and taking into account the views of even very young children is enshrined in various legislation and guidance. Whilst Fiona's mother continued to have Parental Responsibility while Fiona was looked after and the right to be consulted about arrangements for her care, once Fiona had moved into supported accommodation, she was increasingly reluctant for her mother to be told details about her mental health, including all the self-harming incidents. Judgements were made about this by Children's Social Care on a case-by-case basis, in line with legal advice. The supported accommodation provided a weekly incident update by email to Mother because Fiona did not want her informed of every hospital admission.

4.35. The issue of capacity to consent (or not) to medical treatment is also particularly pertinent in this case; children under 16 years can consent to treatment if they are deemed to have sufficient capacity to understand the treatment and the implications of having or not having it. Adults and young people aged 16 years and over are presumed to have capacity to consent unless there is significant evidence to suggest otherwise. Lack of consent can only be overruled in specific circumstances which sometimes, but not

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[20] Statutory Review meetings include the professionals most involved in the child's care. They are held one month, and four months after the child becomes looked after.

inevitably, includes mental illness. Judgements about capacity are governed by the principles of the Mental Capacity Act 2005,[21] which has 5 key principles: the presumption of capacity; that support should be provided to make decisions; that people have the right to make what others might consider to be "unwise" decisions; that anything done by others must be in the persons best interests and that necessary action must be the least restrictive possible in the circumstances. There is evidence to suggest that practitioners considered capacity individually and collectively when appropriate and applied these principles.

4.36. Notwithstanding the impact of an eating disorder Fiona was otherwise in good physical health; the main role of her GP therefore was to: maintain oversight of the services she was receiving for her mental health; respond to any requests for tests /physical examination including weight measurement; and providing telephone advice as requested by the supported accommodation regarding appropriate treatment, mostly for head banging. GPs told this review that they were aware that a lot of people were involved to provide appropriate intervention for her mental health and that they were uncertain what else the practice could offer. However, during the period under review, the surgery sent six letters to her suggesting she make a routine appointment with a GP. The specific reasons for these are not recorded and Fiona did not respond to any of them. None of these letters were followed up and the GPs told this review that doing so was particularly difficult for young people aged 16 years and over. For children under 5 or between 5 and 16 years old they would have contacted the health visitor or the school nurse respectively. In this case it was not easy for them to identify who would be the key practitioner to contact.

4.37. There was no flag on Fiona's GP records that she was looked after; the GP practice had not been notified by the local authority as it should have been and when a copy of the health assessment was received this was not seen by a GP, as it should have been, for reasons that are not known. Health practitioners told this review that they thought that the arrangements for sending and recording notifications were not working consistently well and that the Clinical Commissioning Group (CCG) was planning an audit on coding which needs to be followed up jointly with Children's Social Care to identify and resolve any partnership issues. Fiona did not become looked after until January 2020; prior to that Fiona had a social worker due to being a Child in Need (CIN), but GPs are not usually told about CIN arrangements.

4.38. The GPs were aware of the CPA approach for patients with mental health problems, but they did not know who Fiona's care-co-ordinator was, and they were not aware of the legal entitlement for S117 aftercare. Nor were the GPs aware of the multi-agency safeguarding Managing Self-Harm and Suicidal Behaviour procedures. Anecdotal information from area wide GP safeguarding leads meetings suggests these are common

[21] The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things: understand information given to them; retain that information long enough to be able to make the decision; weigh up the information available to make the decision; communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

issues for GPs; care plans and risk assessments are not consistently received and, unless they have a special interest or training, GPs are generalists who will therefore not be experts for some groups of patients receiving specialist care.

4.39. The typical way GPs promote communication about safeguarding issues across whole practices is by holding Multi-Disciplinary Team (MDT) meetings. These are not held in the practice that Fiona was registered with. Alternative arrangements of coding and alerts on patient records which are collated and distributed to all clinicians fortnightly were put into place in 2019 after a review by the specifically appointed safeguarding lead, which considered what would be the best arrangements for a very large GP practice. [22] Although these arrangements were subsequently regarded positively by a CQC inspection, the criteria do not specifically highlight young people over the age of 16 years including those with complex mental health difficulties; this has been recognised by the practice and will be addressed as a result of this review. Fiona's name did appear on the fortnightly report circulated to the whole team, but there were no discussions or queries raised with the practice safeguarding lead as a result. Since this review, the GP practice has created a young person's GP role, which will sharpen the focus on vulnerable young people. Part of the difficulty in not conceptualising Fiona's circumstances as safeguarding was due to not being aware that strategy meetings were being held, as mentioned previously. Had there been a child protection conference the GP would have been invited and asked for a report, but nationally child protection conferences are not usually convened for older young people in these circumstances.

4.40. Formulation[23] is typically used to build on a diagnosis to inform a patient's treatment by considering their specific history, needs and circumstances. Supported accommodation staff were familiar with this approach, which they find useful to inform their risk assessments and assist in managing crises and reducing staff anxieties. This process was less visible to them for Fiona than their adult customers. Whilst the use of the terminology and specific meeting and recording arrangements is more formal in Personality Disorder services and the (adult) Psychiatric Liaison Team, practitioners told this review that formulation was ongoing, undertaken in meetings and assessments/reviews, but that this could have been more formally recorded and shared with supported accommodation staff.

4.41. The standard acute hospital pathway for children who are 16 and 17 years involves being seen in the Adult Emergency Department. The (adult) Psychiatric Liaison Team provides immediate assessment and support (at times linking in with consultant on call at Children and Young People (MH) Services and requesting follow-up from ICTS). Current NICE

[22] In 2018 the GP practice where Fiona was registered was amalgamated with two others. This meant that the new practice became the largest in Northumberland responsible for 25% of the population. The practice recognised that this was a good time to take stock of safeguarding arrangements and employed a retired GP to conduct a review. As holding MDT meetings for 40 clinicians, many of whom were part-time was not practical, the safeguarding lead developed a system of alerts which are collated and circulated to all clinicians fortnightly, who then night ask the safeguarding lead for advice or follow-up. The data base can also be interrogated for specific issues or patient groups – e.g under 5's for specific discussions with relevant practitioners.

[23] In order to inform treatment formulation is a hypothesis about the mechanisms causing and maintaining the patient's problems. The therapist uses the formulation (and other information) to develop a treatment plan and obtain the patient's informed consent to it. Formulation covers the "5 ps": Presenting problem Predisposing factors; Precipitating factors; Perpetuating factors; Protective/positive factors

guidance for the management of self- harm for young people under the age of 16 advises that young people are admitted to hospital to allow time for assessment and appropriate care planning to be undertaken. The guidance however is not as clear for those between the ages of 16-18 years, although a face-to-face assessment by a PLT practitioner would be best practice. The Emergency Department always contacted the PLT for advice. Depending on the nature of the incident, Fiona's presentation, her attitude to treatment and to being seen by the PLT, a PLT practitioner attended to offer/conduct an assessment. Sometimes PLT staff made extra effort to offer support by attending when she had initially indicated she did not want to be seen, which is good practice. This meant there were approximately 10 occasions when Fiona was not seen, usually because she did not want to be and was felt to have capacity to make that decision. Generally, these were characterised by being relatively minor incidents consistent with previous behaviour. There were four that were more significant; the staggered overdose[24] on 2nd February 2020 and the ligature incidents on the 17th and 26th March and the 22nd of April 2020 (the last admission hours before the incident that precipitated this review). For the latter three occasions Covid may be a relevant context for PLT decision-making about attendance; the hospital had advised staff to minimise unnecessary face to face contact with patients unless clinically indicated. On each of these occasions PLT arranged prompt follow-up by the ICTS.

4.42. PLT staff do not normally attend strategy meetings convened under the safeguarding procedures, they are part of the same agency as the care-co-ordinator and ICTS staff who do. PLT staff are expected to review the records before seeing patients, these include recent progress notes and risk assessments. This review was told that information about and from strategy meetings was included in Fiona's records and that there was also evidence of communication between the care co-ordinator and PLT staff about changing risks. Since the incident which precipitated this review the PLT have piloted having a CYPS worker on-site within their team for a 12-month trial period for children and young adults aged 16 -25 years who attend the (adult) Emergency Department. From the end of 2020 this has been permanently enhanced to ensure there is always a CYPS worker available within the PLT.

4.43. Supported accommodation staff told this review they received conflicting advice due to her age. Children's Social Care would always request 1:1 support in attendance at the Emergency Department based on Fiona being a child, but mental health staff would advise that, in line with the diagnosed condition and behaviours, that the most suitable approach would be to encourage Fiona to attend the Emergency Department and take responsibility for this herself. The care team later agreed to supported accommodation staff encouraging Fiona to make calls to 999/111 and make calls on her behalf if she would not engage with the process, but not support on a 1:1 basis in the Emergency Department. On discharge from the Emergency Department hospital staff would sometimes order taxis for her, sometimes in consultation with other agencies. Discharge transport arrangements for young people are being reviewed to ensure parents or relevant agencies are always contacted and appropriate arrangements made, including someone collecting the patient.

[24] Repeatedly taking amounts of pills above the recommended limits over a period of hours

4.44. A frequent-attendees process offers additional safeguards for adults who attend the Emergency Department after self-harming. Despite a discussion at a strategy meeting in November 2019 regarding the potential benefits of a frequent attendee meeting, this was not achieved for Fiona, although there was an alert on Fiona's PLT record about frequency of attendance. This is because the frequent-attendees process does not apply to children where the expectation is that Emergency Department staff follow the safeguarding policy and pathway which requires that a referral be made to Children's Services, which also has the benefit of being copied to the hospital trust safeguarding team. Referrals were not made for about half of Fiona's attendances, for reasons which are not known. Since Fiona's death, arrangements have been made more robust for teenagers in particular; as well as the continued expectation about referrals to Children's Services for all children when appropriate, the hospital safeguarding team reviews any 13-18 year old child if they attend an emergency care or minor injuries setting more than three times during a four-week period.[25]

4.45. Anyone who has been compulsorily detained in hospital for treatment under Section 3 of the Mental Health Act 1983 has an entitlement under section 117 of the same act to after-care services to meet needs arising from their mental health and reduce the risk of it getting worse or further hospitalisation being required. The duty to ensure these are in place is the joint responsibility of the local (health) Clinical Commissioning Group (CCG) and the local authority. Planning should begin well before discharge so that arrangements are in place when the duty is triggered by a patient's discharge from hospital. Very few children are compulsorily detailed in hospital, so the local authority duty is usually exercised by adult services. In this case records show Fiona was nominally allocated to an adult services team manager in 2018 until input from adult social care was required as she approached adulthood. Fiona was entitled to s117 aftercare services from January 2019, when she was aged 16 years. These were carried out by the children's social worker but subsumed as an element of the ongoing assessment and care planning arrangements under the Children Act 1989, which meant they were less visible than they should have been. Mother and Stepfather told this review that there were not actually aware of any section 117 planning until after she was discharged from hospital in March 2019.

4.46. Records show periodic contact with the adult team manager regarding concerns by a range of practitioners over the whole period under review. The team manager did attend a strategy meeting at the end of February 2020 when the risks were particularly high. However, Fiona's repeated self-harm and mental health presentations could have triggered a formal review of the aftercare services provided to her under s117 of the Mental Health Act 1983. Had a formal s117 review been initiated, bringing together the clinical and social care services, there would have been a review as to whether the services provided were adequately meeting her needs and preventing deterioration in her condition so as to prevent further detention under the Mental Health Act.

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[25] Awareness raising activity has been undertaken with Emergency Department (ED)staff about the particular vulnerabilities of the 16-18 year old group and monthly meetings between safeguarding and ED Matrons

4.47. Support from the Personality Disorder Services Hub (PD Hub), support was less robust that it would have been for adults due to Fiona's age. For example, the PD Hub does not work directly with children although staff will attend meetings to provide consultation and offer individual "scaffolding"[26] support to clinicians, which was offered to the care-co-ordinator. The first consultation was not until the beginning of December 2019 when a meeting was held involving CYPS and Children's Social Care. Although advice about Fiona was given, there was no representative from the supported accommodation present as the meeting originated from a focus on supporting a few young people known to Children's Social Care with similar needs rather than as an individual case discussion. The practitioners present who were not mental health specialists found this meeting particularly helpful; practitioners told this review that developing training locally for non-specialists in the various mental illnesses and their treatment would be very helpful. Staff at the supported accommodation received "scaffolding" for their adult customers, requests to the PD Hub for similar input for Fiona were not met, due to her being a child although staff received indirect support via the care co-ordinator. It was not until February 2020 that supported accommodation had direct contact with a PD Hub clinician during attendance at the health strategy meeting.

4.48. **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.

See recommendations 5 and 7

Theme: the impact of Covid and the "lockdown"

4.49. The national lockdown formally commenced with the Prime Minister's announcement on the 23rd March 2020, however it was clear to agencies what was coming and a number began preparations in the few days before this. From the 13th March 2020 the supported accommodation took the decision to reduce all non-urgent 1:1 support while awaiting further government guidance; customers were informed of the general approach by letter, which described the priorities, anticipated possible further action and indicated that situation was under daily review. The daily six hours 1:1 support for Fiona continued, as did a response to incidents as necessary. However, Fiona had been an active participant in all group activities on offer at the supported accommodation such as the badminton

[26] Scaffolding is any indirect clinical activity that helps clinicians/practitioners improve their practice or implement a technique. This would include advice, consultation, training and teaching. Support with formulation, care management, transition, enhance clinician/practitioners's therapeutic capacity

group; beach walks; pool club and art club. Unfortunately, the supported accommodation had to significantly reduce all group activities to a few that could be safely delivered. In addition, the training provider closed towards the end of March. As previously described, not only was Fiona not able to attend, but also no work was being provided to occupy her.

4.50. During March and April support continued to be provided, mostly through continued face to face contact, in line with individual agencies prioritisation decisions. The social worker made visits on the 23rd March 2020 (and the 16th April 2020) and made a planned video call on the 6th April 2020. The DBT group sessions, which had recently started at the end of February 2020, were cancelled from the 24th March 2020 but arrangements were made to conduct these weekly by phone from the 6th April 2020. Fortnightly visits by the care-coordinator were initially conducted by phone from the end of March 2020; face to face contact resumed as the risks escalated and in line with Fiona's preference. ICTS continued to provide phone support to Fiona and practitioners as necessary but planned supervision sessions with her key worker were not possible in March 2020 as the key worker was working from home; by the end of March 2020 ICTS was considering discharging Fiona and suggested that future supervision arrangements should be made with CYPS.

4.51. Mother told this review that Fiona really missed being able to socialise with her friends and that she herself was no longer able to visit her on a Saturday as she had been doing. Fiona told her social worker that she felt isolated from her family during the lockdown period of Covid. She explained that other customers within the supported accommodation had returned home or to stay with friends/family when "lockdown" restrictions were implemented. Fiona said she did not feel this was an option for her due to no longer having a bedroom at the family home.

4.52. There is evidence that individual agencies considered the impact of Covid on Fiona; but the multi-agency oversight was less robust. The supported accommodation included Fiona in their risk tracker for customers who would struggle. On 26th March 2020 specialist mental health staff[27] attended a virtual multi-disciplinary team to ensure awareness of those children being seen face to face and to support the move to remote working and staff access to support. This recognised that the support had potentially destabilised and that the increase in nature and degree of self-harm was a result of the change and specialist mental health staff held a video call with supported accommodation staff on the 8th of April to take stock. This call did not include the social worker. On the 8th April 2020, a Care Team meeting discussed mitigating the impact of education provision closing by getting work sent to her and Fiona's Mother outlined how family members had maintained virtual contact with her. No representative from CYPS attended this meeting although the care-co-ordinator sent a written report. On the same day the social worker completed a RAG rating for Fiona, and she was deemed as Amber rating. The rationale was that Fiona had a high level of input from other agencies including daily support from Home Group, weekly DBT input, CYPS appointments, and support from ICTS and drugs and alcohol staff as required. These arrangements would have been enhanced by a meeting

[27] the care coordinator, CYPS team manager, community matron, consultant psychiatrist and occupational therapist

that involved ALL the key practitioners, especially if this had been strategy meeting which considered all the individual reduction in protective factors described previously including the feelings of rejection by not being able to isolate with her family and the potential impact of the recently disclosed suicide pact. Having said that, even had there been such a meeting this would likely not have made a difference to the eventual outcome.

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

See recommendation 6 and 7

5. WHAT PRACTICE WORKED WELL?

5.1. When undertaking a review, it is important to also consider what worked well, especially if this might have broader applicability to protecting or supporting other children and families. Examples of what worked well include;

- The strengths of the relationships a number of practitioners had with Fiona and their ability to stay focused on her best interests in both the short and long term.
- Strong relationship and close partnership working between the social worker, the care co-ordinator and the supported accommodation provider.
- The high level of risk was recognised by all practitioners who were well supported by managers.
- Use of strengths-based practice; protective factors were routinely considered at every multi-agency meeting.
- The level of time spent and commitment to Fiona and to partnership working; good attendance at multi-agency meetings by a range of relevant practitioners.
- There is no agreed treatment protocol for emerging Emotionally Unstable Personality Disorder; Fiona was seen as a person not a diagnosis. There was innovation at the care coordination level
- The level of support from the supported accommodation staff especially in the middle of the night, demonstrating care and compassion when they were on their own with Fiona and the ability to stay calm and follow the plans.
- Fiona was happy where she lived and felt supported

6. CONCLUSIONS

6.1. Delivering services to young people like Fiona involves considerable complexity due to her age, the range of applicable legislation and the number of agencies involved. These factors combine to generate several processes (meetings, assessments, documents) which are not joined up. Individual practitioners did their best to manage the various processes in a complementary way, but their efforts were undermined by arrangements which increased rather than reduced the challenges.

6.2. From the beginning of intensive involvement of mental health services in 2018 until her death, practitioners were aware that there was a significant risk of Fiona dying either due to miscalculation during self-harm, or deliberate intent. Whilst this remained the case, at the beginning of March 2020 Fiona's circumstances appeared a little more stable; the consequences of the impact of Covid restrictions, particularly on her day-to-day life was considerable. Despite their best efforts agencies were unable to mitigate this.

6.3. Whilst there are several learning points from this review which will be useful to improve services for children and families in Northumberland, there was also considerable evidence of good practice in this case from all agencies. Accordingly, a conclusion from the most recent triennial review of Serious Case Reviews has considerable relevance in this case too; that" the harms children suffered occurred not because of, but in spite of all the work that professionals were doing to support and protect them".[28]

7. RECOMMENDATIONS

7.1 The individual agency reports have made single agency recommendations. Northumberland Strategic Safeguarding Children Partnership (NSSCP) has accepted these and will ensure their implementation is monitored.

7.2 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
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.

[28] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education page 162

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.