Derbyshire Safeguarding Children Board
Child Practice Review Report

Re: Child Practice Review SILR14B

Concise Review √

[redacted]

Review Process

This serious incident learning review was commissioned by the independent chair of Derbyshire LSCB on 5th November 2014, in agreement with the recommendation of the Serious Case Review Sub Committee that the circumstances surrounding the death of young person did not indicate a need for a Serious Case Review (Section 9 of Working Together to Safeguard Children (Department of Education March 2013)), but that lessons could be learnt by organisations involved.

Circumstances resulting in the review

Subject of the review: Young person (YP): Aged 15 years (deceased)

On [redacted], the local ambulance service was called to the home of a young person (YP) who had been found suddenly and unexpectedly collapsed and unresponsive at home in their bed in the morning. Life support was initiated on the scene and continued in hospital, but, sadly attempts at resuscitation were unsuccessful

The circumstances resulting in the death of the young person (YP) have been established by the coroner who gave a narrative verdict at inquest which included: *"YP's death being contributed to by a number of agencies, due to no safeguarding referral being made*". which included: The immediate cause of death was:

1a aspiration of gastric contents 1b acute morphine poisoning

YP was fifteen years old at the time of their death. The YP lived with their mother, older sister and grandfather. [redacted] The YP had had difficulty sleeping over a number of years and had been known to Child and Adolescent Mental Health Services (CAMHS) since April 2012 and had taken to self medicating with cannabis, which the YP felt helped them to sleep.

Over the review period, the YP started to experiment with a range of other drugs, which they sourced on the internet – including a range of "legal highs". The YP also engaged with a number of internet drug forums where the YP communicated about drugs. Despite a close knit peer group, the YP had significant anxiety, including social anxiety and depression and the YP felt that the drugs that they used had a beneficial effect on their well-being. There is evidence that towards the end of the review period, the YP had experimented with heroin.

The YP was an extremely bright, articulate young person, who achieved well in school, with aspirations to become a doctor, and who had an intellectual interest in the drugs that they used and researched their potential effects. The YP was engaged with a number of agencies, who were trying to support the YP with regard to their mental health, general well-being and their drug use. There is evidence that the YP partially hid their drug habit from some individuals.

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 tragic death of the young person in this case and agreement 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, Youth Offending Service and Social Care. Dr Patricia Field, Designated Doctor for Derbyshire County was commissioned to work with the panel and to undertake the review. [redacted].

All relevant agencies reviewed their records and provided timelines of significant events and 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 and used to produce an interagency timeline. This was carefully analysed by the reviewing officer with the Panel and informed of the areas of interest that required further exploration and consideration. 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 met with the father, and had e mail communication with the mother to gain an understanding of their experiences of the services offered. This valuable insight in to 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 the report and recommendations.

The learning event was held on [redacted] and was attended by 17 professionals who had had significant involvement with YP, in addition to the Reviewer who facilitated the session, the Chair of the Panel 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.

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

The Reviewing officers will meet again with the family to provide them with a copy of the review when 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 Group and the Board

ANALYSIS: Practice & Organisational Issues Identified

The YP and their family, predominantly the YP's mother, were engaged with a number of universal and specialist services during the period of this review, including school, the GP, CAMHS and Young People's Substance Misuse Service. Scrutiny of the timeline, information shared and reflections at the panel meetings and the learning event have highlighted areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together: The following is an analysis of the issues identified:

1. **The benefits of multi-agency coordination through Early Help processes to support YP and their family**

"Early Help" is the vehicle through which all professionals who work with children and their families assess need and deliver services as early as practicable in the child's journey in order to ensure

optimum outcomes for children and to prevent an escalation of need. Early help requires a collaborative approach from all agencies, including schools, with the active involvement of children, young people, families and carers

The start of every Early Help Assessment is the meaningful conversation that every professional who works with children and their families holds with the child and family about their strengths and challenges, in order to work out what services are required. Some services maybe provided or arranged through individual partner agencies, but many will require the involvement and shared assessment and planning of a number of agencies, and pathways through universal and targeted services

Working Together 2015 is very clear that local agencies should work together to provide early help assessment and effective services for children who may benefit from them. In Derbyshire, the Common Assessment Framework was in place for much of the time period under review. This was replaced by the Early Help Assessment in 2014 – a very similar process, but with simplified paperwork. The Early Help process does not appear to be well embedded in the daily practice of the children's workforce in Derbyshire. This is in line with findings in a number of other areas, highlighted in the Ofsted Report on the thematic inspection "Early Help: Whose Responsibility?" published in March 2015, No. 150012

YP was a young person who may have benefited from the coordinated approach that underpins Early Help processes. Individual professionals worked extremely hard to support the YP, and there was evidence of interagency communication, but this did not bring all those involved to a collective view of the needs of the YP and their family, and, often, professionals were working in professional isolation.

Engagement of all involved through an Early Help Assessment would have enabled better information sharing and engagement of the YP and their family in a more holistic assessment of need and planning of services. It may have enabled the support of the school nurse, whose offer of help to the YP had declined. A team around the family approach and joint care plan would have helped to reduce the professional isolation and sense of powerlessness felt by some professionals when there seemed to be no way forward

2. Threshold for referral to Children's Social Care (CSC)

The YP was never referred to CSC by any professional during the period of the time line, despite agreement from the professionals from all agencies at both the panel meetings and the leaning event that the threshold had been met on a number of occasions, for example, when YP was excluded from school for supplying drugs, on the occasion that the YP presented to the emergency department (ED), with evidence of ingestion of drugs and alcohol and when the YP disclosed that they were using some of their father's medication.

There a number of reasons that might have underpinned this:

- Self harm is a term used to describe a situation when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress. There is a lack of clarity amongst professionals about the threshold for referring young people who have self harmed to Children's Social Care, a significant number of whom are at risk of significant harm due to abuse or neglect – and about the likely outcome of a referral. A significant number of these young people are at risk of significant harm due to abuse or neglect and are more likely to have poor outcomes. (Ref: On the edge – NSPCC 2014). It does not appear that staff used their own agency specialist safeguarding professionals for guidance when uncertain about whether to refer.

- Professionals had a perception that a referral was likely to be rejected, implying that the threshold would not have been met. Again, the expertise of local safeguarding professionals

was not used. There was limited consideration of the use of the escalation policy in circumstances where a referral may have been made and then rejected.

- Young people who use or procure recreational drugs for others are often not seen as at risk of significant harm and therefore a safeguarding issue – but may rather be seen as making a lifestyle choice as opposed to being a vulnerable young person. This meant that on the occasion of when the YP supplied drugs to another young person, no multi agency strategy discussion was held. This has been highlighted in a recent Derbyshire learning review (SILR14A). The current Derby and Derbyshire Safeguarding Children Boards' Threshold Guidance (available on the Safeguarding Board website), would suggest that YP would have met the threshold for support as a Child in Need, and may have accessed support via the Multi-Agency Team. Referral would have acted as a central point for collating concern from different agencies, which would have built a fuller picture than that held by any one agency.

- YP was described as a "Grade A" student; the YP was articulate and appeared to be in control of their situation, and to have a good relationship with their parents. It is likely that the absence of neglect and the YP apparent rationalisation of their drug use influenced professional decision making with the result that the focus was on the YP's narrative, rather than on whether thresholds were met.

3. The impact of transformational change on services

In the current economic climate, services need to change and modernise in order to meet their fiscal targets. It is well recognised that times of reorganisation within services can increase risk. It is important that a risk assessment is undertaken at these times, which takes account of the views of the clinical staff providing the service. This is also relevant if there are protracted absences from a team.

Nationally, funding for CAMHS services has been under review. The local CAMHS service was delivered in the context of a recognised underfunding for CAMHS nationally. There is evidence from NHS Benchmarking data that this underfunding is significantly worse in that particular service compared to national and regional funding levels and as such has a significant impact on CAMHS capacity and is likely to have contributed to the shortfall in service. This has been raised with Commissioners and is now on the shared risk register. In addition, Commissioners have committed significant resources to the service in order to reduce risk.

This was against a background of transformational change in both clinical and administrative staff that resulted in a loss of posts. At the same time, some long term study leave and a high level of stress and sickness absence reduced resource within the Team further.

The service provided to the YP and their family from the Child and Adolescent Mental Health Service (CAMHS) Team fell short of that expected, as a consequence of both professional and organisation issues:

- There were delays in access to the service, resulting in some high risk cases being unallocated, and also in the process of referral of the YP to the drugs service
- There was delay in referral and lack of availability of cognitive behavioural therapy.
- There was a lengthy delay in sending letters out to the GP and a lack of communication with the GP when the YP failed to attend appointments
- Supervision is recognised as a key element of safeguarding. Over the time period of the review, there were 3 separate managers, along with a shortfall in supervision for clinical staff, in terms of frequency, consistency and quality of supervision.
- The staff member most involved with the YP was not a permanent member of staff, but was a member of the bank staff. Bank staff work flexibly on an ad hoc basis, specifically for a

named Trust, as needed, but are not permanent staff members. At the time of the review, bank staff did not have the same access to training. This has now been rectified.

Since the time period of the review, some administrative changes have been put in place, including digital dictation so that letters are now sent out within 10 days.

4. Clarity about services offered by CAMHS

There was a lack of clarity amongst other professionals about interventions that CAMHS could offer, the thresholds and timescales used to determine level of urgency of referrals, (12 weeks is not unusual for a routine referral) and also a lack of knowledge about local alternative sources of mental health support for young people. This gave rise to a sense of frustration at times, when professional expectations were not met.

5. Mental Health Services for young people who use drugs.

The YP was recognised by both professionals and the YP's parents to have high levels of anxiety and sleep difficulty and there was a strong feeling that the YP drug taking was, at least in part, a form of self-medication that enabled them to cope. However, Substance Misuse Services for Young People and CAMHS are situated in different providers, and young people with both mental health problems and drug use are predominantly under the drugs service. This meant that the YP was unable to access mental health services at the same time as address their drug use – and it was felt that until this happened the YP would not be able to reduce their drug use.

There was also a lack of clarity from CAMHS on this issue. Although CAMHS were of the view that YP remained an open case, to contact them as required, this was not the impression given to YP's parent, YP themself and the GP, who clearly felt that the YP had been discharged from CAMHS.

Partnership work is currently ongoing between the CAMHS and the Young Person's Substance Misuse Service to develop closer working relationships and to draw up a protocol that will help to support young people with both mental health problems and drug use.

6. Hidden fathers

A number of local and national reviews have highlighted the importance of professional communication with both parents, and the NSPCC have produced a recent summary (March 2015) of the learning from national reviews with regard to "Hidden Men". There was a sense that the YP deliberately withheld information or minimised their drug use when communicating with their father, who was largely unaware of it until a month or so before his child's death. There was only limited professional communication with YP's father from all agencies and, and as a result, he felt marginalised both before and after YP's death, in a situation where he had frequent contact with his child and felt he may have been able to provide support.

7. The importance of systems that enable communication of risk where more than one professional is involved in an organisation

There were a number of organisations where several professionals were involved in the care of YP. In the GP practice, a number of GPs provided care and risk was difficult to communicate – this was a particular issue over the prescribing of codeine to YP, who, at the start of the timeline was being seen by a number of different GPs. The YP was being prescribed codeine to treat headaches. Codeine is an opiate drug, often used for pain relief, but is not recommended as first line for tension type headaches in children. It can be a drug of abuse because of the overall sense of calm and feelings of pleasure that it induces and it should not be prescribed to those who are likely to abuse it.

The GP practice have now put in place brief daily practice meetings to raise awareness of and to facilitate information sharing about vulnerable patients seen recently. This is in addition to monthly multi disciplinary meetings. Previous reviews have also advocated the use of record flagging to highlight risk.

8. Professional awareness of patterns and sources of young people's drug use

It is well recognised that young people's IT skills and awareness of new phenomena such as "Legal Highs" are generally well ahead of parental and professional knowledge. Examination of YP's computer and phone indicated that they had been very sophisticated in their use of the internet and in accessing the "Dark Web" and the YP had successfully concealed traces of their on line activities. The "Dark Web" refers specifically to a collection of websites that are publicly visible, but hide the IP addresses of the servers that run them. [redacted], but it is very difficult to work out who is behind the sites and they cannot be located using search engines. This makes safeguarding children and young people in this arena a challenge.

YP's school have already undertaken some awareness raising with staff and parents since YP's death. The school has reviewed the content of its personal, social, health and economic curriculum, and its staff training, and has bought in to the Amy Winehouse and Addaction drug and alcohol awareness resilience programme. The school has also run an information evening for parents, which was well received and there is a plan to extend awareness to other head teachers locally.

9. Safety when experimenting with drugs

YP died overnight, with evidence that he had taken some drugs late beforehand. YP's father was of the view that there should be a very strong message to young people that experimenting with drugs was highly dangerous. Taking recreational drugs does pose a significant risk of serious harm or death. This applies to both "legal" highs and illegal drugs. Young people must never be given the message that drugs are safe, and they must be made aware of the risks, but there may be circumstances when an approach to harm reduction needs to be made, particularly around the use of drugs when alone, or at night. The Young People's Substance Misuse Services do provide information to service users on harm reduction, including less risky ways to use drugs.

Practice issues

A number of practice issues were highlighted by individual organisations as a result of the learning review. These will need to go through the governance arrangements of those organisations, to monitor, for example:

- Derbyshire Healthcare Foundation Trust: Emphasis on the importance of accurate, documented and updated risk assessments that are analysed to inform care plans.
- Derbyshire Healthcare Foundation Trust: Ensuring access to supervision.
- Royal Derby Hospital: Better documentation of conversations about patients.

Good Practice Identified

A number of areas of good practice were identified during the review, by the panel, by professionals at the learning event and also by the mother of YP, where professional commitment resulted in an

enhanced service:

1. YP's school were unwavering in their support of YP – in their efforts to persuade the YP to engage with CAMHS, in their commitment to keep the YP engaged in sometimes difficult circumstance, rather than adopting a more punitive approach, and in the arrangements that they made so that the YP could go on an extended school trip abroad. This was recognised by YP's parents (and indeed, as reported by the YP's mother, by the YP themself).

2. The YP's GP who saw the YP predominantly in the last few months of their life was tenacious in her commitment to liaise with other organisations (particularly school, the drugs service and CAMHS) and in her efforts to secure services on the YP's behalf, in circumstances where these proved difficult to access. Again, this was recognised by YP's mother.

The two examples above highlight the importance of persistence and of not giving up on young people, who can be difficult to help and who may be engaging in risky behaviour, even in the face of apparent rebuff. This can at times require some risk assessment by the professional – for example in the decision to take the YP abroad, and also in not permanently excluding the YP from school when the YP had supplied another young person with drugs.

3. YP's school hold a fortnightly multi agency meeting to share information and consider vulnerable children. This enables information sharing about vulnerable children, so that professionals can be alert to vulnerable children, to potential safeguarding issues and are able to plan the most appropriate support or intervention.

4. YP's drugs worker was prompt to supply a safe storage box to the YP's mother, to enable safe storage of the grandfather's opiate medication. This is given to methadone or other drug users, but not routinely in this situation – but it was good practice to reduce the risk of YP abusing their grandfather's medication

5. YP's drugs worker was prompt in contacting the GP as soon as she was aware that the YP was obtaining codeine on prescription.

Conclusion

Scrutiny of practice as a result of this serious incident learning review has provided an opportunity to consider areas of good practice in addition to ways in which services may be improved. It is not always easy to steer adolescents who are involved in risk taking behaviour on to a safer course. It is, therefore, important that agencies work collaboratively with each other and with young people and their parents and carers in the assessment of need and the provision of services. Even with this in place, it is not possible to state with certainty that the outcome would have been different, although this remains a possibility.

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:

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

Intended outcome: That local practitioners will assimilate the learning from this report, in order to better support young people in similar circumstances

2. Derbyshire LSCB should ensure the development of an awareness raising and educational campaign about young people who abuse or supply drugs, both legal and illegal, for professionals, parents and young people. This should include use of the internet and referral thresholds and pathways and should also highlight the dangers of drug use, especially at night or when alone

Intended outcome: Professionals, parents and staff will be better informed about some of the ways in which drugs can be sourced, the nature of the drugs and risks associated and feel confident that they know the possible steps to take if faced with a concern. Young people will be more aware of the risks of drug use which may prevent their involvement with both illegal and legal drugs.

3. Derbyshire LSCB should develop and disseminate guidelines to strengthen professional knowledge about referral thresholds and pathways for young people who abuse or procure drugs. This should include circumstances when young people present to Emergency Departments, to other health settings and in schools and other settings.

Intended outcome: To enable multi agency involvement with young people who are known to be using or procuring drugs and to reduce professional isolation. To strengthen professional confidence in Emergency Departments and other settings in knowing when to refer to Children's Social Care when young people present

4. Derbyshire LSCB should review the strategy and implementation of Early Help to ensure that it is embedded in the professional practice of all partner agencies. This should include effective audit arrangements that ensure the robust monitoring of the quality of early help assessments, and the planning, management oversight and outcomes for children,

Intended outcome: To ensure that the children's workforce in all agencies is aware of its responsibilities to ensure that early help is provided within and between organisations, with the aim of improved holistic assessments for children and young people with additional needs and formulation of multi-agency support plans, to improve outcomes for children and enable a shared understanding of risk. Additionally, to reduce professional isolation, particularly when cases appear "stuck"

5. Derbyshire LSCB should continue through training and policy to promote communication with *both* parents (including in Early Help assessments and planning) when there are significant concerns about the wellbeing of children

Intended outcome: To ensure that parents who are not the main care giver (usually fathers) have a voice when there are significant welfare concerns for their child

6. Derbyshire LSCB should seek assurance from all Board members, via the Chief Officer's group, that when undergoing transformational change, or when there is a significant imbalance between capacity and demand, a risk assessment is undertaken that ensures mitigation of significant risks to children and young people. Risks that cannot be mitigated

should be reported to the Chair of Derbyshire Safeguarding Children Board and Children's Trust Board

Intended outcome: To reduce risk to children during periods of transformational change, to ensure staff are adequately supported during these times of change and to avoid the unintended consequences as a result of a service change that is usually part of a measure to improve efficiency

7. CAMHS should produce guidance for other professionals that highlights:

    - referral criteria, including thresholds and response times for urgent, soon and routine referral
    - referral proforma
    - how to access advice from a CAMHS professional
    - alternative sources of mental health support for young people

Intended outcome: To improve quality of referrals to CAMHS and to clarify for other professionals and agencies how and when the service may be accessed

8. The partnership working that is taking place between CAMHS and the Young Person's Substance Misuse Service should continue to develop a protocol to enable the mental health needs of young people who use drugs to be met.

Intended outcome: To better support young people who have the dual pathology of drug dependence and mental health problems

References

- Working Together to Safeguard Children H M Government March 2015
- Hidden men: learning from case reviews Summary of risk factors and learning for improved practice around 'hidden' men NSPCC March 2015
- Derby and Derbyshire Safeguarding Children Boards' Threshold Guidance
- On The Edge – NSPCC 2014

Statement by Reviewer

REVIEWER
Dr. Patricia Field (Designated Doctor for Derbyshire County)

Statement of independence from the case
Quality Assurance statement of qualification

I make the following statement that prior to my involvement with this learning review:-

- I have not been directly concerned with the child or family, or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.