Leicester Safeguarding Children Board

Multi-agency Learning and Improvement Review

Brandon

SUMMARY REPORT

Final Version - 30th April 2018

Lead Reviewer & Independent Author

Catherine Powell, Child Safeguarding Consultant

This is a summary of a multi-agency learning and improvement review commissioned by, and written for, Leicester Safeguarding Children Board. Although the use of a pseudonym was offered to Brandon's family to preserve anonymity for him and his sibling, his family advised us that it was important to them that we used his real name. However, they agreed that measures taken to protect the identity of other family members and practitioners involved in the case should remain.

I declare that I have found no conflict of interest in completing the review, and that I am independent to Leicester Safeguarding Children Board (LSCB) and partner agencies.

Catherine Powell
Child Safeguarding Consultant

Foreword

Response from the Chair, Leicester Safeguarding Children Board

This review makes some significant observations about how despite a number of multi-agency professionals involvement with this young person and his family, they were not adequately supported. It brings to mind how complex and difficult it is to work with a young person with severe mental health issues and who actively refuses to engage with services and the immense pressure that puts on family who are trying to support their child and get help.

For me the pertinent issue that was missed was that the responsibility for engagement should have laid with the professionals and not with the young person. He was clearly increasingly unwell and therefore his capacity to make informed choices as to both his safety, suicide risk and ability to make meaningful relationships with professionals was limited.

I note the learning points of the author in the report and will ensure that the actions and recommendations are implemented, and their impact assessed. There are 4 key assurance questions for the Safeguarding Board that I feel must be addressed.

1. That the LSCB is assured that the improvement journey of Leicestershire Partnership Trust CAMHS following the CQC re-inspection, adequately takes account of this review and that there is a response from them as to how they are addressing the key learning points, both in regard to practice and their engagement with young people.

2. That there is a review by the Local Authority of the quality and model of provision of alternative education for children who, through ill health, are not able to access education in school.

3. That there is some greater awareness raising for professionals around working with adolescent mental health and emotional well-being issues and the pathways to services and responses open to them. The current safeguarding process does not adequately ensure that actions are joined up and taken soon enough.

4. That the Local Authority ensure that schools review their response to perceived bullying issues and ensure that where children appear to be undergoing emotional mental health and well-being issues that they are adequately supported by the school.

Jenny Myers
Independent Chair
Leicester Safeguarding Children Board

Contents

1.0 Introduction

1.1 This report summarises the findings of an independently-led learning and improvement review, commissioned by the Chair of Leicester Safeguarding Children Board (LSCB). The review concerns a 15-year-old child, Brandon, who sadly took his own life. He was a much-loved son, brother and friend. Brandon had previously made good progress at school and had been described as a popular student.

1.2 Whilst there was no indication that Brandon had been subject to child abuse or neglect, the review has been underpinned by the broader definition of safeguarding children given in statutory guidance i.e. the provision of 'safe and effective care' in the context of family life and the delivery of services.

1.3 The purpose of the review, which was conducted in line with the requirements of statutory guidance, was to:

- understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- be transparent about the way data [was] collected and analysed; and
- make use of relevant research and case evidence to inform the findings.

Working Together HM Government (2015:74)

1.4 The review builds on the learning and improvements already instigated across local services in Leicester. Some of these changes relate directly to Brandon's experiences, whilst others have resulted from broader developments in services to children, young people and their families.

1.5 The report sets out the scope of the review, provides a brief background and synopsis of the case, and concludes by outlining the key findings and recommendations to the LSCB.

2.0 Scope of the Review

2.1 The learning and improvement review covers the period dating from Brandon's first presentation to a GP (with anxiety) to his untimely death some 18 months later.

2.2 The reviewers were asked to specifically consider:

- The effectiveness of the multi-agency response to meeting Brandon and his family's needs for support and protection, including assessment and management of risk, and consideration of statutory intervention;
- the response to disengagement from services;
- the response to allegations of bullying within the school;
- the impact of ethnicity, religion, culture and diversity.

2.3 The review process adopted the traditional approach of requesting individual management reviews (IMRs) from agencies. In addition, a practitioner event for those providing care to Brandon and his family was held to gain further insights and inform the learning.

2.4 Brandon's parents kindly allowed me to meet with them at their home, where they shared valuable insights of the services provided to the family. Where possible, these insights have been incorporated into the key findings, recommendations and learning points from the review.

2.5 A multi-agency review panel, chaired by the lead reviewers, was established at the outset to provide critical challenge and support. The Panel, which met on three occasions, comprised senior leads from the following agencies and organisations:

- Clinical Commissioning Group
- A Leicester School
- The Hospital School
- Leicester City Council Children's Social Care
- Leicester Partnership NHS Trust
- Leicestershire Police
- The University Hospitals Leicester NHS Trust

The review process was supported by the LSCB manager and a business support officer.

2.6 The findings of the review have been reported to an extra-ordinary meeting of the LSCB. Arrangements have been made to provide feedback to the family and involved practitioners.

3.0 Brief family background and synopsis of the case

3.1 Brandon, who was of British Sikh Indian heritage, lived at home with his parents and a sibling. He had been diagnosed with a mixed anxiety and depressive disorder and was being investigated for possible autistic spectrum disorder (ASD). At the time of his death he was not attending school.

3.2 The apparent sudden deterioration in his mental health and emotional wellbeing was clearly linked by Brandon, and his family, to bullying within the school. This factor was, in turn, consistently recorded by those involved in his care. Whilst the school made robust enquiries, and found no evidence of bullying in his case, it appears that Brandon's perceptions and lived experience was of being a victim of bullying.

3.3 Those providing services to the family in the period prior to his death include universal health services (GP and school nursing), a hospital emergency department and children's ward, child and adolescent mental health services (CAMHS), audiology services, the local authority early help service, school staff, education welfare service, educational psychology and an alternative education service. Police officers had also attended the family home on one occasion.

3.4 The chronology of events that informed the review was extensive and reflected the nature and complexity of the services provided to the family. A significant feature of the case was that Brandon found it difficult to engage with this provision. Whilst different strategies, including telephone consultation, were tried, there were clear signs that he found the visits of professionals and workers to be increasingly intrusive, leaving his parents, and especially his mother, in the impossible position of being mediator and primary care-provider.

3.5 Examples of Brandon's mother's continuous and chronic unease about her son's well-being and potential for suicide were peppered throughout the chronology and reports. This included making explicit her concerns that Brandon would take his own life and asking for him be admitted to an in-patient unit or to be 'sectioned' for his safety.

3.6 As Brandon's mental health deteriorated, professionals became aware of episodes of self-harm and his expressions of suicidal ideation (thoughts of taking his own life). These were risk-assessed and although consideration was given to a period of in-patient care, clinicians did not believe that this would be in his best interest.

3.7 Brandon's death has caused immense sadness to his family, friends and to his care providers. We should note the expert opinion, provided for the Leicester Partnership NHS Trust serious incident review, that suicide ideation is seemingly common, yet suicide is a rare outcome and extremely difficult to predict.

4.0 Discussion of key findings

4.1 We found that during the period under review, Brandon's daily lived experience became far removed from that of a 'typical teenager'; he was isolated from his peers, not engaging in education, barricading himself in a bedroom (which he shared with his sibling), displaying anger and frustration, and not leaving the house for literally weeks at a time.

4.2 There were times when expectations of parents can only be described as extremely demanding. For example, when risk appeared high, mother was asked to remove or lock-up all sharps, medications, harmful substances, potential ligatures such as ties and belts, provide close monitoring (e.g. check him every15-minutes) and undertake spot checks of his room. These are actions that are routinely taken in high care inpatient units, by mental health trained staff, working shifts – de facto this became a 24/7 expectation of a highly concerned parent in the family home.

4.3 On top of this, there was an expectation that Brandon's mother should attend a 'Living with Teenagers' programme and for parents to set consistent boundaries in managing his challenging behaviours. There was some progress and positive change made with this approach.

4.4 As mentioned at the outset, partner agencies' learning from the circumstances of this case means that there has already been improvement to the organisation and provision of services to children, young people and their families in the City. These changes are reported to being progressed in a timely manner.

4.5 For example, there is now co-location and a joint approach to the management of referrals and decisions about whether a case requires early help or statutory intervention, together with an improved format for early help assessments and review of progress. This is one example of change that has already happened.

4.6 At the time of Brandon's illness there were limitations in mental health service provision, however, an outreach crisis, recovery and home treatment team (CRHT) for children and young people has since been commissioned and has been operational since April 2017.

4.7 Had this service been available at the time of Brandon's illness, specialist mental health workers would have been able to provide a home visit and the face to face assessment, interventions and support that experts found to be wanting, particularly when he became very unwell towards the end of his life.

4.8 Brandon's view of what was happening, and what would be helpful to him, was largely absent, due in part to the difficulty in engaging him in his care, but also in the drive to be responsive to the concerns as expressed by his parents.

4.9 Whilst there was evidence of a high-level of contact between agencies and professionals, no one practitioner took the opportunity to fulfil a 'lead professional' role, bringing Brandon, his family and colleagues together to co-ordinate an agreed multi-agency assessment and plan with clear and timely outcomes and a focus on his recovery and return to school.

4.10 A finding of low level multi-agency collaboration is reflected in the recently published confidential inquiry into suicides in children and young people in the United Kingdom (University of Manchester, 2017). This concludes that supporting young people with mental health crises is a role that should be shared with schools, primary care, children's social care and youth justice services, and is not a role for children's mental health services alone.

4.11 The importance of multi-agency support to children and young people with suicidal behaviour is reflected in the Leicester Safeguarding Children Board procedures. These note that 'effective multi-agency relationships and good information sharing processes are crucial, so that the vulnerability and risk factors for individual children and young people may be properly understood and responded to.'

4.12 Practice in Brandon's case appears to have been broadly responsive, as opposed to proactive. Despite the involvement of several agencies and review at a multi-agency support panel, there was no clear, agreed, multi-agency plan as to 'what success looks like'.

4.13 Furthermore, Brandon had been missing education for an extended period; a factor that was certainly raised as a concern by his parents. After it became clear that he was too unwell to attend his mainstream school, arrangements were made for input from a home tutor, with a view to attendance at the hospital school. There was considerable slippage in these arrangements as well as a delay in progressing an education and health care plan to inform this provision.

4.14 Brandon found it difficult to engage with mental health professionals, despite the service attempting to be flexible in their provision. Care was provided 'via consultation with parents' but this may arguably have reinforced his disengagement. There was no

independent advocate in place, despite this being recognised as good practice for those feeling threatened or vulnerable in accessing their care.

4.15 Despite the concerns raised in this report and elsewhere about a lack of face to face contact, the use of different means of communication (e.g. texting, websites, Apps) may nevertheless be beneficial to young people in similar situations to Brandon and is promoted in policy (Department of Health, NHS England, 2015).

4.16 Brandon's parents are supportive of a need to embed mental health awareness into the school curriculum and to raise awareness of adolescent suicide. The recently published Green Paper (Department of Health, Department for Education, 2017) on transformation within children's mental health services should provide a steer for further developments in joining up mental health and education services.

4.17 Within Leicestershire the NHS Future in Mind is commissioning an early intervention programme designed to prevent mental health problems developing in children and young people. The 'Roots to Resilience' whole school approach increases the resilience and emotional wellbeing of every individual within a school.

4.18 These new arrangements should enable opportunities for promoting good mental health, early intervention and rapid access to support. This sets a positive direction for the future.

5.0 Recommendations

5.1 The questions and recommendations for the Board and partner agencies that follow have sought to ensure that the care provided to children and young people who are experiencing mental health problems is 'safe and effective' and reflects a focus on helping them to 'get back on track' with their lives as soon as possible (Department of Health, NHS England, 2015).

Learning point one

5.2 The review found that despite the involvement of universal health services (GP and school nursing), a hospital emergency department and children's ward, child and adolescent mental health services (CAMHS), audiology services, the local authority early help service, school staff, education welfare service, educational psychology, an alternative education service and the police service, Brandon's case became 'stuck' with little progress made in assessing the extent of his mental health needs and in ensuring his safety and recovery.

5.3 There were signs that Brandon found the involvement of professionals 'intrusive', he disengaged from education, friends and family and his mental health deteriorated with a tragic outcome. Multi-agency work was not effective, there was drift and delay in specialist assessments, and the family were held captive by his illness.

Questions for the Board in seeking assurance that multi-agency working is effective:

a. *What is the understanding of the role of the lead professional in cases that are open to early help services and how does this leadership help to bring together an effective multi-*

agency team around the child and family? Are partner agencies supporting the requirement for the role to be undertaken by the professional best placed to do so? How is the Board assured that management oversight is preventing issues of drift, delay in assessment and lack of progress in achieving positive outcomes for children and young people?

b. How well do strategic leaders in the City understand the roles and provision of partner agencies? How is this understanding of multi-agency working to safeguard and promote the welfare of children and young people reflected through their organisation to operational leadership and to the delivery of services at the front door?

c. What was the pathway and provision for accessing tier 4 CAMHS support at the time of Brandon's illness? How is the Board gaining assurance that there is now adequate provision for children experiencing mental health crises, with access to the crisis, recovery and home treatment (CRHT) team and/or inpatient care when needed?

d. What provision is normally made for children in receipt of education outside of mainstream school? How did Brandon's experience of alternative education[1] compare to that of a similar child?

Recommendations for LSCB sub-groups and partner agencies

i). *That the LSCB ensures that the next iteration of the thresholds document reflects the semantic change in the (draft) April 2018 Working Together document (HM Government, 2017) from 'threshold' to 'criteria for action' and that these are understood and applied by all relevant parties.*

The proposed revision from *'threshold'* to '*criteria for action*' is now likely to be revised in the new statutory guidance due out in summer 2018. The government in their response to the consultation on this proposed change noted that the majority of respondents wished to retain threshold documents in statutory guidance. The government therefore intends to revise the statutory guidance to '*recommend the development and publication of threshold documents as a key responsibility for safeguarding partners'*.

This recommendation will be adapted to reflect the wording in the new statutory guidance, when published, in order that practitioners and agencies are able to identify when children and young people are in need or at risk and are able to respond to the child in a timely and appropriate way. It is scheduled for completion in October 2018.

ii). That the Leicester, Leicestershire and Rutland (LLR) LSCB Procedure and Development Group should seek to review and promote the multi-agency procedures (Chapters 2.27 and 2.28) which include the pathway for children who self-harm and children with suicidal behaviours.

This recommendation is for practitioners to be able to identify when children and young people are at risk of suicide or self-harm and are able to respond to the child in a timely and appropriate way and will be completed by October 2018.

iii). That the LLR multi-agency training group works with CAMHS to provide multi-agency training and awareness of the risks of adolescent suicide, including prevention and how to

[1] i.e. no formal education for three months and then six hours of home tuition over two terms.

'spot the signs'. Reference should be made to the LSCB procedures above. The PAPYRUS material on suicide prevention should also be shared (see references for web-site).

This recommendation is for practitioners to be able to identify when children and young people are at risk of suicide or self-harm and are able to respond to the child in a timely and appropriate way. The references are available on the LSCB website and included in training.

iv). That local commissioners of specialist mental health services (the clinical commissioning group) seek to establish an independent advocacy service and make this available for those accessing specialist child and adolescent mental health services in line with best practice. The LSCB should be notified of progress in achieving this and hold this agency to account.

This recommendation is to ensure that the LSCB is assured that an independent advocacy service is commissioned in line with best practice and that this available for those accessing specialist child and adolescent mental health services. The LSCB received an assurance report from CAMHS in March 2018 and will receive further a progress update in six months.

Learning point two

5.4 The apparent sudden deterioration in his mental health and emotional wellbeing was clearly linked by Brandon and his family to bullying within the school. This factor has, in turn, been consistently recorded by those involved in his care. The allegations of bullying, including sexualised comments, were robustly investigated and addressed by the school. There was found to be 'humorous conversation' that was also described as 'banter'. Recent government guidance has sought to provide advice to school communities in relation to this form of bullying.

Recommendation to Safeguarding in Education Service

v). *To ensure that schools in Leicester have updated their anti-bullying policies in line with updated guidance (Department for Education 2017a, 2017b) and to provide a report to the LSCB that provides assurance on this matter.*

This recommendation seeks for anti-bullying policies and practice within all schools and education settings in Leicester to meet the requirements within national statutory guidance. The LSCB is to receive its first assurance report on this in July 2018.

vi). To undertake a review of the process for monitoring the education of children who have low attendance at school and require alternative provision and to provide a report to the LSCB that provides assurance on this matter.

This recommendation is to seek assurance that children who have low attendance at school and require alternative provision are receiving suitable education. The LSCB is to receive its first assurance report on this in July 2018 and six monthly progress reports thereafter.

In addition to the recommendations above the LSCB, in considering the report, and separate to the learning from this review, agreed that there was a need for effective secondary school representation on the LSCB. They therefore, further agreed that a further new recommendation is to be crafted regarding this. The recommendation below has therefore also been adopted.

vii) *That the LSCB should remind the secondary school sector of their statutory duty and to secure appropriate representation and attendance on the LSCB Board*.

This recommendation seeks to ensure that there is appropriate secondary school representation and attendance on the LSCB Board that results in effective communication and implementation of key safeguarding messages to and from the board.

In order to achieve this recommendation the Local Authority, Divisional Director for Learning and Improvement will attend every future meeting of the Education Improvement Partnership and use this opportunity to seek appropriate representation and attendance on the LSCB Board on behalf of the LSCB Independent Chair. This action is scheduled for completion by July 2018.

6.0 Response from parents

6.1 As Independent Chair, I was fortunate to have the opportunity to meet with Brandon's parents at the start of the process and at the conclusion of the report with his mother to share the learning from the review, as well as to discuss the key findings and recommendations. Brandon's mother on hearing the findings provided the following response:

'*If I could tell practitioners and professionals one thing about what would make the most difference to children in similar circumstances to Brandon, it would be that they need to listen to mothers around what is happening for their child - they are with them every day and know their child best*.'

6.2 We are grateful to both of Brandon's parents for their contribution to this review and for giving us the opportunity to meet with them in person as part of the process.

References

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HM Government (2015) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* London: DfE.

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http://llrscb.proceduresonline.com/

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University of Manchester (2017) *Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).* Manchester: University of Manchester.

Glossary of Abbreviations

ASD Autistic Spectrum Disorder

CAMHS Child and Adolescent Mental Health Services

CRHT Crisis, recovery and home treatment team

GP General Practitioner

IMR Individual Management Review

LLR Leicester City, Leicestershire and Rutland

LSCB Leicester Safeguarding Children Board