LUTON SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW – Child L

'Learning Together'

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INDEX

A	Introduction	3
1.	Why this case is being reviewed	3
2.	Succinct summary of case	3
3.	Time frame for the review	4
4.	Family composition	4
5.	Methodology	4
6.	Research questions	5
7.	Methodological comment and limitations	6
B	Findings	8
8.	Introduction	8
9.	Appraisal of practice: a synopsis	8
9.1	Key Dates table	8
9.2	How this case opens a wider window on safeguarding challenges	11
9.3	Appraisal of professional practice in this case	11
10.	What is it about this case that makes it act as a window on practice more widely	19
11.	List of findings	19
12	Findings in detail	20
12.1	Finding 1	20
12.2	Finding 2	25
12.3	Finding 3	29
12.4	Finding 4	33
12.5	Finding 5	36
13.	Additional Learning	40
13.1	Promoting effective referrals	40
13.2	Gaps in information-sharing	41
14.	Conclusion	41
	References	42
	Glossary	44
	Appendix 1	45

A. Introduction

1. Why this case is being reviewed

1.1 Luton Safeguarding Children Board (LSCB) agreed to conduct a Serious Case Review (SCR) regarding Child L, a 16-year old girl who died by self-strangulation in her family home July 2016.

1.2 The SCR Sub-Committee considered Child L's death and how to respond at their meeting of 13th July 2016. It was agreed that the criteria for an SCR had been met, and that the Independent Chair of Luton Safeguarding Children Board (LSCB) should confirm an SCR once she had received formal notification. This was confirmed to the Panel by a letter from the Chair on 10th August 2016.

1.3 The decision was in line with the guidance for undertaking an SCR in *Working Together to Safeguard Children* (2015):

(a) abuse or neglect of a child is known or suspected; and
(b) (i) the child has died [of suspected suicide] 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.[1]

2. Succinct summary of case

2.1 Child L was a 16-year old child of S Asian parents, and a younger child in a large sibling group. She and her siblings had been known to statutory services since her early childhood, with two lengthy periods of Child Protection (CP) Planning. The family had their last Children's Social Care (CSC) involvement when Child L was 11 years old .

2.2 She came to notice of services again her final year at school (Year 11), when she began to behave differently, adopting unusual habits of eating and sleeping, and revealing to her favourite member of school staff that she was unhappy and anxious. The situation escalated in May that year. Over a short period, Child L self-harmed for what seemed to be the first time, told the school that her mother hit her, and took a significant overdose. She was in hospital for 4 days and Child and Adolescent Mental Health Services (CAMHS) became involved. The first Monday after being discharged from hospital, she brought

[1] *Working Together to Safeguard Children*, 2013 (since revised in 2015), and Local Safeguarding Children Boards Regulations, 2006 (Regulation 5)

her possessions to school in black bags and refused to return home (eventually agreeing to do so later in the day).

2.3 At the end of May, Children's Social Care (CSC) Early Help Service got involved, and a senior worker had meetings both with mother and Child L in early June. Things appeared to have improved for her. She had been given early study leave for her exams, the final point of her school life. She came into school for her exams, but did not complete most of these.

One evening in early July, she strangled/hanged herself at home and died. It was discovered later on in the summer that in one exam paper she had written what appeared to be a suicide note.

3. Time frame for the review

3.1 The *Learning Together*[2] model of case reviews focuses on a recent period of time, so that current multi-agency systems can be examined, and staff who have been involved with the child and family are more likely to be available to contribute to the review. In this case, we focused on a period of change in Child L's behaviour, which coincided with her important last year of school. We therefore chose the period: **September (start of year 11 July)**.

The family history was taken into account, as a context for understanding Child L's behaviour.

4. Family composition

4.1 Family members are all British/S Asian

Methodology

5.1 Luton Safeguarding Board decided to use the SCIE *Learning Together* model in the conduct of this review. The Board reflected on what size review was proportionate for this case, and decided a full review was needed. Therefore in this case, all the elements of a full SCR were adopted. Details of the *Learning Together* model and the process of this review are given in **Appendix 1** of this report.

5.2 Review expertise and independence

The review was led by two independent professionals:

[2] Social Care Institute for Excellence (SCIE) systems model, developed by Fish, Munro and Bairstow, and now used for learning reviews and Serious Case Reviews. Please see Appendix 1 for details.

- Sally Trench is an accredited reviewer with the Social Care Institute for Excellence (SCIE), with extensive experience of writing SCRs, using both traditional Part 8 methodology, as well as more recent systems models. She is also an SCR Panel Chair, with a lengthy background in local authority social work (adult mental health, children and families/child protection, and quality assurance).
- Tom Savory is working towards accreditation as a *Learning Together* Review author with SCIE; he has undertaken training in the SCIE methodology and received supervision from SCIE while undertaking this Review. His professional background is in social work with children and families.

5.3 Collaboration

Learning Together adopts a collaborative approach via a Review Team and Case Group see below:

Review Team membership was at a senior level with representation from Children's Social Care (Early Help and Child Protection and Quality), Child L's school, East London Foundation Trust (for CAMHS), the local Clinical Commissioning Group (CCG), Luton and Dunstable University Hospital Trust and Luton Community Health Trust. There was a large Case Group (the professionals who worked with the child/family), with similar agency representation made up of front-line staff, and managers who had been involved in the case. Eighteen professionals took part in individual interviews/ conversations, and several of them made themselves available for two lengthy meetings where the material for the review was checked, discussed and analysed.

There was also an introduction to the *Learning Together* model for Review Team and Case Group members, at the start of the process. The Review Team met 7 times, and two of these meetings included the Case Group, for two full "feedback" days.

There was a very welcome willingness to share information across agencies, to reflect and evaluate practice together and to consider what could improve the protection of children and young people in Luton. This openness is not always easy to achieve, especially in the aftermath of the tragic death of a young person who was well known to many in the professional group.

6. Research questions

6.1 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why in that particular context – to identify what may be the "deeper", underlying issues that are influencing practice more generally.

It is these generic patterns that count as “findings” or “lessons” and which constitute the wider learning which local authorities and LSCBs are expected to pursue.

6.2 The research questions which underpin a *Learning Together* review identify at the start, areas of local safeguarding practice that it is expected the case will illuminate. They do not constrain other potential areas of learning. In this case, Luton SCB set the following questions:

1) How well are we in Luton currently identifying and responding to adolescents at risk of deliberate self-harm or suicide?

2) How well do we listen to, and act upon, the wishes and feelings of children and young people?

3) How well do we understand and address issues of culture, ethnicity, religion and diversity in our assessments of children and families?

6.2.1 In the event, the review has not surfaced sufficient information with which to answer the final question.

There is ample contextual data about diversity in Luton and associated social need, with significant impact on the demand for public services. However, this review has not provided very much information about how these factors affect the way services are delivered. This is not to say that they are not thought about, but it was not apparent in our review. The one assessment that took place during the time of the review was by CAMHS, and there was no evidence in the records that Child L’s ethnicity or religion were explored or taken into account – or that the attitudes of her family towards mental health difficulties were explored. It has not been possible to comment on wider assessment work.

6.2.2 Members of the Review Team spoke about practice which they observe in their own agencies. They stated that staff “know what ethnicity means”, but tend to rely on simple stereotypes, rather than adopting a more nuanced approach, which tries to explore “what does this situation mean for this family, given their ethnicity, religion, culture, etc?” Members of the Review Team also suggested that training courses need to be improved to support culturally sensitive practice.

7. Methodological comment and limitations

7.1 There were three areas of constraint for the review process:

- Two local authority senior managers were active members of the Review Team, representing Children's Social Care and communicating back to the service. The “front door” team for CSC was not directly represented on the Review Team due to operational needs of the service. This meant first-hand

knowledge was not always immediately available when the Review Team discussed practice in RIAT.

- A number of key professionals in RIAT who were involved with Child L were agency workers. Most of these had left their posts and the area, and were unable or unwilling to participate in the Case Group meetings. This was also the case for a key worker from CAMHS and from the school. Fortunately, we had managed to interview some of these people before they left, so that we had their views about their work. But, their role in discussing the emerging findings in multi-agency meetings, and in checking what had been written, was missed.

- By the time that this report was being drafted the arrangements at the "front door" of CSC had been developed to respond to the issues outlined in Finding 1 (below). This has created challenges in the drafting of the Review report to ensure that it is relevant for the LSCB.

7.2 Family participation

There were two meetings between the Lead Reviewers and Mother (with Father joining near the end of the first meeting). We learned that her parents had growing concerns about Child L's changed behavior in the autumn of Year 11 (detailed below, in Para 9.7).

B. Findings

8. Introduction

8.1 The findings – the main body of the report – begin with a synopsis of the appraisal of practice. This sets out the views of the Review Team about how timely and effective the interventions with Child L and her family were, including good practice but also identifying where practice fell below expected standards. It aims to provide explanations for this practice, or indicates where these will be discussed more fully in the detailed findings.

8.2 There is then a reminder to the reader that the aim of this review is to provide a "window" on the Luton safeguarding system, rather than just consider the particulars of what happened in this case. We draw out ways in which features of this case are common to other work that professionals conduct with children and families, and therefore how they can provide useful organisational learning to underpin improvement ("a window on the system"). The "wider" significance may apply locally, regionally, or nationally.

8.3 Finally, the report discusses in detail the 5 priority findings that have emerged from the review. The findings explore how well local safeguarding systems are supporting individuals, teams and whole services to offer effective help to children and families. They also outline the evidence that indicates that these are not one-off issues, but underlying patterns, which have the potential to influence future practice in similar cases.

9. Appraisal of Practice: a Synopsis

9.1 Key Dates Table

The time reviewed is Child L's academic Year 11 (September to July).

Oct	Child L's parents notice a change in Child L's behaviour, described by them as "disturbed sleeping, her eating habits changed". They describe her as becoming increasingly removed from family life and these changes worry them.
07 Jan	In school, a fellow pupil reports that Child L has "a lot of paracetamol in her bag to take". School speaks to child and mother about this.
23 March	Child L has been sending a lot of emails to her Higher Level Teaching Assistant (HLTA). This is discussed in school, and action is taken by the safeguarding team to establish appropriate "professional boundaries". Child L is spoken to about this, and is

	told that she will be given opportunities to speak to HLTA in school.
2nd April	School aware that Child L is not keeping to the advice about emailing, and she is spoken to again by the SENCO. Child L is taken to see GP by mother who is concerned about changes in her behaviour and GP prescribes iron tablets for her extremely low iron levels.
3rd May	Telephone call from mother to school, saying that Child L has self-harmed at home on back of her hand. Mother is advised by school to make doctor's appointment for Child L.
	Child L makes allegation in school that her mother has hit her (NB: RIAT record states it was father).
	School contact Children's Social Care (RIAT). School is advised to speak to mother. Assistant Head Teacher telephones home, speaks to mother and older sister. Brother comes into school to discuss. Child L is sent home.
10th May	Child L takes an overdose of paracetamol and iron tablets, and drinks nail varnish. School call an ambulance and she is taken to hospital.
	Child L admitted to hospital. She requires treatment to counteract the effects of both sets of pills, and stays in hospital for 4 days.
13th May	When Child L is medically fit for discharge, she is seen by the Duty CAMHS worker for an assessment – a step required before she can be discharged. A CAMHS psychotherapist assesses Child L, who denies any further intention to self-harm or try to commit suicide. He agrees for her to be discharged, and sets up a follow-up appointment for the following week. Child L goes home from hospital (this is a Friday).
	RIAT ring school and leave message (about referral from 3rd May), saying the case does not meet their threshold, and therefore school should make a referral to Early Help.
16th May	Child L comes into school with her possessions packed into plastic bags. She says there were family arguments all week-end about her overdose, and she does not want to go home. She continues to behave erratically during the school day.

	School make urgent referral to RIAT, and are advised to speak instead to Early Help.
	During this day, there are a number of negotiating phone calls, to try to clarify whether RIAT or Early Help should respond. At the end of the day, the issue remains unresolved, and Early Help send the referral information to Emergency Duty Team (EDT). (On the following day, a CSC manager decides that Early Help should take the case).
	In the afternoon, Child L is eventually persuaded to go home with her mother. She appears reluctant to do this, but agrees on the condition that she will be able to see the HLTA the next morning, to report on how things have gone at home.
	SENCO speaks to CAMHS psychotherapist about the events of the day. He says he will be seeing Child L on the following day.
17th May	Child L comes into school, but there is no opportunity for her to see the HLTA. School remain concerned about her behaviour and how to keep her safe. She is escorted to and from lessons. A decision is made that she should be sent home on early Study Leave. Extra English coaching will be provided at home three times a week.
17th May	Child L and her mother attend follow-up appointment with CAMHS psychotherapist. On this occasion, Child L talks about hearing voices which tell her to do stupid things (new information).
	The psychotherapist is concerned and now believes Child L should have a psychiatric assessment. He discusses this with the psychiatrist in the team, who does not agree with this request. A (later) team meeting decides that the psychotherapist should pursue the assessment, possibly joint-working this with another team member if required. The aim is to find out what is causing Child L's behaviour.
17th May to 7th June	Child L's exam period. She is reported to be unsettled in exams.
18th May	Early Help Service allocate case to Senior Family Support Worker who has known the family in the past.

19th May	Child L taken to see GP by Mother who is concerned about recent events.
20th May	Senior Family Support Worker has introductory telephone conversation with mother. Visit arranged for 25.05.16.
25th May	Home visit by Senior Family Support Worker. Mother agrees only to work being done with Child L, not with the rest of the family.
1st June	Senior Family Support Worker takes Child L out and has chance to speak to her alone. Child L does not report any problems, and upon return to the home, mother says Child L has been happier of late and she does not feel the family need any further support.
7th June	Child L's last exam and end of school for her. Later in the summer, one of her exam papers is found to contain what amounts to a suicide note. The examining board send this back to the school.
10th June	Final home visit by Senior Family Support Worker. Child L does not engage at all on this occasion.
Late June	Multi-agency professionals meeting arranged – to share information and views before closing case. Meeting postponed and re-arranged for 8th July.
July	Child L dies by self-strangulation in the family home.

9.2 <u>How this case opens a wider window on safeguarding challenges</u>

This case puts in stark perspective the challenges involved in understanding the lived experience of young people and providing help that is timely and effective. Teenage years are renowned to be a difficult time, when young people are desperately seeking their own identities, striving for independence while still being dependent on family, and being heavily influenced by peer groups. We have seen how these teenage circumstances can lead to a situation where self-harming of different kinds can become "contagious" and potentially a cultural norm – eg, in schools.

During this time, schools and families alike may only get to glimpse what is really going on for young people, and CSC "front door" staff even less so. There is therefore a challenge: how to respond sympathetically to teenage distress and to distinguish young people who are in crisis and in need of a social work assessment? How to understand, or "hear", what young people are

trying to tell us by their help- seeking behaviour, even when they cannot clearly articulate the source of their troubles? What do we do when they choose to speak to someone who is not a "safeguarding" member of staff? How should we use the knowledge we have of a young person, and avoid thinking too readily that we know them and what they are capable of? And how can we do all this in a context of busy, pressured work environments, where there is ever increasing demand on the limited available resources? These are some of the issues that the case of Child L raises which are questions pertinent to work with many young people, to their families, schools, hospitals, CAMHS, and CSC.

9.3 Appraisal of professional practice in this case

9.3.1 The following appraisal outlines the Review Team's views about how well professionals carried out their roles and responsibilities in working with this young person and her family. It also provides a link to the analysis of why things happened as they did, including the wider systems factors. It is these general findings which allow us to translate the learning from an individual case to the wider work of safeguarding agencies.

9.3.2 Child L did seek the help of the adults around her, many times in the months leading up to her death: she had been telling professionals how unhappy she was, she had taken an overdose, and said that she had thoughts of suicide from when she was in Year 7 (aged 12). However, these events did not result in effective prevention; once there had been a mental health assessment, no follow-up or treatment resulted. There is no knowing whether her death could have been prevented, but there were opportunities in the months leading up to it, to try to understand what was distressing her and to intervene with child-centred purpose.

9.3.3 The period reviewed when Child L most needed professionals to be tuned into the significance of her help-seeking behaviours, coincided with a time of organisational and personnel change for the school, CAMHS and RIAT. These changes were happening during the lead up to exams, and in the exam period, when young people are known to experience stress and are possibly prone to deliberately self-harm. This became one widely-accepted interpretation of Child L's distress. The failure to focus on what Child L had to say about what was troubling her was compounded by poor practices in all the agencies in relation to adequate history-taking, recording and inter-agency communication.

9.3.4 In modern Britain, professionals who work with children and families in various settings are believed to share a common understanding about giving children a voice, including what might get in the way of a child

"telling" what is troubling them. It is thus of real concern that the systems designed to help Child L were unable to respond to her effectively, when she was distressed and seeking help "in plain sight". Sadly, one of the outcomes of this history is that it will never be possible to understand what may have been "the final straw" which caused her to take her own life.

Family background

9.4 Child L's early childhood was characterised by ongoing domestic violence, and she and her closest siblings had been the subject of CP Plans for two periods of 3 years and 2 years. Senior school staff were aware that Child L had arrived in Year 7, still the subject of a CP Plan. This came to an end in that first year, and gradually there was a sense that the family had become more stable and settled. Father had returned to live at home and now had a job, and Mother was seen as a protective and caring parent, who engaged with the school.

9.5 Child L's secondary school life had been, or appeared to be, settled for Years 8, 9 and 10. She was in an all-girls school. Child L herself was seen by staff as a quiet and diffident young person, someone who was a "follower" in her small group of friends.

9.6 This review focuses on the second half of Year 11, which became a period of evolving crisis for Child L. This was her last year of school, and exams were approaching, about which she was reportedly anxious. Child L was also believed to feel sorry to leave school, a familiar response for many girls with uncertain prospects for further studies or work.

9.7 <u>Information from parents:</u> Child L's parents report that they began to notice changes in her behaviour around October 2015, when she stopped eating with the family, preferring instead, if she ate at all, to eat pizza and pasta and to drink sugary drinks. Generally, she was eating and sleeping very little, and became more withdrawn. On one occasion, her mother observed Child L in bed at night with her body stiff and her eyes wide open but "black" in presentation. They consulted the GP about these changes and their concerns for Child L, and were advised that they were the result of the nutritional deficiencies of her poor diet. Iron tablets were prescribed when it was found that she had extremely low iron levels.

School find out about Child L's collection of pills and their response (January 2016)

9.8 Child L was a child who had not stood out during her time at the school, and it is this which gave her new behaviours from January 2016 such significance.

School's response to the "hoarding" of pills and other items, including junk food, was to offer advice about healthy eating. This was a missed opportunity to be more curious about other aspects of her behaviour, and why her friends were worried about the possibility of her taking an overdose of paracetamol. **Finding 2** explores how the impact of high levels of social need and deliberate self-harm increase the chances that some children will be left at risk, including in settings such as a busy secondary school.

It is well understood that children don't always find it easy to talk to adults, but will sometimes confide in other children, and when they do so, either with words or with actions, this should be taken seriously. The school's response in this case was to focus on Child L's poor eating habits, rather than thinking about the hoarding of pills and other objects, and about her friend's concerns for her wellbeing. The potential consequences of this response are explored further in **Finding 4**.

School's response to Child L's emails to the Higher-Level Teaching Assistant (HLTA)

9.9 From March onwards, Child L regularly and frequently emailed her HLTA, often with emotional messages about her unhappiness. The HLTA, a relatively inexperienced and junior member of staff, appropriately consulted senior school staff about this developing situation.

Senior school staff saw Child L's behaviour as worrying and intrusive, and wondered whether she had a "fixation" about the HLTA. They discussed this in their Safeguarding Team meetings, and then requested Child L to stop the emails, although she would be able to have face-to-face time with the SENCO (who knew her well) and with the HLTA, if she needed this. This meant that she had the opportunity to speak to school staff when she needed to. This was good practice.

The HLTA believed that Child L had something she wanted to disclose but felt unable to tell about this. It emerged that school staff (and RIAT) believed that they were unable to act where there was not an explicit allegation of harm; the distinction between behaviour and an oral allegation or physical evidence is discussed in **Finding 4**.

9.10 There are no notes of the discussions of the Safeguarding Team, and deficits in recording are a consistent feature in this case across all the agencies involved**.** The school's view that Child L's behaviour was designed to get the attention of the HLTA became fixed for a while, even after more evidence of Child L's unhappiness emerged in her written messages and her self-harming behaviour. This common error in cognitive reasoning remained unchallenged in part because of the lack of support and advice for safeguarding staff in schools.

This lack of supervisory challenge and how it affects their views or biases is explored further in **Finding 3**.

The school's SENCO, who had known Child L and her family since Year 7, was regularly involved with her. It is clear that she offered considerable time to Child L, and this was good practice. However, this contact was in the context of a busy day job and a lack of safeguarding supervision. Key information arising from the contact with Child L was neither recorded nor shared effectively either within the school or with other agencies.

Multi-agency response when Child L tells school that she has been hit by her mother (3rd May 2016)

9.11 The SENCO was not in school on the day Child L made an allegation of physical abuse against her mother, and Mother telephoned the school to report that Child L had self-harmed (scratching herself with a compass). The Assistant Headteacher dealt with this matter in her absence. She was unaware of recent events, including the hoarding of pills and the emails about Child L's unhappiness at home. There was no easily accessible account of recent events, nor of Child L's child protection history, especially in the midst of responding to a child protection allegation.

This meant that the whole context of Child L's family experience was missing to the Assistant Headteacher as she dealt with the events of 3rd May.

9.12 This was the first time that Child L was known to have hurt herself and the first time that she talked about the causes, indicating an escalation in her help-seeking behaviour. The Assistant Headteacher spoke to Child L on her own, which was good practice. Child L was frequently seen on her own at school, which was a place where she had good, trusted relationships with some members of staff. Child L wrote an account of events at home that morning for the Assistant Headteacher, which included her allegation that she had been hit by her mother.

9.13 The Assistant Headteacher contacted RIAT and asked for a social work assessment to be carried out. This was in line with child protection procedures, and was good practice. There followed what can only be described as a series of miscommunications, misunderstandings, or both, between the Assistant Headteacher and the RIAT social worker. Neither the school nor RIAT took account of Child L's history when discussing the presenting situation; this created a significant gap of information that should have informed decision-making.

The call from school to RIAT was managed as a "contact" and not a referral, and was recorded as such. The school were asked to speak to the mother, and get more information, leaving the school to understand that they were to "deal with it themselves". This response was, according to the Case Group

members, a typical one when making a referral to RIAT. **Finding 1** explores the experience of referrers and the management of requests for a social work assessment.

The Review Team believe that this was in fact an appropriate referral from the school, which should have been accepted for a social work assessment. The response of RIAT was inadequate, and their write-up of the contact conflicts with the information school believe they provided (but did not send in writing). The issues created by poor recording practice across the agencies is a consistent feature in this case.

9.14 There is no evidence of any consideration of cultural, gender or family attitudinal factors and their impact on Child L. **Finding 3** considers the lack of advice/support and supervision for safeguarding managers in school, as a necessary means to challenge fixed views.

The multi-agency response to Child L's overdose (10th May 2016)

9.15 Child L sent a note to the HLTA asking for help, and then disclosed that she had taken an overdose of Paracetamol and iron tablets, and had drunk nail varnish. The school's immediate response to this emergency was very good. School staff contacted her parents, she was located quickly (hiding) in the school, and the emergency services were called promptly.

9.16 In line with safeguarding guidance and training, the ambulance paramedics made sure that they saw Child L alone before admission to hospital. This was good, protective practice; however, there is no record of what she said to them. It is recorded that the school told paramedics that Child L was suffering with exam pressures.

9.17 The school subsequently sent a referral to CAMHS which misleadingly asserted that Child L's allegation of being hit had been "found to be untrue". This was incorrect; the most that could have been said was that Child L's allegation had not been substantiated as it had not been investigated. The school attributed the overdose to exam pressure and this became the dominant story (as well as the view that Child L was angry about the constraints on her emailing the HLTA). There continued to be a poor exploration of what was now an escalating pattern of self-harm and distress; instead each incident was being viewed discretely.

9.18 Child L told the Triage Nurse in the hospital Emergency Department admitting her that she'd had suicidal thoughts since Year 7, but the significance of this was never afterwards explored with her; it is unclear whether the record he made was read by subsequent practitioners. Child L was seen alone by the paramedics and the medical staff in the emergency room; after that it is unclear who else managed to see her alone, as her mother was with her in hospital.

9.19 The usual referral to CAMHS was made by the Ward doctor for Child L, and their assessment was undertaken, as is routine, when she was judged to be medically fit for discharge. In this case, this happened on a Friday. The focus of the CAMHS assessment was on exam pressure, this being the reason reported by school for Child L's overdose. It is also a familiar "trigger", with the high number of adolescent suicides nationally which are related to exam pressure and an increase in self-harm around exam time. The risk assessment was reliant on the family who would decide what to share about the recent context for her behaviour, as well as historical information about domestic abuse during her childhood.[3]

9.20 At this point, there was a distinct lack of shared information about the potential backdrop to Child L's self-harm, including a serious overdose. There was no joint assessment or meeting which would have resulted in more of the relevant information being shared, and contributing to a holistic assessment of Child L. **Finding 5** explores the current approach to responding to young people who are admitted to hospital following an overdose.

9.21 At the point of discharge, there was no discharge meeting (which would have been rare to have in a case like this), so there was no plan and no shared understanding of what would happen next. In particular, the possibility that the week-end might be very difficult for Child L and her family was not apparently considered. The hospital sent a discharge report to the school nursing service but this did not include information that Child L had talked about suicidal thoughts since Year 7, and this was never shared with the school. This was poor practice.

9.22 The CAMHS psychotherapist made a follow-up appointment for the following week and letters were sent to Child L's GP by both the hospital and CAMHS. This follow-up by CAMHS was in line with their team requirements (to be within 7 days), and this was good practice.

Responses to Child L arriving at school with her bags packed and stating she doesn't want to go back home (16th May)

9.23 On the following Monday, Child L arrived at school in a distressed state, bringing a large number of her possessions with her in black bags. She told school staff that there had been family arguments all week-end about her overdose, and she refused to go home. The school did not know of her discharge, so her arrival at school on the Monday morning was unexpected.

9.24 Again, an appropriate referral was made to RIAT for a social work assessment, this time in response to the urgent situation which was unfolding at the school.

[3] The review was told by the psychotherapist that he did not see Child L alone on this or the subsequent occasion when he met her. However, Mother has suggested that he did see her alone at least once.

This was good practice. This received the same response as before: the school should talk to the parents, and then this should be referred to Early Help. This led to an intra-agency dispute: RIAT maintained that the threshold had not been met for a statutory social work assessment whilst Early Help maintained that given her level of distress, and the recent history, Child L should be seen that day by a social worker for assessment.

In their decision-making, RIAT did not take into account Child L's early childhood trauma, nor the seriousness of her recent self-harm and overdose, both of which are significant factors in teen-age suicide[4]. The Review Team regard this response as inadequate in the same way that the previous one was. The matter was "resolved" when Child L did go home, reluctantly, with her mother. The following day, the Team Manager directed that Early Help should pick up the case.

9.25 Over the weeks prior to her overdose, Child L had been more and more distressed, but each episode was treated individually rather than in a context of escalating behaviour and cumulative risks. The sympathetically curious response to this pattern would have involved the objective to get to the bottom of what was happening for her. **Finding 4** considers the extent to which the absence of professional curiosity can lead to potential risk to children being missed. It should have been clear at this point that Child L needed someone to talk with her about what was happening, and this should have involved a professional social work assessment.

9.26 In school the following day, Child L was behaving "strangely" and erratically, and staff were so concerned about "what she might do" that she was closely supervised. In practical terms, this could not continue. Senior staff therefore decided that she should begin her study leave early, and would be at home with tutoring support. The idea was that she could be more closely supervised by her family. This decision continued to regard Child L's family home as safe and protective, despite her recent allegations and her self-harming behaviour. Without having first explored these issues in order to test these assumptions with the family, this was poor practice.

9.27 Child L and her mother saw the CAMHS psychotherapist later that day, which raised more serious concerns about her state of mind, including her account of voices telling her what to do. He has stated that he did not see Child L alone.[5] He told Child L and her mother that he wanted to arrange a psychiatric assessment, and Child L agreed to this. His subsequent discussions about this with the Psychiatrist and the psychiatric nurse were unrecorded, as was the decision about how the case should be dealt with at a later team meeting

[4] '*Suicide by Children and Young People', National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).* Manchester: University of Manchester, 2017

[5] Child L's mother has since told the Lead Reviewers that the psychotherapist did see Child L alone at this appointment. There is thus a discrepancy in the information given to this review.

(scribbled notes suggest that this was for the psychotherapist to see Child L again and pursue with her the causes of her self-harming behaviour). The absence of written records of these critical discussions apparently resulted in a muddle about what would happen next, and there was no tracking system for patients of the team at that time. Child L did not receive any follow up from the CAMHS and her needs were not met.

NICE Clinical Guidance[6] sets out the clinical standards for a comprehensive psychosocial assessment of people who have self-harmed. The risk assessment and planning by CAMHS in this case fell far short of acceptable standards of clinical practice, and this has been the subject of a separate internal review by the CAMHS which was conducted concurrently with this Review. This has resulted in a system being put into place to ensure that all referrals are followed up and tracked.

Follow-up work in the community – 18th May onwards

9.28 Early Help quickly allocated the case to the Family Support Worker who had known the family in the past, and she contacted the family in a timely way; this was good practice.

9.29 In this period, Child L was studying at home, with some visits from a school tutor. She went into school only for her exams. Her mother was concerned about Child L's strange eating and sleeping patterns, and she took her to the GP with a query about "seizures". The (trainee) GP recorded a plan to follow this up with Child L, which did not happen. The GP practice had been kept informed via letters from the hospital and CAMHS about recent events. Therefore, this lack of follow-up or liaison with CAMHS was poor practice.

Child L's mother returned on her own the next day to see her usual GP, and they discussed Child L's clinical symptoms. In view of Child L's age and the complexity of her presenting needs and recent history, a consultation in her absence was inappropriate on the part of the GP. However, despite everything that had happened, and continuing concerns, there was still no plan of follow-up by the GP which was a poor response leaving Child L potentially at risk.

The GP Practice received the Discharge Letter from hospital which contained information that Child L had talked about having had suicidal thoughts since Year 7. However, this information was not acted upon as the letter was filed without being reviewed by any of the GPs in the Practice and only came to light after Child L's death. The filing away of important correspondence without it being reviewed by a GP and subsequently shared with those working with Child L is poor practice. The GP Practice has since reviewed its arrangements for handling incoming correspondence.

[6] NICE, CG133, reviewed and updated October 2016

9.30 The allocated Family Support Worker visited Child L and her family at home three times, taking her out to talk on her own once; this was good practice. However, Child L was unwilling to engage with this worker. She said that she was seeing someone from the CAMHS Service (she had seen someone, but nothing further was arranged) and seemed to welcome this.

Child L's mother declined any further support from Early Help, so the case would be closed to the Family Support Worker who appropriately tried to convene a professionals meeting with partners before closing the case. The purpose of this meeting was to ensure that support for Child L was in place for the summer period, and this was good tenacious practice. CAMHS were asked to provide a report for this meeting but this did not happen and this was not good practice.

9.31 The professionals meeting was arranged for late June, but had to be postponed. It was rearranged for July, but then never happened as this was the day after Child L's death.

10. What is it about this case that makes it act as a window on practice more widely?

10.1 Luton SCB saw that a review of this case could provide a useful response to the following broad questions (already set out in Para 6.2), which relate to safeguarding practice across the local multi-agency network:

- How well are we in Luton currently identifying and responding to adolescents at risk of deliberate self-harm or suicide?
- How well do we listen to, and act upon, the wishes and feelings of young people?
- How well do we understand and address issues of culture, religion and ethnicity in our assessments of children and families?

10.2 The Independent Reviewers and members of the Review Team analysed a large amount of data, most of which came directly from those who worked with Child L and her family, and from key documents in the case. Members of the Review Team, with senior roles in the agencies involved, contributed strategic information about their organisations and the factors affecting their single and multi-agency work – including levels of resources, demographic information[7], changes in structure, and practice standards. We concluded

[7] Children & YP in minority ethnic groups make up **61%** of all Luton children

that there were systemic patterns, or findings, which held true not just for this case, but which affected practice more widely.

10.3 The **5 findings** have been formulated in the context of high levels of social need in Luton, and the resulting demands on services. Luton was described as having many of the features of an inner-London borough, including extensive diversity, social deprivation, housing problems, and anti-social behaviour, including the growth of gangs.

11. List of findings

Finding 1:
Are ongoing developments of the Luton MASH improving practice for cases where the immediate risk of harm to a child is not readily evident, given that during the period under review the dialogue between referrer and CSC in such cases tended to be about thresholds, rather than keeping the child at the heart of the discussion? (Multi-agency work in response to incidents)

Finding 2:
In a context where levels of deliberate self-harm (DSH) by young people are increasing, there is a risk of not exploring whether DSH, including a serious overdose, is either a safeguarding issue and/or indicates the onset of mental health problems for individual children, increasing the chances that some children will be left at risk. (Professional norms and culture in response to incidents)

Finding 3:
The standard arrangements for key safeguarding responsibilities in schools, rely heavily on individual roles, without any requirement for reflective safeguarding supervision. This makes it unlikely that predictable errors of human reasoning will be picked up or rectified, such as seeing a particular child's DSH as copy-cat behaviour, despite evidence to the contrary. (Cognitive biases)

Finding 4:
Professionals do not routinely understand help-seeking behaviour by children as evidence of their being potentially at risk, but feel that they need to wait for a verbal allegation of abuse or neglect before taking action. This increases the risk of appearing to children themselves that however loudly they shout, adults are not listening. (Professional-child interactions)

Finding 5:
The routine response to a young person admitted to hospital following an overdose, is a referral to the CAMHS for a mental health assessment. The absence of a system for agency information-sharing in such cases creates the

risk that wider welfare issues are not addressed effectively even when a young person is at their most desperate. (Management systems)

12. Findings in detail

12.1 Finding 1:

Are ongoing developments of the Luton MASH improving practice for cases where the immediate risk of harm to a child is not readily evident, given that during the period under review the dialogue between referrer and CSC in such cases tended to be about thresholds, rather than keeping the child at the heart of the discussion? (Multi-agency work in response to incidents)

The work of safeguarding and promoting the welfare of children tends to be arranged on a spectrum or hierarchy of needs of the child. Cases are often then categorised in terms of what "tiers" of Services are required, and the boundaries between one tier and the next may be referred to as "thresholds", with cases typically described as "meeting the threshold" or not for a tier of services. The issues of what exactly those thresholds are and the monitoring of how well they are operated are the responsibility of the Local Safeguarding Children Board, and are the focus of much strategic work.

On the ground, individuals and agencies approach the "front door" of CSC in order to discuss concerns about a child and what kind of service or response is required. The negotiation of thresholds can become very difficult unless the presenting information is clear cut, and the interaction between those wanting to make a referral and those receiving their information can become a "contested space" as to whether the information meets the threshold for a referral.

This review was informed that this difficult conversation was often not handled in a child-centred way in the previous structure of CSC, the RIAT, which was in place when the events of this case review happened. As a result, a curious and empathetic approach to the child's needs was often lost. The front door arrangements changed to a multi agency safeguarding hub (MASH) whilst the review was being completed.

12.1.1 How did the issue feature in this case?

There were two attempts to make referrals by Child L's school that prompted the Review Team to look more closely at the response of RIAT to requests for help and the sharing of concerns about children. This was during what was a period of rapidly escalating crisis for her.

On the first occasion, after Child L's allegation of physical abuse by her mother, the school contacted RIAT with little expectation that a referral would be accepted, having had previous experience of similar cases. They were subsequently unsurprised by a "pushback" from RIAT, on the grounds that the situation was not urgent enough. They received advice to speak to the mother about the allegation; they did so, and were told by Mother and other family members that the allegation was untrue. Child L was sent home from school with an older brother.

The second attempt to refer was made by school three days after Child L had been discharged from hospital, following her serious suicide attempt. She had brought her possessions in black bin bags into school, and was refusing to go home. On this occasion, RIAT again did not see this as an urgent matter which reached the threshold for a social work assessment, and directed the school to contact Early Help instead. Early Help did not regard this as an appropriate referral for them, as the situation needed a more urgent response. The school had already involved Mother, and together with her they persuaded Child L to return home, missing a key opportunity to demonstrate to Child L that adults were hearing her unhappiness and trying to help.

Our appraisal of practice has indicated that accepting a referral and completing a social work assessment by RIAT would have been the appropriate response to both of these episodes. Both attempted referrals, from a source which knew Child L really well, suggested a young person in crisis and possibly at risk of harm. However, what struck us was not only the absence of a social work assessment on each occasion but also the fact that the school had expected that their request for help would not be accepted.

It also struck us that the RIAT response failed to galvanise the school into finding out more about what was going on for Child L, to better advance their referral with stronger evidence. On the contrary, it seemed to set school into "fire-fighting" mode, dealing with the immediate presenting problem, on both occasions of getting Child L to go home, while diverting their focus from a considered and curious approach to Child L's distress.

This created a tautological situation in which the school both expected their referral to be rejected by RIAT and did nothing to increase the chances that is would be accepted, and when Child L had returned home this was taken by CSC that the crisis had been resolved and the need for a social work assessment averted because the threshold had not been met.

12.1.2 What makes it an underlying issue?

There was a consensus during this review that the RIAT responses to Child L, described above, were inadequate, and we wanted to explore with participants whether the issues at the front door that had emerged as such a significant feature of this case, with a loss of focus on Child L, were unique to this case, or whether there was a wider system issue.

We found the same issue being reported to us for the period under review, with case examples being shared, of disagreements with those managing the front door about whether thresholds had been met for a referral to CSC, and that this resulted in a loss of focus on the child.

On the other hand, we were also informed of the dissatisfaction that exists within CSC with the poor quality of some referrals, with limited and poorly presented information which can make it difficult for those managing the front door to determine the right threshold of response, and that this also resulted in a loss of focus on the child. Inevitably, there has been frustration for both "sides" of the interaction. Brandon et al's 2016 triennial review of SCRs underlines this point: "…protection for children can be blocked at the entry point to CSC because referrals lack clarity in the way concerns about risks of harm are presented. Practitioners need to be mindful that their referral is more likely to be logged for "information only" unless the risks of harm to the child are made clear and specific". (p 242)

12.1.3 What is known about how widespread and prevalent the issue is?

There is now only one 'front door" for referrals to CSC – the MASH, which now sits together with Early Help.

A Serious Case Review published by the Luton LSCB into the case of Child J (June 2017) found that in November 2015, "the RIAT in Luton was experiencing disproportionate number of contacts, large turnovers of staff and poor management of resources at the time that the Child J died and that staff did not feel they had sufficient time to read and understand all the information…" It continues that, "Sound decision making at the "front door" is critical for the overall reliability of the safeguarding system. Without effective management of resources at the "front door" any structure will be unreliable and will undermine the wider safeguarding processes. Luton has recently introduced a MASH which should improve information sharing across agencies however for this to be fully effective it will need to be adequately resourced and managed". (p44)

All contacts/referrals[8] come through this one route. Data published by the Department of Education for 2015-16, shows that the rate of Referrals per 10,000 (0-17 population) in Luton at (501.7850) is higher than the regional figure of 425.50 per 10,000 However, it is lower than both the national rate off (532.20)) and the statistical neighbours rate of 535.42 per 10,000 (0-17 population).

According to the data collected regionally, Luton has the highest number of contacts per 10,000 (0-17 population) for 2016/17 in the East of England. However, there was a considerable reduction (by 31.5%) in the number of contacts at the 31st March 2017 when compared to the 31st March 2016 .The number of contacts that converted into referrals is low, but has increased steadily over 2016/17 from 14.4% in Quarter 1 to 21.0% in Quarter 4. This means that for every 4.8 contacts to the Multi-Agency Safeguarding Hub (MASH), 1 converts to a referral

The rate of deprivation in Luton is high (47th out of 152 local authorities) as is diversity (61% in minority ethnic groups, compared with a national average of 22*%).*

The issues described in this finding in relation to the management of thresholds in the face of the volume of work are not unique to Luton. A 2017 Ofsted blog[9], "Creating an effective front door", suggests that the complexities of front door transactions are shared across the country, where "…local authorities are struggling to get the front-door service right", and that "applying thresholds consistently is still a challenge".

It concludes that "Children need the right help no matter what time the referral comes in, the quality of the referral, which staff are on duty or the management arrangements". In other words, the child's experiences and the child's needs must remain at the heart of the work.

12.1.4 Why does it matter?

Identifying children who need an immediate response to protect them from harm or further harm, depends on reliable and consistent systems for child-centred dialogue at the point of contact/referral. This in turn relies on a shared understanding of how to make appropriate referrals, and linked to this, a good co-working relationship between people working in partner services, especially schools, who are the "eyes and

[8] In Luton, 'contact' is the name for all approaches to the MASH, and 'referral' is the name for those contacts which progress to having a social work assessment (a Tier 4 response).
[9] Ofsted and Eleanor Schooling, Social care monthly commentary: March 2017, 'Creating an effective front door'.

ears" of the safeguarding system, and the police and social workers who will provide the rapid response and assessment.

Brandon et al's 2016 analysis of SCRs (2011-2014)[10] consider what happens when these negotiations about thresholds are not consistently working well: "As in our previous biennial analyses, differences in perceived thresholds for child protection intervention could lead to frustration or breakdown in effective working, resulting in children falling through the gaps or their needs not being met". (p15)

Children are likely to be safeguarded more effectively under a referral system that creates resilience at the margins by balancing both clarity of so called "thresholds" and their application with a style of interaction that promotes dialogue and a certain degree of humility in the decision-making process.

Finding 1: Are ongoing developments of the Luton MASH improving practice for cases where the immediate risk of harm to a child is not readily evident, given that during the period under review the dialogue between referrer and CSC in such cases tended to be about thresholds, rather than keeping the child at the heart of the discussion? (Multi-agency work in response to incidents)

The front door service of the multi-agency safeguarding system provides a critical function of identifying children requiring a social work response and helping ensure there are adequate resources for that response by signposting "lower level" concerns to the appropriate services. It is complex work, and not easy to get "right", especially when there are problems in the partnership of giving and receiving a referral. Sue White et al have written about the complexity, noting that knowledge in child protection is known to be both "slippery" (difficult to codify – what is "it" that we are concerned about) and "sticky" (difficult to share across professional and institutional boundaries).[11] As a result, there may be a number of "false negatives", where appropriate safeguarding referrals are turned away.

This case review has identified that, during the period under review, there was a difficulty, perceived as a "contested space", in consideration of cases which do not clearly meet the Tier 4 criterion for acceptance as a referral. This suggests that it is relevant for the Board to continue to monitor and support the progress being made in the current MASH.

[10] Brandon et al, 'Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014' Final Report, May 2016, Department for Education

[11] Sue White et al, 2014

QUESTIONS FOR THE BOARD TO CONSIDER

- How useful is the notion of a "contested space" in relation to the management of thresholds through the current MASH arrangements?
- Has the MASH been designed to address this issue?
- What feedback has the Board had – or will it receive – about MASH and how it is dealing with contacts/referrals? Is it Board receiving the right range of qualitative and quantitative data to give it the monitoring information it needs to be confident that thresholds are being managed well?
- How can the Board help to support an on-going and open dialogue across all agencies about the experience of those in contact with the front door to services?
- Role of escalation: is the Board aware of how well "escalation" is being used, in relation to the "contested space" described in this finding? What role does the Board have in promoting an effective use of escalation?
- How would the Board know if there had been improvement in this area?

12.2 Finding 2:

In a context where levels of deliberate self-harm (DSH) by young people are increasing, there is a risk of not exploring whether DSH, including a serious overdose, is either a safeguarding issue and/or indicates the onset of mental health problems for individual children, increasing the chances that some children will be left at risk.
(Professional norms and culture in response to incidents)

Deliberate Self Harm (DSH) is a term that refers to the activity of hurting yourself on purpose. The seriousness of harm can range across a whole spectrum, from superficial to life-threatening. For example, DSH often involves superficial (or more severe) cutting on arms or elsewhere on the body, and may be hidden by clothing. In many instances, it is seen as a response to anxiety, typically causing a "relief" from this, and it can also be a distraction from intrusive suicidal ideation. A different kind of DSH is an overdose, normally of medication of some kind. This has the potential for extremely serious consequences, some of which may not be understood or anticipated by the child or young person.

DSH is increasingly common among young people nationally, as well as in some schools in Luton. As it becomes a more usual response to stress for young people, it raises the difficulty for practitioners, of simultaneously accepting that it is now a more common response by pupils to exam

pressure or even to a story line in a television soap opera, and at the same time maintaining appropriate curiosity and exploration of potential psychiatric difficulties for children and/or whether they have been abused or neglected, or at risk of such. This case review highlighted a growing tendency to do the former to the detriment of the latter.

12.2.1 How did the issue feature in this case?

There were three known incidents during the time under review where Child L set out to deliberately harm herself. Her friend told the school that she had a stash of pills in her locker, which the friend feared might be used for self-harm. Her mother told the school that she had cut herself with a compass. And lastly, she swallowed paracetamol, iron pills and nail varnish, leading to her admission to hospital. However, none of the individual incidents nor the evident escalation between them, led to professionals in the school, hospital, CAMHS or social care to a concerted effort to find out the source of her help-seeking behaviour, or her unhappiness. They did not go further to check the working hypothesis that hers was “only” copycat behaviour, or linked to the usual stress of the exam period, or (eventually one predominant belief) to her wish to gain the attention of a member of staff. Latterly, school staff decided that Child L was angry when being requested to stop emailing the HLTA, and this was the cause of the escalation in her DSH. With hindsight, we know that there were potential indications of the onset of mental health problems, including her account to the CAMHS psychotherapist that she was hearing voices telling her what to do. Little remained known of Child L’s experience of life at home, which had previously been marked by extreme domestic abuse, or the impact of these early experiences.

It is important that we stress none of the staff involved were uncaring about Child L, and efforts were made to elicit the appropriate assessment of her situation. Exploring the professionals’ responses, as part of the review, we noted how the growing incidence of DSH among young people meant that the gravity of Child L’s help-seeking behaviour, by various DSH means, including an overdose, was simply not recognised as of serious concern and in need of further exploration.

12.2.2 What makes this an underlying issue?

When we explored this issue further with participants in the review, members of the Review Team and Case Group from Child L’s school, from the acute hospital, and the CAMHS team spoke about the increasing numbers of young people, mainly girls, who are harming themselves deliberately through cutting and overdoses.

Hospital and CAMHS professionals described a typical spike in DSH and referrals into their services during the run-up to exams (and to mock exams), so they are inclined to associate this behaviour with exam-related anxiety.

During the period that Child L was admitted to hospital (April 1st – June 30th, 2016) 149 children attended the Emergency Department with an acute mental health issue, deliberate drug overdose or deliberate self-harm.

The LDUH reports that during the whole of 2016 to 2017, 284 children (under the age of 18) attended the LDUH Emergency Department with an acute mental health issue, deliberate drug overdose or deliberate self-harm, 90 (31 %) were male and 194 (69%) were females and 152 (54%) were from Luton. Over that year there were 143 acute mental health admissions to LDUH Paediatric Wards.

It is clear from the data provided by the hospital that the numbers are significant, due to the high-risk nature of mental illness. The hospital reports that the age that children present is getting younger, children from the south Asian community are presenting more often, and admissions to Tier 4 Units is also increasing – 17 in 2016/17 – 11 from Luton.

Professionals explained to the Review Team that in this context it does seem appropriate not to automatically assume that DSH reflects a serious problem – safeguarding or psychological. The response to Child L's self-harm incidents was not therefore a one-off but something more customary. Professionals also highlighted their having noticed that children themselves have in some instances begun to "normalise" cutting, minimising its significance and not seeing it as a "big deal".

12.2.3 What is known about how widespread or prevalent the issue is?
How many cases are actually or potentially affected by this finding? To gauge how big a problem this finding represents, we would need to know how many known incidents of DSH do result in a multi-agency safeguarding and mental health assessment relative to how many do not. These data are not available as far as we know.

However, it is clear that the number of cases potentially affected is large, given the data available about the incidence and genesis of DSH, including cutting and overdoses:

a) There is evidence to suggest that rates of self-harm in the UK are higher than anywhere else in Europe.[12]

b) Self-harm and suicide are 2-3 times more common in areas of social deprivation.[13] Child L's school, and many other parts of Luton, fall into this definition.

c) According to data provided to this review by the Luton and Dunstable University Hospital, for the year 2016-17, there were 284 attendances of children and young people at the hospital with an acute mental health issue, deliberate drug overdose or deliberate self-harm (See Finding 2).

d) According to the study "*Suicide by Children and Young People"* published in May 2016, suicide is the leading cause of death in young people in the UK, accounting for 14% of deaths in 10-19 year olds, and the most common method of suicide being hanging/ strangulation (554, 60%). Self-harm was reported in 52% of under 20s, with over half of young people who die by suicide having a history of self-harm with cutting and self-poisoning (overdose) being the most common methods. Self-harm has risen in the last 15 years—in 2014, one in five young women reported having ever self-harmed, twice the rate in young men and three times higher than reported 15 years ago. The "Truth Hurts" Report gives very useful messages about the importance of school for many children who self-harm, including the need for school staff and others who work with young people to have a much better awareness and understanding of self-harm. (p7)

12.2.4 Why does it matter?

The needs of children whose self-harming behaviour is like that of others – e.g. in a school setting – may not be understood in the wider context of their lives and this may mean that opportunities for understanding and intervening to prevent an escalation of behaviours and addressing the cause is missed, leaving the child or young person at ongoing risk of harm.

FINDING 2: In a context where levels of deliberate self-harm (DSH) by young people are increasing, there is a risk of not exploring whether DSH, including a serious overdose, is either a safeguarding issue and/or indicates the onset of mental health problems for individual children, increasing the chances that some children will be left at risk.
(Professional norms and culture in response to incidents)

12 'Truth Hurts' report
13 'Dying of Inequality' report

The *raison d'etre* of multi-agency efforts to safeguard children and young people, is to keep them safe from harm and promote their welfare. The increasing rates of self-harming among young people is alarming and is in danger of being regarded as a normal, almost acceptable response to the pressures of adolescence, including academic testing. This review has highlighted an additional unintended consequence of the increase in young people deliberately harming themselves.

Many professionals view DSH as a single type of behaviour rather than occurring along a spectrum, and with a range of causes. This makes it less likely they will notice escalation and identify high risk, potentially life threatening, behaviour or identify what is at the root of it. This may include overlooking indicators of the onset of mental health problems, or signals that a young person is suffering from past or current abuse or trauma. As such it represents a significant vulnerability in the reliable functioning of our safeguarding systems.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is the Board aware of the levels of DSH – by cutting or self-poisoning among local adolescents?
- Is the right data being collected to support the LSCB to understand this issue locally?
- Is the Board aware of the responses – in schools, in other settings? Is the effectiveness of these responses evaluated?
- How can the Board support the awareness of current research (e.g., from Manchester University – see references) about young people, suicide and risk factors, to underpin appropriate responses and services?
- There is a strong message from the report "Truth Hurts" that young people at risk of self-harming see school as a place to get support from peers, teachers and other staff. Are there ways in which this knowledge could lead to the development of relevant prevention measures? Time is needed for giving attention to each individual child who may be self-harming. Is it realistic to expect busy school staff to achieve this? Can the Board have a role in bringing agencies together to think about who and how might help providing a better response?
- What training is offered to professionals in various settings, but especially in schools, about the nature of DSH and responding to DSH? Does any training provided adequately highlight the spectrum of harm and range of possible causes?
- Could the views of children and young people be sought via a self-reporting, confidential questionnaire? And might this include what would be a helpful response if they currently self-harm or might do so?
- How would the Board know if there had been improvement in this area?

12.3 Finding 3:

The standard arrangements for key safeguarding responsibilities in schools rely heavily on individual roles, without any requirement for reflective safeguarding supervision. This makes it unlikely that predictable errors of human reasoning will be picked up or rectified, such as seeing a particular child's DSH as copy-cat behaviour, despite evidence to the contrary. (Cognitive biases)

12.3 As set out in Statutory Guidance, all schools in England should have a designated safeguarding lead. This person should be an appropriate senior member of staff, from the school leadership team. It is the responsibility of the school to ensure this person will have the required training and skills to undertake the role as defined within statutory guidance, compliance to which is measured at point of Inspection by Ofsted.

It is reported that supervision remains an area for development across education in Luton, and that creating the balance between support and effective case reflection can be difficult within the education context. In Luton, commissioned support in relation to safeguarding is available to education, however, the commissioning of these arrangements are at the discretion of schools and will be subject to schools' identified needs and budgetary considerations.

The demands of running a busy secondary school, especially where there are high levels of social need, inevitably affect the time and energy that staff at all levels have for individual attention to pupils, and this will be harder where a pupil either struggles to articulate what is distressing them, or may be frightened to tell a secret (see Finding 4).

12.3.1 How does the issue feature in this case?

Child L was on a CP Plan when she started secondary school in Year 7, and the current SENCO had known her at that time, and again became involved with her in Year 11. Child L's mother had engaged with the school when required, and was regarded as a caring parent. The family's historical problems, of severe domestic abuse, appeared to have been resolved after Father moved back into the family home in Child L's Year 7.

Child L had been a quiet, unremarkable child for the past three years, and although she was of low cognitive ability and struggled with academic work, she was not seen as of special concern – especially not in comparison with many other pupils.

Her stated explanation for her unexpected and dramatic change in behaviour was that she was suffering from exam stress. Her

HLTA – the recipient of the emails – did not believe this to be the cause, not least because Child L was not someone with high academic ambitions and associated anxieties; and increasingly her emails and other communication with the HLTA suggested serious personal unhappiness dating back for several years.

Senior school staff believed that Child L's behaviour was an attempt to get the HLTA's attention, and that in fact she was fixated on the HLTA, and was angry when access to the HLTA was limited. (This view was confirmed in conversations with school staff and the CAMHS psychotherapist, with whom they had discussed Child L).

The increasingly unhappy and desperate content of Child L's emails was not seen as fresh evidence that should prompt a re-think about her situation and her needs. Her early history was not (apparently) considered, nor was there professional curiosity about what might be happening in her life to cause such a dramatic change in her behaviour. Even when Child L made an allegation of physical abuse against her mother (3rd May 2016), the school believed Mother's denial that any such thing had happened, and sent Child L home into her care (and again two weeks later, when Child L said she did not want to go home).

The "fresh eyes" of a professional supervisor or school nurse might have challenged the assumptions being made, and allowed for an alternative exploration of Child L's behaviour and circumstances.

12.3.2 What makes this an underlying issue?

According to the human performance literature, one of the most persistent and important problematic tendencies in cognition, is our human slowness in revising our view of a situation or problem. It is one repeatedly found in child abuse inquiries[14]. Once we have formed a view on what is going on, there is a surprising tendency to fail to notice, or to dismiss, evidence that challenges that picture. It is also well established that we are cognitively not able to police this bias ourselves, even if we are aware of its possibility. That is why fresh eyes and independent challenge are so crucial.

Discussions with the Case Group and Review Team highlighted two relevant issues:

Firstly, the "safeguarding lead" role is assigned to an individual, who carries the responsibility for advising all other staff, supporting pupils,

[14] Munro, 1999

making decisions and communicating with other agencies. The content of the work is demanding and significant, in relation to the wellbeing and safety of children, and requires skill, knowledge and experience. It can also be emotionally very difficult. Some safeguarding leads continue to have full teaching schedules.

Secondly, apart from the constraints caused by the busy and pressurised school day, school staff generally do not have access to safeguarding supervision which would provide one means of testing out their understanding of a child's worrying behaviour, or other potential factors in the child's family life. The local authority Safeguarding in Education Manager is not in a position to give advice to schools regarding individual cases, but is a point of contact in relation to wider safeguarding matters.

12.3.3 What is known about how widespread or prevalent the issue is?

Different schools have different arrangements for how they discuss and manage concerns about a child's behaviour. It is not known what kinds of advice, or consultation including challenge, are available to all schools in these circumstances. However, it is clearly true that schools are very busy places, and in many Luton secondary schools, there is a high level of social need among the families of the pupils. All in all, it is a difficult climate in which to "dig deeper" into what might be the genesis of a child's self-harming, or "help-seeking" behaviour.

Data provided by the school to this Review indicated that in 2016-17 the school received Deprivation Funding for 68 per cent of pupils. The school also reports that for those pupils categorised to a Level of Need between 1-4, 60 per cent were categorised as being in Level 3(19%) and Level 4 (41%).

Members of the Case Group also highlighted variation in the skills and experience of safeguarding leads in different schools, and absence of specific, mandatory training for this role.

The Review Team noted that other organisations (hospitals, community health services) with large staff groups nonetheless manage to construct supervisory arrangements, in particular for safeguarding. This reflects their understanding of the principle that "safeguarding is everyone's business", and that it is not easy or straightforward but benefits from professional supervision.

In 2017, the Luton Safety in Education Manager produced a "Model Supervision Framework for Education Providers" which reinforces the need for supervision for staff with complex safeguarding responsibilities in schools. The guide clearly indicates the several

functions which supervision would fulfil, including “Provide space for case discussions” and “Encourage critical reflection”.

12.3.4 Why does it matter?

The “troubled” behaviour of children in a school setting is inevitably filtered via a framework of “what this behaviour commonly means” and what “type” of child s/he has come to be characterised as in school life. This has the benefits of making the task manageable which is of keen importance in a very busy school environment. However, without supervision or critical challenge by another means, where that heuristic is false, we can predict that it will go unchallenged.

Schools are the “eyes and ears” of the safeguarding system, as they are a universal service which has regular contact and familiarity with their children, and often with their families as well. This gives them a critical role in picking up on safeguarding issues for a child/young person. Safeguarding supervision can offer key school staff a means of checking and exploring their understanding of a child’s concerning behaviour, making it less likely that serious problems go unnoticed.

FINDING 3: The standard arrangements of key safeguarding responsibilities in schools rely heavily on individual roles, without any requirement for reflective safeguarding supervision. This makes it unlikely that predictable errors of human reasoning will be picked up or rectified, such as seeing a particular child’s DSH as copy-cat behaviour, despite evidence to the contrary. (Cognitive biases)

Designing a safe system means taking into account people’s psychological limitations and requires understanding and recognition of the main human errors of reasoning, and building in strategies for detecting and correcting them. According to the human performance literature, one of the most persistent and important problematic tendencies in cognition, is our human slowness in revising our view of a situation or problem. It is one repeatedly found in child abuse inquiries (Munro, 1999). Once we have formed a view on what is going on, there is a surprising tendency to fail to notice, or to dismiss, evidence that challenges that picture. It is also well established that we are cognitively not able to police this bias ourselves, even if we are aware of its possibility. That is why fresh eyes and independent challenge are so crucial.

Schools are at the front line of the safeguarding system, given that they are likely to have the most regular and consistent contact with children and young people. The key safeguarding role is typically designated to a lone

individual, who rarely has a professional safeguarding qualification, and completes the task on top of teaching or other responsibilities and without regular reflective supervision. The case of Child L draws attention to how this creates a significant challenge to effective safeguarding because it is well established that we are cognitively unable to police our own biases in human reasoning.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is there agreement across Board members of the importance of reflective supervision due to innate cognitive biases that everyone is vulnerable to?
- Has the question of reflective supervision, with a focus on safeguarding, been discussed by the Board previously? In relation to any profession? In relation to schools?
- What role can the Board take to support creative thinking about who and how this might be provided for those playing key safeguarding roles in schools?
- How is this challenged by the structural separateness of all schools?
- In this context, would the Board consider the "Model Supervision Framework for Educational Providers" – and how it might be implemented, including who might provide supervision to school staff?
- How might the Board know whether anything has improved?

12.4 FINDING 4:

Professionals do not routinely understand help-seeking behaviour by children as evidence of their being potentially at risk, but feel that they need to wait for a verbal allegation of abuse or neglect before taking action. This increases the risk of appearing to children themselves that however loudly they shout, adults are not listening. (Professional-child interactions)

Children and young people in distress can demonstrate a range of help-seeking behaviour, varying according to their age and stage of development. In this country, DSH behaviour has become very common among children 12 and upwards, and may as a result have lost some of its impact on professionals dealing with such children. Children who are not very articulate or confident, or of low cognitive ability, may find it difficult to express themselves directly – or indeed may be fearful of doing so, for a number of possible reasons. These children may not receive the action that their behaviour is calling out for – because of the reluctance or perceived inability on the part of many professionals to respond where there is a lack of a "disclosure", allegation or physical evidence of abuse.

12.4.1 How does the issue feature in this case?

Child L struggled to tell the HLTA what was disturbing her and making her unhappy, though she was increasingly clear that she had been troubled for several years, and that this related to home life in her family. School staff were aware that speaking clearly about herself was a common problem for Child L, whose communication skills were said to be very poor. Although senior staff discussed the change in her behaviour and tried to understand what might be causing it, it seemed that they quickly settled on the explanation of "attention-seeking behaviour, and fixation with the HLTA". (link to Finding 3). This view was communicated to fellow professionals via referral forms and in telephone discussions.

In March 2016, Child L began to write very frequent and personal emails to her HLTA, seeming to ask for help with her feelings of unhappiness and distress. The result of this was a strict limit on this contact being imposed by the school. Her first (known) incident of scratching herself occurred on 3rd May; when RIAT did not accept a referral for a social work assessment, the school negotiated for Child L to return to the care of her mother. A similar pattern happened on 16th May – after Child L's serious overdose and discharge home from hospital, and her bringing her possessions to school in black bags and refusing to go home. School staff again made a request for a social work assessment, but were told to discuss the situation with Child L's mother. This day also ended with Child L going home, albeit reluctantly. As Child L's behaviour became more desperate, school and RIAT agreed that "nothing could be done without a disclosure, or concrete evidence".

When Child L did make a concrete allegation that her mother had hit her, the school believed Mother's denial rather than Child L's allegation (again, see Finding 3).

Following her overdose and admission to hospital, Child L was assessed by a CAMHS team member. Her mother was present for all her contacts with CAMHS, giving Child L no opportunity to speak in confidence about what might be troubling her.

12.4.2 What makes this an underlying issue?

Case Group and Review Team members confirmed that practice in this case was not unusual in any way. Professionals in all agencies believe that they have limited options to pursue, as a safeguarding matter, distressed behaviour where there is no verbal (oral or written) disclosure or allegation. This is generally described as there being "no evidence" to investigate.

12.4.3 What is known about how widespread or prevalent the issue is?

Children who are struggling with a range of emotional problems may not readily talk to adults/professionals about what is going on for them; if they tell anyone about what is going on for them, it is more likely to be another young person. The "Truth Hurts" report, based on the responses of young people to their inquiry, noted that "…young people who self-harm can find it very hard to talk about it and are often afraid of how people will react." (p6).

Similarly, only about 25% of children who are sexually abused "tell" what is happening to them at the time[15]. Cawson and colleagues' research noted that (in relation to sexual abuse) "A particularly distressing feature of these cases was that the children had tried to tell, either by giving specific information, or in their behaviour and demeanour, but this was not acted upon. Several of the children exhibited significant changes in behaviour – running away, deteriorating school attendance and deteriorating physical appearance – which were not considered in the context of possible abuse" (p26).

The many constraints to "telling" may be more powerful where a child has low confidence to begin with, a lack of routine articulacy or indeed encouragement to express herself in other areas of her life.

Brandon et al (2016) commented that many children "may struggle to express their needs or feelings, or to engage effectively with services, and in the suicide cases reviewed the roots of the young people's problems were never addressed in a meaningful way. Thus, professionals need to be aware of "silent" ways of telling, through verbal and non-verbal, emotional and behavioural changes in children. In many of the cases it was evident that the voice of the young person was not always heard, and when a young person articulated distress (verbally or through their behaviour) it was often not understood or responded to appropriately." (p 110)

12.4.4 Why does it matter?

The difficulties for children and young people to speak out when they are troubled, or when they may be being (or have been) abused or neglected, are – or should be – well known to all professionals working with children and families: a fear of consequences for themselves or their abusers; a fear that they will not be believed; shame for what has happened. When young people cannot communicate with words, they may express themselves through their behaviours.

[15] Cawson et al, 2000, p86

Adults working with children and young people are often worried that they do not have the professional skills to listen to them when they are help-seeking, and are often concerned not to say the wrong thing, or make the child/young person repeat their story again to someone professionally qualified to hear what they have to say. However, when children and young people are help-seeking, they will often choose who they talk to, and what can make the difference at those times is having a trusted adult that will listen with empathy to what is troubling them, and to offer support and respond with purpose.

This review was told that there are different attitudes attached to self-harming behaviour and seeking help for mental health problems across certain religious groups (including Child L's), and these, along with beliefs about the consequences of suicide, need to be understood by all professionals in the safeguarding network. However, this was not something that emerged in this review.

Where there are difficulties, of all sorts, for children in telling what is troubling them, the system is not well placed to take further steps to find out more. For some young people like Child L, this means they are likely to remain without the understanding and protective action that they need, and their help-seeking behaviour may escalate.

The Review Team and Case Group agreed that giving a child the opportunity to be spoken to alone (without the child having to "choose" this in front of a parent or carer) is an essential safeguarding step. This should ideally be a trusted or familiar person, but this is not always possible in a crisis.

FINDING 4: Professionals do not routinely understand help-seeking behaviour by children as evidence of their being potentially at risk, but feel that they need to wait for a verbal allegation of abuse or neglect before taking action. This increases the risk of appearing to children themselves that however loudly they shout, adults are not listening. (Professional-child interactions)

The importance of listening to the "voice" of the child is a truism in child protection. There are a number of factors which, either singly or together, have the effect of reducing our ability to listen to the "voice" of a child. This is especially true where there is no direct allegation/disclosure, or other concrete evidence of what might be affecting the child. As we have seen above in Finding 3, a settled view of the child's behaviour may already be in place. Busy professionals do not always have the opportunity to see a child alone, despite the intention to do so. And the child may find it very difficult to tell about what is troubling them. All of these factors need to be considered

and better understood by those tasked with keeping children safe, including those who cannot "tell" but who are exhibiting "help-seeking" behaviour.

A safe system needs to be designed to enable busy professionals to hear a whole range of messages from children, including non-verbal ones.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is the Board aware of the distinction made between behaviour which communicates distress and a verbal allegation or other forms of concrete evidence?
- Is there a need for an in-depth look at how this distinction is perceived across agencies? In particular, when responding to concerns about a child?
- Does the Board have a role in positive promotion of "listening " to help seeking behaviour?
- Is current safeguarding training sufficiently focussed and assertive on this point?
- How will the Board know things have improved in this area?

12.5 FINDING 5: The routine response to a young person admitted to hospital following an overdose is a referral to CAMHS for a mental health assessment. The absence of a system for agency information-sharing in such cases creates the risk that wider welfare issues are not addressed effectively even when a young person is at their most desperate. (Management systems)

There is a well-understood, and well-used, response to a child's overdose: an urgent referral to hospital for medical assessment, followed if appropriate by medical treatment and care. The further procedure, within hospital, is to make a referral to CAMHS, whose risk assessment of the patient is required before he/she can be discharged. The CAMHS procedure includes a guaranteed follow-up appointment which is meant to be seven days.

There is not routinely a mechanism for multi-agency information sharing/referral to CSC when a child is admitted to hospital in this way. Instead, the hospital ward staff send a notification form about the young person's admission to their Safeguarding Team, who forward it on to the School Nurse and GP.

CAMHS is normally the only agency involved at this point in assessing the young person's mental state and potential underlying causes for self-harm. It is not clear that the custom and practice in the local CAMHS is to seek "background" information from partner agencies. However, there is no

straightforward system by which routine checks can be made for background data. So, their information is likely to be (as it was in this case) limited to what family members, including the child, are willing to tell them. Knowledge about the child's psycho-social history, any involvement with CSC, or other more recent factors, can easily remain unknown, especially where there is no multi-agency meeting to share information and consider any past or current safeguarding issues for the child.

12.5.1 How did the issue feature in this case?

In response to Child L's overdose, her school made a referral to CAMHS (though this was already in train via the hospital). The CAMHS duty officer (a psychotherapist in the team) met with Child L on the day she was judged medically fit to be discharged. He made a risk assessment of Child L with her mother, but had no background information to assist him in this task. He was not aware of the notes made in the Emergency Department which recorded that Child L had said she had had thoughts of suicide since Year 7, her first year of secondary school.

The written referral to CAMHS from the school (most likely not yet received by the time of the first meeting with Child L) included minimal information about her extensive experiences of domestic abuse as a young child. It also stated that she had recently reported a physical assault by her mother, but that this was (wrongly) "found to be untrue". Thus, some information was available, but it was limited and inaccurate.

In the following week, the psychotherapist had a telephone conversation with senior school staff (SENCO), in which the view of Child L's behaviour – as part of her fixation on the HLTA, and a reaction to being "separated" from the HLTA – was discussed.

After the psychotherapist's second appointment with Child L and mother, he became more concerned about her mental state. At his CAMHS team meeting, the case was explored and it was decided that the psychotherapist should continue to work with Child L, and get additional support from a specialist nurse if need be. The aim would be to find out more about the underlying reasons for her behaviour.

The school's approach to RIAT had not been accepted on 3rd May, nor was it again, on 16th May. Had either of these contacts been agreed as referrals and led to a social work assessment, it is possible that a multi-agency meeting might have been held, which could have brought together information about the family and Child L's history, and allowed CAMHS and CSC to explore the situation together with the school.

12.5.2 What makes this an underlying issue?

Review Team and Case Group members spoke about their frequent frustration when trying to find out information from RIAT, or the initial

MASH (Phase 1 – until April 2017) in relation to a child of concern. As noted above, in Finding 1, a dialogue to try to explore together the best way to help a child (including consulting historical records) is not normally offered by RIAT or the previous MASH. Information is not passed on unless the case clearly reaches the S47 threshold.

There is, perhaps insufficiently publicised, a pathway whereby background information can be provided, via the Early Help Service. It is not known how often callers are signposted to this service. Some members of the Case Group were previously unaware of this offer.

Case Group members said that what happened in this case is routine practice in the local CAMHS. Assessments are regularly conducted without the benefit of contextual information, especially when this is not provided by the child or family.

The referral form to CAMHS, if a handwritten form is used, does not give adequate space for the kind of information required. It is only the online form which allows the "boxes" to expand.

Convening a multi-agency meeting for all children who take a serious overdose, and who require admission to hospital, would have significant resource implications for all agencies, and it would be unlikely that they could attend for many such meetings. It is not the hospital's practice to arrange such meetings, except in exceptional cases.

Cases which are well-known (repeat admissions, already known to CSC) are more likely to have a partnership response. But this means that the lesser known children, where a holistic assessment and information-sharing might be of equal value as a means of understanding their behaviour and the risks posed, do not receive a multi-agency response.

12.5.3 What is known about how widespread or prevalent the issue is?

In terms of demand, the LDUH reports that in 2016 to 2017, 284 children (under the age of 18, of whom 152, or 54% were from Luton) attended the Emergency Department with an acute mental health issue, deliberate drug overdose or deliberate self-harm (see Finding 2), and there were 143 acute mental health admissions to LDUH Paediatric Wards. The hospital reports that those children who were not admitted will have been seen by either a CAMHS or Psychiatric clinician based in the hospital and will have received a follow up in the community as required.

It is understood that many acts of self-harm do not come to the attention of healthcare services, and hospital attendance rates do not reflect the true scale of the problem. Practice elsewhere in the country is not known, but with the increasing numbers of children and young people attending hospital for self-harm related issues, it is likely that trying to

convene regular multi-agency meetings as the starting point of an assessment would bring the same resource challenges as elsewhere. Current NICE Guidance sets out the standards for a comprehensive psychosocial assessment of people who have self-harmed.

The 2016 study "Suicide by Children and Young People" found that although there are many antecedents of suicide in young people, self-harm is a crucial indicator of risk and should always be taken seriously, even when the physical harm is minor.

Brandon et al 2016, "For many of the young people in the SCRs, previous life experiences and adversity were mostly recognised, but not necessarily addressed, as professionals struggled to react to crises in the lives of the young people. For example, witnessing domestic abuse as a child was not considered in relation to later behaviour, partly because it was not documented and shared". (p114)

For children where there are no apparent safeguarding concerns, the reluctance to share information, to ensure compliance with the Data Protection Act, is clearly a widespread constraint on information-sharing. The question then arises as to whether a serious overdose, requiring hospital admission, can or should be regarded as a potential safeguarding issue and therefore one which should be explored in partnership through information-sharing.

12.5.4 Why does it matter?

Given that self-harm is a symptom of "underlying emotional and psychological trauma" (para 5.2.2), there is a clear need for mental health professionals to explore the reasons for the young person's behaviour, to identify appropriate help (or protection). There needs to be an alertness to potential harm within the family, or elsewhere, which is may be being kept secret. School and CSC, and possibly the child's GP, are sources of information about a child which would add to the mental state assessment, and would not leave the CAMHS professional solely reliant on what the child plus parent or carer has told him/her.

Children who are assessed in a single agency are less likely to receive a holistic assessment, and may not receive the protective services they need. This may be especially true for children (see Finding 4) who find it difficult to talk about their distress and the reasons for it.

Brandon et al (2016) conclude that, in relation to working with adolescents, "Sharing information is not enough when supporting these vulnerable adolescents. Professionals need to have clarity about their own role and an understanding of other professionals' roles to work together effectively". They go on to state that "Multi-agency meetings with professionals involved in a case can encourage information to be

shared and roles to be clarified, improving multi-agency working and allowing professionals to gain a holistic view of the case". (p 116)

FINDING 5: The routine response to a young person admitted to hospital following an overdose is a referral to CAMHS for a mental health assessment. The absence of a system for agency information-sharing in such cases creates the risk that wider welfare issues are not addressed effectively even when a young person is at their most desperate. (Management systems)

The routine response in Luton to a young person who has taken an overdose is to arrange a mental health assessment by the CAMHS team (after appropriate medical treatment). Although this may be an adequate response for many of the cases of DSH which present to hospital, it will not be the right response for every child. The current system does not allow professionals the time and the means to explore critical information about the child's circumstances (past and present). These may not come to light, especially if the family members are the only informants.

Thus, the assessment may not get to the reasons for the child's behaviour. This is especially problematic where a child is – for whatever reasons – unwilling or unable to speak openly about these reasons (Finding 4). The problem is in not knowing which children are left in vulnerable situations.

QUESTIONS FOR THE BOARD TO CONSIDER

- Does the Board regard safeguarding as an element to be included in assessing cases of children's self-harm (those which are serious enough to warrant hospital admission)?
- What role does training currently play in supporting a better understanding of self-harm, and does the training material include the idea of safeguarding as an integral part of the professional response?
- Might there be ways, other than a meeting, to pull together information from partner agencies to underpin a CAMHS assessment for a child who has self-harmed and been admitted to hospital?
- Are there confidentiality issues which might be constraining the asking for and sharing of information – if safeguarding is not seen as part of the reason for asking?
- To support the LSCB's focus on adolescent mental health and DSH in 2017/18:

  Is the Board aware of different attitudes to mental ill health or emotional problems among different communities or groups in Luton (based on religion or ethnicity)? Might some problems be more likely to be hidden

or difficult to talk about? What might this mean for developing sensitive approaches to children and families with MH problems?

13. Additional Learning

13.1 Promoting effective referrals

This case has highlighted the need for training, collaboratively for both "sides" of the transaction, about how to make and receive an effective referral to Luton MASH. The approach of the Early Help Service to the management of contacts and referrals is well regarded across the partnership and lessons from that service about what works could provide the basis for this training.

13.2 Gaps in information-sharing

The Review Team were told that discharge form sent from hospital to a patient's GP are often filed without the GP reading them. This is due to the large volume of such "notification" letters. There may be a flaw in people's belief that they have shared information, which in fact may be left unnoticed by their fellow professional. In this case, the letter contained information about Child L's suicidal ideation from Year 7, critical information which was not noticed by a number of the professionals who had contact with her, and was not shared with others.

14. Conclusion

This review ends without a clear understanding of the cause of Child L's self-harming and ultimately her death. This lack of understanding held true for the many professionals who tried to respond to her, but whose interventions were either misdirected or inadequate. Ultimately, whilst Child L repeatedly and increasingly tried to tell about her distress, there was a collective failure to listen alertly and curiously to "the voice of the child" in this case. Given the increase in DSH amongst young people in Luton, it is vitally important that there is positive learning from this very sad case so that other young people will receive a different level of attention when they seek help.

We understand that one of the strategic priorities for the Luton Safeguarding Children Board in 2017/18 is adolescent mental health and Deliberate Self Harm, and we hope that this review will offer useful and timely lessons.

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Glossary

CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CP	Child Protection
CSC	Children's Social Care
DSH	Deliberate Self Harm – including cutting and overdoses of harmful materials
EDT	Emergency Duty Team for Children's Social Care
EH	Early Help Service, for children and families needing help below the level of a social work service
GP	General Practitioner – the child's medical doctor
HLTA	Higher Level Teaching Assistant
LSCB	Local Safeguarding Children Board
LT	Learning Together (SCIE systems model for case reviews)
MASH	Multi-agency Safeguarding Hub – the 'front door' of Children's Social Care social work service
RIAT	Rapid Intervention and Assessment Team – previously the 'front door' of Children's Social Care social work service (at the time of this review)
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SENCO	Special Educational Needs Co-ordinator
SW	Social Worker
YP	Young people

APPENDIX 1

Learning Together Methodology and Process

1. This review has used the SCIE Learning Together model – a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *WT* 2013 now requires all SCRs to adopt a systems methodology.

2.. The Learning Together model is distinctive in its approach to understanding professional practice in context; it does this by identifying how systems influence the nature and quality of work with families. Solutions then focus on redesigning systems to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4. The basic principles – the 'methodological heart' of the Learning Together model – are in line with the systems principles outlined in *Working Together (WT)* 2015:

   a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

   b. **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it

   c. **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.

   d. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.

   e. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5. **Typology of underlying patterns**: Findings are described using the categories developed by SCIE to provide a means of grouping together the kinds of systems issues which are found. There are six broad categories of underlying issues:

    1. Multi-agency working in response to incidents and crises
    2. Multi-agency working in longer term work
    3. Human reasoning: cognitive and emotional biases
    4. Family – Professional interaction
    5. Tools
    6. Management systems

    Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

6. **Anatomy of a finding**: For each finding, the report is structured to present a clear account of:

    - How did the issue feature in the particular case?
    - How do we know it is an underlying issue? (not peculiar to this case and not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
    - What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
    - What are the implications for the reliability of the multi-agency child protection system?

7. **Review Team and Case Group**

7. 1 **Review Team**

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by at least one and often two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Organisation	Role
SCIE	Independent Lead Reviewer (2)
LBC	LSCB Board Manager
LBC	Principal Social Worker
LBC	Principal Solicitor
LBC	Integrated Service Manager for Early Help
LBC	Safeguarding in Education Manager
ELFT	Named Professional for Safeguarding Children
ELFT	Consultant Psychiatrist, CAMHS
CCG	Head of Safeguarding Children and Designated Nurse Safeguarding Children
CCS	Named Nurse

7.2 **Case Group**

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 18 Case Group professionals, and two family members. Case Group members were invited to an Introduction Meeting (to explain the Learning Together model and the SCR process) and later to two feedback meetings.

Health:
GP representative
CAMHS psychotherapist
CAMHS Nurse
CAMHS psychiatrist
School Nurse Team Manager
CHILDREN'S SERVICES:
Early Help Manager

Early Help Family Support Worker
Early Help Senior Practitioner
RIAT Team Manager
RIAT Service Manager
Education:
Headteacher
Assistant Headteacher
Higher Level Teaching Assistant
SENCO

8. **Structure of the review process**:
   A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

   The Review Team form the 'engine' of the process, working in collaboration with Case Group members. The Review Team held an introductory meeting for the Case Group at the beginning of the process, to explain the Learning Together model and the process they would be part of. Case Group members were then involved via individual conversations, and in two multi-agency meetings/Workshops, where they were asked to give feedback on interim/draft reports. There was helpful and open discussion at these meetings, with Case Group members adding significantly to the understanding of the material which had emerged from the conversations and reading of key documents.

   The Review Team were involved in collecting and reading data, including a multi-agency chronology and key documents. Together with the Lead Reviewers, they met to analyse the material and contribute to the findings via a series of 7 meetings.

9. **Scope and terms of reference**

   Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference. In this review, we noted and explored the questions (Para 6.2 of the main report) which the Luton SCB had posed as of particular interest.

10. **Sources of data**

10.1 **Data from practitioners**

Workshop Days were held at which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of the material presented. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provided a 'window on the system'?

10.2 **Key Practice Episodes and Contributory Factors**

Following on from individual conversations, the first Workshop Day aimed to piece together the practitioners' 'view from the tunnel' and a selection of Key Practice Episodes (KPEs). These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the **why** questions – an exploration of the Contributory Factors which were affecting their practice and decision-making at the time.

10.3 **Participation**

The Learning Together model relies on professionals contributing very actively to the review and the resultant learning, as it is their unique experiences which help us understand what happened and why.

We know that participation in a case review can raise anxieties and distress about what has happened to children, especially so when a child has been known to a school for several years. The lead Reviewers and the Review Team are grateful for the willingness of the professionals to attend difficult meetings and to engage actively in the review.

10.4 **Data from documentation**

The Lead Reviewers and members of the Review Team were given access to the following documentation:

- Copies of Child L's emails and other written notes from her to school staff
- Referral form from school to RIAT
- Contact form completed by RIAT
- Letters from CAMHS psychotherapist to GP
- Serious Incident Review Report
- Child L's English Language exam paper
- Key Dates chronologies from agencies
- Notes from CAMHS meeting
- Records of internal school correspondence regarding Child L
- Brief history of involvement by CSC with the family
- Notification of a Serious Incident for consideration for a Serious Case Review or other type of review or audit
- Early Help Assessment Form

- Record of Educational Psychology Service (from 2010)
- Letter from Ambulance Service to Luton CSC, 10/5/16

10.5 **Data from, friends and community**

The Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

In this review, Child L's mother and father met with the two Lead Reviewers during the review and gave helpful information.