Suffolk Safeguarding Children Board

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LSCB 'Young Person C' SCR Response Document

1. Introduction

On 18th August 2014, Suffolk Local Safeguarding Children Board (LSCB) Serious Case Review Panel was alerted to the death of Young Person C, which had occurred in Suffolk on August 4th 2014.

Clarification was sought by the Independent Chair of Suffolk LSCB as to the legal status of Young Person C when she died and confirmation was received on 22nd September 2014 that she was accessing Section 17 Leave of Absence whilst being detained under Section 3 of the Mental Health Act (1983).

It was therefore agreed by the Independent Chair of Suffolk LSCB that the case met the criteria for a Serious Case Review, according to Chapter 4 of Working Together to Safeguard Children (2013) which states 'an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 1983.

Regulation 5(2)(b)(i) includes cases 'where a child died by suspected suicide'.

Working Together 2013 (under which this SCR was initiated) allows LSCBs to use any learning model consistent with the principles in the guidance, including systems based methodology.

A decision was made by the LSCB SCR Panel to appoint, Briony Ladbury RN, RM, HV cert, FP certificate, BA (Hons) Protecting Children, ENB Specialist Practitioner Award (Child Protection), MSc in Inter-professional Practice (Society, Violence and Practice) an Independent Overview Writer for this case and she was appointed in January 2015.

A systems based methodology was used. Single agency chronologies of agency involvement were merged into one integrated multi-agency chronology document of over 300 events. This was a main data source for this review.

An SCR Reference Group was appointed and oversaw the preparation of the chronologies, and some of their staff were interviewed by them as the chronologies were compiled. The SCR Reference Group members provided the leadership role for their specific agencies and undertook to seek out, prepare, provide and clarify data as the SCR progressed. The Reference Group met on two occasions. There were two reflective learning events attended by practitioners involved in the case. These events gave practitioners an opportunity to understand who did what and why and to identify ways where practice could be improved.

The Overview Writer and Independent Chair, accompanied by the LSCB Manager, met with the Mother of Young Person C on several occasions and her comments and reflections form part of the report and of the LSCB press release.

Suffolk LSCB met at an Extraordinary Board meeting held on the 16th June to consider the Serious Case Review report and full accepted the recommendations as laid out on pages 68/69 of the SCR report.

The Board then went on to consider the incidental learning identified in the Report, actions already taken to date, their impact and other actions required to address the learning.

2. Recommendations

The recommendations take into account lessons learnt from closely analysing the evidence submitted for this SCR. Some of the lessons that emerged were **'incidental learning'** and remote from the events that led to C's death. They are however relevant to safeguarding children practice more broadly. The incidental learning is grouped in the Report for the agencies to address as part of their overall internal safeguarding responsibilities. Suffolk Safeguarding Children Board will require assurance that the incidental lessons and learning have been dealt with as part of agency improvement plans.

Whilst the Independent Overview Writer identified no root causes in this review, some of the lessons were linked to the outcome for C in some way and these are described as **'contributory factors'**, due to their relevance to the final incident outcome.

Finally, there are recommendations that relate to the **'thematic learning'** arising from this review, and further recommendations for the LSCB to monitor the implementation of learning. Both are intended to assist sustained improvement for the children's sector as a whole.

2.1. Incidental Learning – Recommendations for All Agencies

Within three months all of the individual agencies involved in this SCR should audit the incidental learning attributed to their organisation (including those that apply to 'all agencies') in this report to ascertain

whether the issues are generalised across their service provision or attention is required in one part of the system only.

LSCB View

The Board endorses and agrees all incidental learning identified in the report. Any incidental learning identified for agencies not represented at the Extraordinary Board Meeting or by members of the Reference Group were made aware of the proposed incidental learning recommendations before the meeting and raised no objections. The Board supports the recommendation that all agencies should audit the identified incidental learning, they should take action where required and report to the Board accordingly with the action plan for their agency and the progress they are making.

Action Taken

The LSCB has captured all incidental learning points from the report, as agreed at the Extraordinary Board meeting and advised partners accordingly. The LSCB Independent Chair will request all agencies to provide an action plan by October 2015 that outlines the recommendations made from the agreed audit work with timescales and work undertaken thus far.

In most cases, Agencies have already implemented revisions or new initiatives as a result of the incidental learning from this review. Work includes:

- Investment in a new data base system by Norfolk and Suffolk Foundation Trust (NSFT) that will assist in ensuring that information from all previous encounters with service users/carers are readily accessible to clinicians and considered. NSFT will also review how third party information is recorded and reflected in risk assessment.

- Joint work is taking place between NSFT and Suffolk County Council to ensure that the Signs of Safety Assessment tool is understood by staff so that the focus of joint discussions in assessing risks ensures the voice of the child/young person remains central.

- A CQC Action plan with reference to safeguarding systems is in place at Colchester Hospital.

- Over the past few months the Named GP for Ipswich and East Suffolk CCG and West Suffolk CCG has visited a considerable number of localities and Practices encouraging them to have group discussions in their Team meetings about children and young people where there are concerns about vulnerable patients or issues of safeguarding .

- Information on the CCG websites also encourages this practice of peer review, and these sessions contribute to GPs' Level 3 safeguarding continuous practice development.

- The named GP in Suffolk will be attending Signs of Safety and Wellbeing Training with the use of the Signs of Safety model will be rolled out and encouraged.

2.2. Contributory Factors

2.2.1. North Essex Partnership Foundation Trust

Within six months NEPFT should enable staff working in Tier 4 Psychiatric Services to undertake cultural awareness training which includes issues relating to rural/farming communities.

Within three months NEPFT should review and update the 'In-Patient Observation and Engagement Policy (March 2014)' to add as standard an environmental risk assessment prior to home leave being taken.

LSCB View

The LSCB recognises the importance of specific awareness training required to ensure individual family environmental risks are included in home leave assessments. The LSCB acknowledges the work already been undertaken by the Trust but would want to see evidence of embedding and impact of the changes in policy and training.

Action Taken

The NEPFT have already amended their policy to reflect this finding and it now includes environmental risk as a component of an assessment for home leave.

The St Aubyn Centre has moved quickly and a system is now embedded that includes environmental risk when leave plans are being developed for their patients. These risks are now explicit and discussed with the supervising parent before they leave the unit.

In addition, NEPFT has already incorporated information about assessing risks and taking into account cultural and environmental considerations into the Safeguarding Children level 3 training, in addition to developing a specific training for clinicians working in Tier 4 for roll out in the late autumn.

LSCB Actions

The LSCB will request reports from NEPFT at 3 month and six monthly intervals respectively that outline **in detail** the training package developed and the numbers of staff trained and impact of any such training in issues relating to risk assessment relating to young people living in rural/farming communities.

The LSCB will request reports from NEPFT at 3 month and six monthly intervals respectively that outline **in detail** the revisions made to the In-Patient Observation and Engagement Policy and any impact as a result of audit.

2.2.2. Norfolk & Suffolk Foundation Trust

Ensure that robust plans are in place to improve communication and information sharing between teams and with other professionals in the children's sector, including GPs, particularly when children and young people disengage from the service and to raise the standard of record keeping and provide an audit trail.

Ensure a robust system is in place for receiving and forwarding telephone messages that can provide an audit trail of what is sent to whom and the response or outcome.

LSCB View

The LSCB endorses this recommendation. Information must flow within and between organisations to ensure that professional decision making about children's safety and wellbeing are made in light of all relevant and pertinent information.

Action Taken

The Norfolk and Suffolk Foundation Trust are working to a comprehensive action plan formulated from the CQC Inspection Report 2015.The plan includes specific recommendations including the requirement to develop mechanisms for practitioners to routinely share important health relapse and crisis plans with other relevant health professionals.

All of the areas of communication and information sharing are embedded within current policy C89 Safeguarding Children, Q12a - Non Access visits and missed appointments, C82 Clinical Risk and C98 CPA.

Staff are reminded of the importance of informing all parties of disengagement particularly where safeguarding concerns are highlighted and in any event staff are tasked to undertake a risk

assessment in connection with the missed appointment and utilise this to inform their decision making.

The importance of record keeping and sharing information is consistently raised within; mandatory training including safeguarding, risk assessment and suicide management modules, also via operational safeguarding meetings, champion events, case discussions and MDT meetings and in consultation with the NSFT safeguarding duty team. The duty team receive on average 200 calls per month many of which include issues around records, communication and risk.

The system within NSFT for receiving and forwarding telephone messages is under review at present with some teams operating a duty system which enables calls to be taken, logged and passed on with a clear audit trail. Further work is being undertaken in order this can become a trust wide approach.

LSCB Actions

The LSCB will hold the NSFT to account by reviewing their action and implementation plans for improving information sharing, communication and telephone messaging at 3 months and then at least every six months until the Board is assured that actions are complete.

The LSCB has already initiated a request for regular reporting from NSFT in relation to the Improvement Plan developed as a result of the CQC Inspection held in October 2014 and will receive the next report at the LSCB meeting in July.

The LSCB advised all partner agencies in April 2014 of a letter dated 3 March 2015 to Chief Executives of local authorities, Directors of Children's Services, Police and Crime Commissioners, Local Safeguarding Children's Boards, Health and Wellbeing Boards and GPs from Home Office, Dept of Health, Dept for Communities and Local Government, Ministry of Justice and the Dept of Education advising of a joint commitment to share information effectively for the protection of children and subsequent new Government Guidance on Information Sharing.

The updated Government Guidance was sent via a briefing note to all LSCB partners is on the LSCB website and discussed in training fora.

2.3. Thematic Factors

2.3.1. NHS Commissioners NHS England/Suffolk CCGs

Within three months, the NHS commissioning partners (NHS England and Suffolk CCGs) should provide assurance to Suffolk LSCB that the arrangements for all sub-contracted services delivering care to children and young people in Suffolk are mapped, clear and considered in Section 11 and practice audit arrangements.

LSCB View

The LSCB endorses this recommendation and extends this recommendation to all agencies.

Actions Taken

NHS England and Suffolk CCGs have accepted this recommendation and will provide a report within the three month timescale to the LSCB learning and Improvement Group

LSCB Actions

As part of the existing Section 11 Audit Programme the LSCB, through the Learning and Improvement sub-group, will request a report from NHS England and Suffolk CCGs, within the agreed timescale, that provides a clear overview of how arrangements for all sub contracted services will be mapped, clear and considered in Section 11 Children Act reporting and practice audit arrangements.

In addition, the audits for all agencies, which have a 100% return rate, will place an increased emphasis on the arrangements for ensuring the compliance of contracted providers to safeguarding requirements

2.3.2. Suffolk LSCB

Within three months, Suffolk LSCB should review its current Learning and Improvement Framework to ensure it sets out the expectations for SCR participation and enables all partners to meet their own accountability and assurance requirements.

By October2015 the Suffolk LSCB should hold the agencies involved in this SCR to account by reviewing the single agency action and implementation plans developed in relation to the incidental learning identified in this SCR.

At least every six months, until they are assured that actions are complete, Suffolk LSCB should seek periodic assurance from the agencies involved in this SCR that lessons learned specific to their agency have been disseminated to the workforce.

Within three months, the LSCB should reassure themselves as to the impact of the CYPS action plan already in place to improve the system of informing a referrer of a referral outcome.

Suffolk LSCB should agree an 'embedding the learning' plan to ensure the thematic lessons from this SCR reach a wide range of practitioners in the children's sector.

LSCB View

Suffolk LSCB endorses all recommended actions.

LSCB Actions

The LSCB Case Review Panel has agreed to evaluate the SCR methodology and practitioner experience for this SCR and to utilise the findings, along with the evaluation of the LSCBs previous SCR, to issue guidance to partners on the expectations for SCR participation. Work on the revision and development of new guidance has been started, based on the previous evaluation, and will continue following publication of this report.

A comprehensive action plan to monitor all SCR recommendations (including those for the LSCB) and incidental learning from all partner agencies will be developed and included as an agenda item at the August Executive Group and October Board meetings in order to provide assurance and measure impact.

Within the next three months, the LSCB Learning and Improvement Group will develop the appropriate additions to the LSCB Section 11 Children Act template in order to ensure that they are able to receive feedback from partner agencies on safeguarding arrangements for sub contracted services.

Within the next six weeks, The LSCB, utilising the LSCB Training Strategy and Training Sufficiency Group will develop a plan to ensure the provision of appropriate training materials and briefings to ensure thematic learning takes place across the partnership. This plan for embedding the learning will be incorporated and monitored as part of the wider amalgamated Incidental Learning Plan.