Briefing: Serious Case Review Young Person 'C' July 2015

A Serious Case Review (SCR) was published on 2nd July 2015 in response to the tragic death of 'Young Person C'. The full report can be found here.

Young Person C was an inpatient at a specialist NHS Child and Adolescent Mental Health Unit run by NHS North Essex Partnership Foundation Trust. At the time of the incident which led to her death, she was receiving care under Section 3 of the Mental Health Act (1983). The incident took place while Young Person C was on home leave with her father at his farm in Suffolk. It was reported that Young Person C accessed a veterinary medication, which she self-administered, fatally.

The SCR heard consistent descriptions that Young Person C was a likeable, bright, intelligent, and popular young person, who was a perfectionist and somewhat impatient by nature. She enjoyed sport and the outdoors and was a successful long distance runner. HM Coroner's Inquest, which took place on 2nd April 2015, gave a narrative conclusion acknowledging the events that happened on the day of Young Person C's death and her significant history of mental illness.

It was indicated that there was insufficient evidence to be sure that Young Person C had intended to take her own life at the time of the incident and that her action may have been a cry for help.

Serious Case Review

Young Person C's death met the criteria for a Serious Case Review according to Chapter 4 of Working Together to Safeguard Children (2013, 2015) which states that '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**'.

All SCRs are commissioned under statutory guidance issued by HM Government in order to provide a sound analysis of what happened in a particular case and why, and what needs to happen in order to reduce the risk of recurrence.

Working Together (DfE 2015) stipulates that a SCR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way that data is collected and analysed;
- Makes use of relevant research and case evidence to inform practice.

In launching the SCR in relation to Young Person C, Suffolk LSCB's Case Review sub-group identified an SCR Reference Group to support the SCR process. It was agreed that the purpose of this SCR would be to:

- **Review the circumstances leading to the incident** that caused the death of this young person and establish what lessons are to be learned from the case about the way in which local **professionals and organisations work individually and together** to safeguard and promote the welfare of children.
- Assess the adequacy of risk assessment and consideration of safeguarding issues, and SCR the relevant documents that make up the Trust's internal investigation to assess the adequacy of its findings and recommendations.
- **Identify clearly what those lessons are** both **within and between agencies**, how and within what timescales they will be acted on and what is expected to change as a result.
- Involve the family of Young Person C as considered appropriate and in accordance with their wishes and feelings.

An FAQ sheet giving an overview of the structure and process of the SCR can be found here.

An Independent Overview Writer, Bryony Ladbury, was appointed to undertake the SCR Report. Briony has a background in safeguarding children work in the NHS both in strategic and practice contexts, producing and quality assuring NHS contributions to Serious Case Reviews and leading on developing NHS participation in Serious Case Reviews for NHS England.

Data and Evidence Base

For the purpose of this SCR a narrative chronology, prepared by an Independent Overview Writer, was drawn from information in individual chronologies submitted by every agency that had involvement with Young Person C within the SCR timescale set by the Reference Group, with additional context and detail from a range of single agency reports and care summaries.

The complete chronology describes Young Person C's journey through the system during the timescale of the SCR. The narrative summaries include the most relevant interactions and interventions that occurred.

Internal Serious Incident (SI) investigations were immediately launched by the key agencies that were providing mental health care to Young Person C at the time of her death. These were made available to the SCR Overview Writer and fed in to the narrative and analysis.

Reflective Sessions for Practitioners

Reflective sessions were held for practitioners who had direct involvement with the case, away from the work place, where they could learn more about the SCR process and purpose and clarify any gaps or misinterpretations of the chronology data. It also gave an opportunity for agencies to reflect and discuss the early findings and the lessons that were emerging.

Recommendation Themes

The Independent Overview Writer found that the evidence reviewed did not offer an overall 'root cause' for the tragic circumstances around C's death. However, some contributory factors were identified, alongside incidental learning which inform the recommendations coming out of this SCR. These recommendations include:

- Increase awareness of cultural and environmental factors within risk assessment.

- 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.

- Raise the standard of record keeping and provide an audit trail (including telephone call logs and messages).

- Ensure that 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.

Further recommendations are made that 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.

Suffolk LSCB have published their response to the Independent SCR Report, which can be found here.

Actions in relation to the learning identified will be monitored by Suffolk LSCB and the thematic lessons from this SCR will be disseminated to a wide range of practitioners across the children's sector.

National Case Review Repository

In collaboration with the Association of Independent LSCB Chairs, the NSPCC stores all published UK Case Reviews from 2013 onwards in a library catalogue here.

NSPCC Case Review Thematic Briefings

The NSPCC also publish a range of thematic briefings, focusing on different topics and pulling together key risk factors and practice recommendations from published case reviews to help practitioners understand and act upon the learning. Themes include:

- Types of Abuse (Neglect, Domestic Abuse, Online Abuse etc.)
- Children and Families at Risk
- Challenges to Professional Practice
- Learning for Specific Sectors (Health, Education, Housing etc.)

NSPCC Case Review Thematic Briefings can be found here.