Child T
Child Safeguarding Practice Review

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2 INTRODUCTION BY INDEPENDENT AUTHOR

I was commissioned to undertake this review in January 2020 by the Local Safeguarding Children Partnership (LSCP).

I was fortunate to be able to speak to the parents prior to the Covid-19 lockdown. I am so grateful for their involvement in seeking the learning from their child's tragic death. I was able to personally share with them the draft of the report during lockdown. I was struck by how they were able to accept the learning from the review, despite continuing to be in a high state of grief, exacerbated by the impact of lockdown on the family to access support and the normalities of life. I urge the Local Safeguarding Children Partnership to ensure that there continues to be contact with the parents to offer support and share the progress of the learning.

I would also like to thank the services and individuals who contributed to the review, testing my thinking about what happened, and their commitment to take learning forward in real time.

Due to Covid-19, the lockdown and extra pressure on services, this was a different situation in which to conduct a review. Nevertheless, the Sutton agencies showed great dedication to carry on with the review and enabled meetings and learning sessions to be undertaken virtually.

I hope that I have enabled Child T's voice to come through in this review and, that from this tragedy, other young people and their families are able to receive the support that enables them to move forward through life.

3 EXECUTIVE SUMMARY

Child T was found hanging, at home, in November 2019. In the previous eight months the only services involved with the young person were a special college and adult sleep clinic. During these final months, insomnia was impacting on this young person's ability to manage education, with attendance at 50%. However, otherwise Child T's parents reported that the young person enjoyed being at the college, which was the right place at the end of a series of inappropriate educational settings.

The sleep clinic had invited Child T for appointments, but these were refused due to the pre appointment sleep monitoring required the use of electronic devices

or a sleep diary. Child T had a fear of electronic devices and did not want to show others any writing due to dyslexia.

The period focussed on, in depth, for this review spans November 2017 to November 2019 as it was during this time that more services became involved with the family.

Child T was the eldest of the children in the family. This was a high functioning family, but Child T felt different to the others and less intelligent. Child T's parents compensated for this by encouraging the innovation of their child which led to Child T setting up a little business at 13 years old.

Child T was observed, at an early age, to be different from other children, not socialising and having obsessional interests. During primary school there were some behavioural problems, but these were managed. To achieve a smooth transition to secondary school, there was an application for a statutory assessment of educational needs, but this was refused, although there was additional support provided for the child following a diagnosis of Autistic Spectrum Disorder.

At secondary school, Child T's behaviour deteriorated and culminated in nine exclusions and, finally, permanent exclusion in 2016. Given that this was a young person seen to have low level special educational needs, the use of an exclusion pathway was not an effective way of addressing the problems because this is known not to improve outcomes for those with special needs and, in this case, had an negative impact.

Child T was placed at a Pupil Referral Unit (PRU), where high level support was provided for the next two years. The young person was allocated an Outreach Worker who developed a good relationship with the whole family. Nevertheless, the behavioural problems continued and there were also concerns about Child T's low mood.

In December 2017, Child T was involved in an altercation with another young person, at school, which was seen to be racially motivated but, according to the parents was not. This led to a Prevent referral due to concerns that Child T was at risk of radicalisation. This incident caused conflict for Child T both at school and at home, escalating the young person's oppositional behaviour and heightened the intensity of their response to authority.

There followed four suicide attempts and then a further incident culminating in a hospital admission. Whilst being assessed by the Child and Adolescent Mental Health Service (CAMHS), Child T denied suicidal intention and was diagnosed with a Conduct Disorder and discharged home.

Within two weeks there was a further admission when Child T had an emotional crisis following an altercation with the father. In hospital, Child T continued to be aggressive and uncontrollable.

CAMHS, the PRU and the siblings' school raised safeguarding concerns, and these were escalated within Children's Social Care resulting in a Child in Need Plan.

Multi-agency interventions were undertaken. There was a plan for family therapy, but this never came to fruition. Meanwhile, the PRU pushed for an Education, Health and Care Plan to support Child T, but it took nearly a year to find an appropriate placement. Despite the interventions, there seemed to be insufficient understanding of the underlying cause of Child T's problems and the impact these had on the family relationships and capacity to cope.

When Child T commenced the special needs college, in September 2018, the young person reported feeling calmer and, by March 2019 had withdrawn from services, but still only managed 50% attendance at the special needs' college due to insomnia.

This review has identified areas of good practice in how agencies recognised safeguarding issues and, within their own services, tried to engage Child T. However, there are also areas for learning, in relation to how agencies worked together to achieve outcomes; to have a shared understanding of a young person's issues; the robustness of the child in need plan to achieve positive change; and the need to have a family focus when there is a child with complex emotional and behavioural needs.

4 REASON FOR COMMISSIONING THE LOCAL SAFEGUARDING CHILDREN PRACTICE REVIEW

The Local Authority submitted a notification of serious child safeguarding notification to the national Child Safeguarding Practice Review Panel within the statutory timescale after Child T's death was reported.

On 16 December 2019, a statutory Local Safeguarding Children Partnership (LSCP) Rapid Review meeting was held to consider whether the criteria for undertaking a Local Child Safeguarding Practice Review (LCSPR) had been met based on the

initial chronologies. The grounds for the decision to recommend a LCSPR at this point was that Child T had a complex presentation and a history of previous suicide attempts and thoughts to end their life. There had been involvement from a range of services and individual professionals which raised issues about the effectiveness of individual agencies and partnership working.

On 23 January 2020, the National Panel confirmed the decision that the case met the threshold for undertaking a LCSPR and the LSCP was advised that the learning from the local review could form part of a national review at a later stage.

The safeguarding partnership concluded that there was learning to gain in respect of the following five areas that align to the criteria for undertaking a LCSPR by examining:

- Multi-agency safeguarding responses to adolescents where there is complex presentation in relation to Autistic Spectrum Disorder (ASD), mental health, substance misuse, youth offending and whether there was sufficient joining up and provision of services.
- Recurrent themes in relation to learning from single agency individual management reviews, multi-agency case audits, serious case reviews and other learning reviews relating to adolescent mental health, special educational needs, drug use and offending which has led to a serious child safeguarding incident or death;
- Single agency safeguarding and service provision for children over the age of 16 years who need to access specialist services provided by AMHS as not available within paediatric services.
- Transition planning from Children and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS).
- Specific areas of practice where there may be a gap in knowledge, understanding, experience and management oversight to respond effectively to mental health aspects of ASD and related child safeguarding concerns.

The scope of this Local Child Safeguarding Review is based on the requirements and quality standards set out in the Safeguarding Practice Review Panel: Practice Guidance (2019) and Working Together 2018 and includes:

- To review the circumstances and analyse critical incidents in the care of Child T during the period of 21 November 2017 to 2019 and provide any other significant relevant information prior to this time.

- To review the professional involvement during Child T and the family's involvement with services, specifically mental health, special educational needs, drug use and offending behaviour.
- To frame questions to explore and seek clarification on whether anything could have been done differently to prevent the death from occurring.

- To engage directly with the mother and father to explore their experience of parenting Child T and their perception of the effectiveness and impact of services and professionals.
- To engage directly with frontline practitioners and their managers to examine standards of practice and compliance with procedures and protocols with a view of identifying if there is future learning to improve practice and services.

5 BACKGROUND, HISTORY, KEY CIRCUMSTANCES AND CONTEXT OF THE CASE

5.1 BACKGROUND

Child T was nearly 18 years old when taking their own life in November 2019. During the previous 8 months no service, apart from the 6th form college, had been involved with Child T. However, in the previous years there had been substantial contact with several services, but this had ceased, apart from education, in the months preceding the death.

Child T was a caring young person who would help siblings with homework and would worry about their parents. Child T developed some good relationships with adults and teachers at the college attended during the final months of life.

Both mother and father spoke about Child T as proud parents who recognised their child's achievements and skills. They, along with the schools the young person attended, retain pieces of Child T's work as a noteworthy legacy to this young person's life.

Child T was very intelligent, inventive, and keen on engineering, enjoying practical problem solving and excelled at working with an engine. Child T was also an adrenaline junkie and loved rollercoasters. Child T loved engineering and was able to use tools successfully, having been taught by the grandfather.

5.2 HISTORY

Child T was the eldest child. From an early age Child T was inquisitive and loved building things.

The parents had no other child to measure Child T against until starting nursery. At 4 years old they could see their child seemed to be 'different' to other children, with a tendency to sit alone when in the company of others.

In those early years Child T had difficulties in reading and would use avoiding techniques. At infant school, the parents discussed these issues with the school, and it was recognised that Child T had some behavioural issues which were managed within the school setting.

In 2012, the Special Educational Need Coordinator (SENCO) asked the GP to refer to CAMHS as Child T was having difficulty with friendships, had unusual obsessional interests. The GP referred to CAMHS and was diagnosed with Autistic Spectrum Disorder.

At the end of 2012, the school 1 applied for a statutory assessment of educational needs for Child T, which seemed to be to enable support during the transition period to secondary education. This was refused due, at the time, Child T's needs not meeting the criteria, but arrangements were made for school action plus support to be in place within secondary school.

During the first year of secondary education (2013) the school support continued but there were behavioural issues, and these continued until the young person was permanently excluded in 2016. Between September 2013 and February 2016 there were nine exclusions due to oppositional behaviour, mental health needs and conduct issues. Missing school caused Child T to feel frustrated due to a decline in grades and the parents appealed to school 2 to manage the young person's behaviour differently.

In 2014 there were reports of Child T attempting hanging following a school exclusion and demonstrating violent behaviour towards others. School 2 made a safeguarding referral, but the case was not considered to meet the threshold for section 47 as the children were not deemed to be at risk of significant harm and the parents were proactive in seeking help.

Child T was permanently excluded in January 2016 and was transferred to a PRU. An Outreach Worker was allocated to the family and established a long-term, supportive, relationship. However, in this setting, Child T's behaviour continued to deteriorate considerably, including inappropriate use of knives and scissors and a fixation on firearms. It was deemed that this placement could not meet the needs of Child T. By 2016, Child T was known to the Youth Offending Team (YOT) and had received a Youth Conditional Caution for possession of a bladed article on school premises. This was dealt with by YOT. In addition, there was a referral to the Substance Misuse Team due to Child T's interest in cannabis, but the young person would only engage in an initial assessment.

In January 2017, Child T came to the attention of the police due to an argument with teaching staff. Following discussion with the parents, the police took no further action due to the school offering enhanced special educational needs support.

In March 2017, an Education, Health and Care Plan (EHCP)[1] was issued for Child T and considerable work was undertaken to identify an appropriate provision to meet the young person's needs. Various provision was considered or tried but none were able to fully meet the needs for Child T.

5.3 CONTEXT

5.3.1 Prevent Referral

The situation escalated to crisis in December 2017 following an incident in which Child T had a confrontation with another child which resulted in a Prevent referral being made by the school due to Child T's inappropriate comments regarding Islam. However, the parents' impression of the incident was that their child was fearful, and, despite their efforts, the young person felt the need to carry a small weapon to school. The parents reported that Child T had several difficult placements where the young person felt unsafe and was struggling to find the right path through the education system.

This incident appears to have been the catalyst for taking Child T's problems to a dangerous level, including a severe impact on the whole family and difficult relationship between child and father.

Two key referrals were made; one was made to the Multi-Agency Safeguarding Hub (MASH) by the siblings' school which was allocated to Families Matters, the early help service, due to concerns about the impact of Child T's behaviour on the siblings; the other, was to the YOT for prevention support due to concerns about the risk of Child T to radicalisation.

5.3.2 Incident leading to first Hospital admission

On 04 January 2018 Child T crashed a car, leading to being arrested for failing to stop for the police, driving away, no driving licence and no insurance. There was evidence, in the boot of the car, of piping to aid a suicide attempt which led to Child T being taken to the Emergency Department (ED) on 05 January 2018.

[1] Statutory assessment under Children and Families Act 2014

Child T admitted that this was a suicidal attempt, which the father reported, was not the first attempt in 3 weeks. Child T described using illegal drugs, including opiates and MDMA.[2]

Child T was informally admitted to hospital and assessed by CAMHS. Initially, the plan was for Child T to be admitted to a mental health unit once a bed was available.

During the admission there was liaison between CAMHS and the Families Matter Social Worker and discussion regarding the Prevent referral. It was agreed that a referral would be made to the Adolescent Outreach team (AOT), a CAMHS community team which offers a Tier 4 mental health service. The team assessed Child T in hospital and decided that, as Child T was keen to go home, a multi-agency discharge plan should be developed to enable Child T to receive help at home instead of admission to an adolescent mental health ward as this would be less restrictive on the young person. A contingency referral was made to a Psychiatric Intensive Care Unit, but as this unit only accepts young people who are sectioned under the Mental Health Act, this was felt likely to be rejected as Child T had been, up until now, managed within a general paediatric setting.

On 10 January 2018, a Mental Health Act Assessment was undertaken. Child T denied suicide ideation and stated that the crash was an accident. This assessment concluded that Child T had a Conduct Disorder but no evidence of depression or psychosis.

Child T's father was reportedly keen to have his child home and the discharge went ahead.

5.3.3 Community Follow up

On 12 January 2018 there was liaison between the CAMHS professionals and Families Matter to discuss a referral for Multisystemic Therapy (MST)[3]. Dr 1 completed the MST referral.

On 15 January 2018 Dr 1 and the Psychologist from the AOT met with Child T's father alone as Child T chose not to attend. At this meeting, the father disclosed the level of violence that the family were subjected to by Child T and expressed a keenness to work with the MST.

Between 17 and 22 January 2018, Child T's behaviour again raised concerns as the school reported that the young person had offered another pupil MDMA. Child

[2] 3,4 Methylenedioxymethamphetamine is a powder form of ecstasy. It is a stimulant and can produce hallucinogenic effects.

[3] Multi-Systemic therapy is a community and family intervention that works with young people who are at risk of going into care or custody due to aggressive or other antisocial behaviour (CAMHS IMR)

T's mother alerted the AOT that Child T had a low mood, loneliness and was using alcohol and self-harming. The AOT concluded that the risk to Child T remained high.

On 25 January 2018 Child T and parents attended an appointment with Dr 1 and AOT. At this appointment Child T became angry with everyone, demanding sleep medication due to not having slept, culminating in the young person becoming violent. Child T was the one to call the police and was arrested for criminal damage at the CAMHS centre. Dr 1 reported safeguarding concerns to the MASH team as Child T's father had said he was frightened of Child T who had also broken a sibling's tooth.

On 26 January Child T's father reported to CAMHS that the young person had been acting strangely since returning from the police station. The following day Child T caused damage in the home which was reported to the Social Worker who was advised by CAMHS that Child T needed to be assessed at ED.

5.3.4 Second Hospital Admission

On 27 January 2018 Child T was assessed in ED by the psychiatric duty doctor who recorded that there had been a physical argument between the young person and father over the latter's refusal to give the former co-codamol. Child T was observed to have self-harm lacerations and the father reported that Child T had been expressing suicidal thoughts. Child T was observed to rebuff these reports due to wanting to go home but the father said he could not manage his child at home. During this assessment Child T reported misusing co-codamol, Xanax[4], promethazine[5], and cannabis. Child T was admitted to the general paediatric ward on 28 January 2018, in an angry state and was found with a lighter burning a dressing gown. It was deemed unsafe for Child T to remain on the ward and, on 29 January 2018, Dr 1 advised that social care would need to accommodate the young person as there was no mental illness. This was opposed by Child T's father who reported feeling 'blackmailed' by the services.

During this admission Child T was policed by a hospital security guard due to aggressive and disruptive behaviour.

5.3.5 Multi-agency Meetings during Second Hospital Admission

Between 29 January and 30 January 2018, multi-agency meetings were held both in the hospital and at the school which concluded the need for further safeguarding referrals. A Mental Health Act Assessment was undertaken, led by Dr 2 who noted that Child T described drug use and a sense of hopelessness.

[4] Xanax (Alprazolam) is a benzodiazepine medication used to treat anxiety and panic disorders.
[5] Phenergan (Promethazine) can be used for short term insomnia and is available over the counter

However, Dr 2 noted that some of the "stories seemed rehearsed or borrowed from films".

On 30 January 2018 Child T was discharged with a treatment plan of risperidone[6] and referral for Cognitive Behavioural Therapy (CBT) or family work, parenting classes, and youth mentor. It was also agreed that Dr 2 would take over consultant responsibility, to give the opportunity for Child T to develop a fresh relationship with CAMHS, and that there was no further role for AOT.

5.3.6 Community Follow Up

On 31 January 2018 Dr 2 saw child T and mother. The dose of risperidone was increased, and Dr 2 noted that Child T displayed little insight or empathy which, although aligned with the ASD diagnosis, was an important aspect to manage.

On 1 February 2018 Child T and mother were seen by Dr 2 and the Families Matter[7] team worker. Child T agreed to a sleep clinic referral and to see an ASD worker.

On 5 February 2018 Child T's behaviour deteriorated again, refusing risperidone, self -harming with evidence of suicide intention. The parents sought the help of the GP who contacted CAMHS who discussed safety planning with the parents.

The parents chose not to take Child T to ED on this occasion due to the attitude of the nurses following the previous admission.

5.3.7 Child in Need Plan

On 05 February 2018, the case was opened by the Referral and Assessment Team. There followed a strategy meeting on 20 February where the decision was for the case to be managed under a Child in Need Plan.

On 28 February 2018, a CiN meeting was held and a plan developed which directed all action regarding Child T's emotional wellbeing to CAMHS, including a need for a referral for family therapy. In following six months there was input from Children's Social Care, Targeted Youth Service, Youth Offending and CAMHS.

Meanwhile, the CAMHS intervention progressed. On 07 March 2018 Child T and mother were seen by Dr 2 who prescribed Sertraline[8] and Phenergan for sleep problems. There was a further incident on 17 March 2018 when Child T was

[6] Risperidone is an anti-psychotic medication that can be used for children

[7] The Families Matter service was an early help service which was disbanded in April 2018 when Sutton changed to a locality service model.

[8] Sertraline is an anti-depressant, prescription only drug.

assessed in ED due to reporting ingestion of MDMA, Xanax and vodka but refused any blood tests and was discharged home.

On 20 April 2018 Dr 2 saw Child T who reported having stopped sertraline and having a place at college but still having a problem with insomnia. Dr 2 made a referral to the paediatric sleep clinic.

On 06 June 2018, a Child in Need meeting was held. Child T was reported to be better, not using drugs although sleep and self-harm remained an issue. The professional network agreed that there needed to be support during the transition to the college in September. Family therapy had not been commenced but there is some evidence that the family were asking for this, although also seemed less available for visits. It was agreed that the case would close once Child T had commenced college.

Between June and August 2018, the Targeted Youth Service undertook individual work with Child T following a referral for being on the edge of care. The work ceased in August as the outcomes had been met.

5.3.8 Transition to College

On 03 September 2018, Dr 2 saw Child T with father and was informed that Child T was starting college but still has sleep problems and asked for zopiclone. Dr 2 explained the dependency risk and referred to the adult sleep clinic.

On 06 September 2018, Child T started at College. Although there were some incidents of difficult behaviour and poor attendance, this was seen as a positive placement, enjoyed by Child T.

On 17 October 2018, Dr 2 and a worker from the Family Support Team met Child T who reported settling at college. Dr 2 prescribed zopiclone and melatonin for sleep, after a discussion around the risks. It was at this time that Children's Social Care closed the case, in agreement with the professional network and the family.

5.3.9 Substance Misuse Intervention

On 30 October 2018 the Switch worker had the first appointment, following a referral from YOT as part of a court Order, with Child T who was unhappy about the referral as substances had not been used for 6 months but was interested in learning more about drugs.

13 November 2018 a second, and final, key working session with Switch worker was held with Child T who disclosed having tried Valium and GHB[9] for 3 days due to self-medicating for sleep problems.

[9] GHB is Gamma Hydroxybutyrate, a class C banned drug. It can cause a sedative and anaesthetic effect.

On 07 January 2019, Dr 2 saw Child T for the last time. Child T reported doing ok and was finding the zopiclone and melatonin [10] helpful. However, Child T expressed a wish not to see CAMHS again. It was agreed that the case would remain open until Child T's birthday. Meanwhile the GP was asked to maintain repeat prescribing.

5.3.10 January 2019-November 2019

Between January and March 2019, the YOT closed the case as the Referral Order had been completed and CAMHS closed the case as agreed with the family in October 2018. Meanwhile the GP saw Child T, referring to the sleep clinic, which Child T chose not to engage with and reviewing the medication which Child T decided was no longer needed.

On 03 July 2019, The EHCP Annual Review was undertaken and no amendments made. Child T did not attend as having trouble sleeping which was affecting attendance at the college. However, noted that Child T was enjoying a vocational course.

On 21 November 2019 Child T was found by mother hanging in the attic of their home.

6 QUESTIONS RAISED REGARDING HOW AGENCIES WORKED TOGETHER

Several questions were identified from the review of the chronology, IMRs and discussions with staff.

6.1 DISCHARGE FROM THE WARD

- Considering how difficult it was to manage child T on the ward, was it the safest option to discharge him home where the siblings lived and knowing the child had a 'volatile' relationship with the father?

When Child T was in hospital for the second occasion, the discharge plan, seemed to focus solely on the needs of Child T, despite the precursor for admission being a breakdown within the household in due to Child T's response to the Prevent referral[11]. Indeed, the ward staff expressed surprise and concern that the young person was discharged home after just 2 days of a harrowing time on the ward, including Child T becoming angry with the mother in front of staff. Nevertheless, there were limited options available, a psychiatric ward or care placement, which

[10] Zopiclone is a prescription only drug used for insomnia causing a significant impact on the individual's life; melatonin is used for sleep problems in children but needs close prescription management.

[11] HM Govt (2015) Prevent Duty Guidance (Counter-Terrorism and Security Act 2015, S26)

were not deemed to be appropriate or necessary as the parents were willing to work with agencies.

The IMR group considered that a multi-disciplinary assessment before discharge would have led to a better insight into the whole family's needs.

6.2 STRATEGY DISCUSSION

- What consideration was given to the needs of the rest of the family?

On 6th February 2018, the Strategy meeting culminated in the decision that the case did not meet the s47 threshold but led to a child in need plan.

The strategy discussion divided opinion as to whether the children in the family should be considered in need of support or protection. The decision was for a Child in Need plan but, given the safeguarding concerns raised by both education and health, this decision was examined with the IMR panel. This concluded that there were appropriate agencies involved to contribute to the decision but, also, a view that it was a way for Children's Social Care (CSC) to be taking the lead in the case.

6.3 HOW INTERCONNECTED WERE THE INTERVENTIONS?

- Between February 2018-October 2018, there were interventions by CAMHS and Children's Services, as well as schools and education support services.

Child T seemed to be considered by individual issue or incident and interventions commenced for these. The review of IMRs, and subsequent discussions with IMR authors, highlighted the pattern of issues or incidents being responded to without inter-professional discussion to coordinate interventions. This could have been avoided if there was a process in place to appoint a lead professional to manage cases where there are several agencies involved with a family.

6.4 PARENTAL CAPACITY

- Did the parents have the emotional capacity to deal with Child T's needs and how did this impact on the effectiveness of their relationship with services?
- How did Child T view the services?

The chronology gave an overwhelming impression of how the parents would try to engage with services but would then withdraw due to Child T's insistence. On the one hand there was a lack of deep understanding of what Child T wanted from services, whilst on the other this was a persuasive young person.

6.5 How did services assess the young person's needs?

- Did services ensure that assessments were holistic or focused on the reason for referral to that service?

  Following the crises of January 2018, a range of services were employed in supporting Child T. However, some seem focused on symptoms such as substance misuse or offending behaviour. It was not clear within the chronology or IMRs what outcomes, beyond resolving the individual issues, could be achieved for Child T to improve the emotional and behavioural wellbeing.

6.6 Who was part of the professional network decision making?

- Who were the key players and who needed to be part of the understanding about the diagnosis and decision making regarding the treatment plan?

  There was a sense of considerable frustration from the ward staff during Child T's admissions in January 2018. This was especially in view during the second admission, which was not for a specific suicide attempt but following an incident of violent behaviour by Child T.

  The hospital IMR noted that ward staff raised their concerns on several occasions with CAMHS and CSC. They then escalated their concerns to the Named Nurse for Safeguarding Children, who attempted to communicate with the lead agencies and arrange a multi-disciplinary meeting. Meanwhile, there was evidently communication between CAMHS, CSC and education and meetings arranged.

  The ward staff had substantial observations of the way Child T reacted to the parents and how the young person behaved on the ward. The second admission seems to have been a traumatic experience for the young person, parents, and staff. The impact of these two days does not appear to have been fully acknowledged by the main professional network in considering the interventions required for the family.

6.7 What services were involved with the family between March and November 2019?

There seemed to be a dearth of information regarding Child T after seeing the GP in February 2019, apart from the college. However, the agencies confirmed that they were not involved during this time. This seemed to highlight the isolation of the family from services.

7 Analysis of Practice

The terms of reference identified 4 key themes for exploration: Individual needs of the young person; family history and dynamics; Quality of practice; Pathways

for support from services. Further themes were identified during the review which were concluded to fit within the 4 core themes.

7.1 THEME 1: THE INDIVIDUAL NEEDS OF THE YOUNG PERSON

Child T was an intense young person, with whom individual services tried hard to work with. However, as pointed out by the parents, Child T 'did not fit' the profile for management by many of the services. There was a consensus of the professional group that there would be a number of other young people who would have a similar profile to that of Child T.

The suggestion here is that it was Child T who, somehow was the problem. On the contrary, what this illustrates is that if a child, or young person, does not appear to fit into how a service is structured, there is a problem with the service.

7.1.1 The issues faced by Child T

Child T has been described as having a range of issues:

- Autistic Spectrum Disorder
- Dyslexia
- Insomnia
- Behaviour
- Conduct Disorder
- Mental illness
- Substance misuse
- Risk of radicalisation
- Youth offending
- Being different to siblings

Child T was diagnosed with ASD but, according to the mother, did not receive any specific support from CAMHS following the diagnosis. The young person's mother puts this down to the complications of services not crossing borough boundaries e.g. schools in one borough but GP in another. Child T's parents did not view the ASD as being the main issue but, rather, dyslexia and insomnia.

Child T's parents highlighted that dyslexia had a significant impact on Child T's self-esteem, and this would lead Child T to steer away from anything requiring reading or writing. However, there was little evidence within the IMRs of how services dealt with this, either due to the perceived focus of the review being more about behaviour and mental health, or the professional network not assessing this as being a major issue for Child T.

During Child T's last 2 years of life, insomnia became a dominant issue. This was commented on extensively by Child T's parents and final school placement, as well as CAMHS and GP. The impact of not being able to sleep seems to have been

the driver for Child T to attempt to seek medication from the GP and to self-medicate via non-prescription drugs or, more worryingly, gaining access to prescription drugs via the internet.

Insomnia was deemed to be the main reason for poor attendance at school, and the final school placement made allowances for this. However, there does not seem to have been much exploration by services of the underlying cause of the insomnia. Instead it was known that a referral to the sleep clinic had been made by Dr2 and there was an over reliance on this to provide a solution for Child T. However, the children's sleep clinic did not cater for the over 16 cohort and a second referral had to be made to the adult sleep clinic. This clinic did not offer a treatment plan that Child T could engage with and, due to non-attendance, closed the case. The issue of transitional services for 16-18-year age range will be addressed later.

Child T continued to struggle with insomnia. Medication was prescribed by GP1 and, in February 2019, Child T indicated that there the problem had resolved, the medication was discontinued, and Child T was not seen by a health service again. It is not clear whether the insomnia had been resolved or that Child T had decided to totally self-medicate.

Given that there was some recognition of low mood, there does not appear to have been a real consideration of depression[12] by the health services. Yes, Child T was prescribed benzodiazepines for short periods, but this seemed to be driven by Child T and there was no apparent therapeutic follow up.

There was an overwhelming sense from the IMRs, that Child T was not viewed in a holistic way but in terms of addressing individual issues. For example, Child T's father described his concern regarding the professional intervention when his child was considered to be at risk of radicalisation.

Here was a young person who had an inquiring nature, who would test boundaries. The view of this young person's parents was that there was no risk of radicalisation and only one version of events was considered by the agencies involved.

This event was still on the father's mind when Child T was admitted to hospital following a suicide attempt. In view of the reports that there had been other suicide attempts in the weeks prior to this one, it suggests that the radicalisation scenario and subsequent Prevent referral had a negative impact on Child T and the family. The event also seemed to divert the professional network away from focusing on how to help Child T to manage life. Already feeling different to siblings

[12] Orchard, F. et al. (2017) Clinical characteristics of adolescents referred for treatment of depressive disorders *Child and Adolescent Mental Health*, Vol22. (2) pp61-68.

and peers this seemed to take a bright young person, albeit with a troubled mind, into the realm of offending.

There is insufficient evidence to conclude the extent to which Child T used illegal substances or any involvement in criminal activity with others. The CAMHS Consultant (Dr2), when undertaking the Mental Health Act assessments during the second hospital admission, described Child T as talking about drug use and a sense of hopelessness but Dr2 suggested that some of the stories seemed 'rehearsed or borrowed from films'.

There are three pictures of Child T, firstly that of a young person who was bright, pleasant, inquisitive, and innovative, leaving a legacy of achievements at home and school; the second of a troubled young person who struggled to come to terms with their ASD and dyslexia, leading them to experiencing poor mental health; thirdly, there is the young person who is challenging authority and on the edge of being exploited both criminally and radically. There is plenty of evidence to prove the first two pictures but a dearth of quality facts to evidence the third. It is not clear whether this was due to Child T elaborating events to try to fit in with peers or just to stand out in a different way to that of a young person with special needs.

7.1.2 Perceptions of mental illness versus conduct disorder

The difference in the perception of CAMHS in contrast to the other professionals was illuminated within the different IMRs. Child T underwent several assessments by different professionals within CAMHS. The definitive diagnosis was that Child T had a conduct disorder and did not have a mental illness. However, the language used by others within IMRs and in conversations, overwhelmingly alluded to the difficulties for Child T due to mental illness.

This difference in perspective is a challenge to fully digest due to the evidence that there were several multi-agency meetings and liaison between CAMHS and other services. This appears to have been a block in the way of the professional network being able to move beyond dealing with the crisis points in Child T's life.

If there had been a clear understanding that the diagnosis was one of Conduct Disorder, then the services could have agreed the care plan with the family over a period in line with the NICE treatment pathway[13]. This would entail offering interventions such as multisystemic therapy to the young person but with an 'explicit and supportive family focus'[14]. The MST was available, but it is not fully clear as to why this was moved forward. Although variations of this pathway were

[13] NICE (2017) Clinical Guidance: Antisocial behaviour and conduct disorders and conduct disorders in children and people: recognition and management.

[14] NICE (2017) Clinical Guidance: Antisocial behaviour and conduct disorders and conduct disorders in children and people: recognition and management

in the plans created by both consultant Psychiatrists (Dr 1 and Dr 2), this was not enacted by the professional network.

Some services viewed Child T as having a mental illness or mental health problems which required the specialism of CAMHS. Meanwhile, CAMHS acknowledged that there were mental health issues but that these could be addressed within the community. This seems to suggest that there is a disconnection of mutual understanding as to the pathways of care for a young person who has complex needs involving behaviour and mental health.

Child T was reported by family members and professionals to suffer with low mood and poor self-esteem. This was seen to escalate at times into suicidal ideation and action but, then professionals could be diverted by Child T who would then dispute the suicidal attempt by suggesting accidents or general risk taking.

This reasserts the view that professionals focused on Child T's symptoms rather than taking a holistic assessment of what the needs of this young person, and their family, were to achieve a positive outcome in life.

In terms of conduct disorder, the American Academy of Child and Adolescent Psychiatry state:

> "*Treatment is rarely brief since establishing new attitudes and behavio*(u)*r patterns takes time*"[15]

Although there was considerable, committed, and commendable, work done with Child T, this appears to have had insufficient coordination and outcome focus. There also seems to have been an over reliance on low level services, e.g within school, rather specialist help. This demonstrates a national problem in how children are identified in requiring specialist services and a shortage of the necessary services.[16]

7.2 THEME 2: FAMILY HISTORY AND DYNAMICS

This was a family of high functioning adults and children. However, there were two children with special educational needs. This placed pressure on the parents to ensure that the individual needs were met. The parents wanted the best for all their children and encouraged Child T to progress interests to exhibit the young person's skills and merits.

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[15] American Academy of child and Adolescent Psychiatry: Conduct Disorder https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Conduct-Disorder-033.aspx : accessed 04 April 2020.

[16] Children' Commissioner (2020) *The State of Children's Mental Health Services*

The professional network did question the suitability of some activities that Child T took part in, encouraged by the father. However, this depends on whether the lens is focused on a disruptive young person, on the edge of crime, or adjusting the lens to see a young person who is inquisitive and trying to make sense of their world.

The family are catholic and gain support through the church community. However, the parents report that Child T had moved away from the church and had not held any faith.

7.2.1 Families in isolation

This was a family struggling to manage the unpredictable behaviour and mood of one of their own. They would manage to move forward and then would be faced by an escalation of problems resulting in a crisis for Child T. This led to Child T being the dominant element within the household.

It is not unusual in families where there is a child with additional needs that there can be a sense of all decisions and actions revolving around that one child. However, for this family Child T was not only the focus of their life but was persuasive and, at times of escalating crisis, overpowering to the point of there being a risk of harm to self or others.

Child T was able to persuade their father to buy, over the counter, medicine to aid the young person's desire to self-medicate. Child T was able to persuade both parents of the need to go home from hospital, to disengage from services, and to seek a mainstream placement under the Education, Health and Care Plan.

The persuasive behaviour seemed to be a way for Child T to control both self, family and, at times, professionals. This led to periods of a 'normal' family life until such times as Child T could not manage the emotional stress of seeing oneself as different from their siblings, not achieving at school, feeling isolated from peers, and not being able to visualise a future life. Child T's parents described their child as having:

'four brains whirring at once, in different directions.'

The periods of escalating crisis had a significant impact on the wellbeing of the whole family. At these times, the parents struggled to keep Child T safe and sought help. However, this help seemed indecisive, plans would change, or assessments would take too long to be undertaken, meaning that the crisis passed or became one being acted out in a public setting, out of the control of the parents. The outcome of this was for the problems to flourish rather than a strong solution to be found.

By March 2019, Child T chose to disengage with services, despite still struggling with insomnia, although without the use of prescribed medication.

If the family therapy had been progressed then this might have enabled the parents to have access to a service in their control, rather than Child T's, to accept.

7.3 THEME 3: QUALITY OF PRACTICE

The focus of this theme is in the way agencies worked together. On their own they followed their procedures but, despite coming together, did not fully comprehend the need for a joined-up view. There are three main areas of practice analysed: perception of professional hierarchies; safeguarding decision making; evaluation of multi-agency working.

7.3.1 Perception of Professional Hierarchies

There seemed to be a view from some in the IMR group, that the CAMHS Consultants were seen to be the dominant professional group who made the decisions for Child T's treatment, without question.

This led to a sense that the two consultants involved had opposing views regarding the treatment options, due to the different plans suggested by the Psychiatrists.

The CAMHS IMR set out clearly that there was no conflict between the two professionals, and, in fact, one sought the view of the other in making the decision for Child T's treatment.

Nevertheless, the IMR group described how the Psychiatrists consistently have different approaches to the treatment of young people, one via a medical route, the other using a multi-systemic approach. NICE promotes the need for multimodal interventions for young people with conduct disorder[17] which does not appear to have been achieved in this case. Nevertheless, the CAMHS team seem clear that they reach their decisions through peer review and discussion. In Child T's case, the Clinical Director was kept informed of decisions and this appears to have been in relation to whether the care should be led by mental health or social care. However, this is not sufficiently understood by other agencies and can create the illusion that CAMHS Consultants are distinct from the multi-agency network.

7.3.2 Safeguarding

There were several safeguarding concerns, or formal referrals, raised by health and education. However, as Child T was known to the early help service, it was the policy for any contact with the MASH to be passed straight to that service.

[17] NICE (2019) Treatment and Care Options for Children and Young People with Antisocial Behaviour and Conduct Disorder

This meant that the concerns were not assessed by a social worker but dealt with by a Family Support Worker.

The referrals came during the period of crisis between December 2017 and January 2018. There were referrals in relation to the impact of Child T's behaviour on the siblings, alongside the Prevent referral focused on Child T.

At this time, the family were in crisis and needed intensive support. Child T was a risk to self, siblings, and parents.

The impact of the pathway for referrals for those already in the system was that the family sought their own coping strategies, in isolation. Meanwhile, there was frustration from the frontline workers within health and education regarding the risk to the family from not addressing their needs.

There was good practice by education in pushing for action by Children's Social Care. This escalation worked effectively. As soon as the CSC service manager was made aware of the issues, the case was opened by the Referral and Assessment Team. This demonstrates strong partnership working.

The subsequent strategy discussion was well attended by the key agencies, although the police were absent.

The strategy discussion resulted in a difference of opinion across the participants as to whether all the children should be assessed under S47 or S17 of the Children Act 1989. The decision to consider the family as children in need does not appear to have been formally challenged by those who were the opinion that the children were at risk of significant harm.

This difference of opinion has been explored with the professional group. The reason for not challenging the decision seems to be two-fold; firstly, education had already used the escalation protocol to get the case opened by the Referral and Assessment Team, and did not want to be seen as constantly oppositional; secondly, other agencies seemed to accept the view that, as the parents were keen to get support and engage with professionals, the child protection route was unnecessary.

There is no evidence of any agency having any concerns regarding the parents in terms of abuse or neglect. This corresponds with the decision to follow the Child in Need route and not Child Protection. The concerns were firmly focused on the inability of the parents to keep the children safe from the risks posed by Child T, without professional intervention.

7.3.3 Child in Need Plan

Following the strategy meeting, a Children in Need Plan was developed by the multi-agency network. Crucially, this included the need for family therapy, which

was pushed for, initially, by Child T's father. However, this, along with any actions relating to Child T's emotional wellbeing, was directed to CAMHS to address and no timescales were specified. In June 2018, the case was closed without the family therapy or sleep clinic being achieved. The reason for the family therapy not being offered was, according to the CAMHS IMR, that the parents no longer wanted this due to the number of professionals already involved. The plan also seems to have focused on Child T rather than the siblings. It would have been advantageous to have had a plan that identified what needed to change for the siblings, i.e., safety, support as potential young carers of their eldest sibling.

The CSC IMR comments that the final CiN meeting in June 2018 did not hold practitioners to account for not completing actions from the initial meeting. Indeed, there did not appear to have been any formal escalation to question this decision. However, this could be viewed in the context of Child T and family feeling overwhelmed by the number of appointments and professionals involved.

The CSC IMR and fact checking conversations suggest that Child T's mother was keen for the cases of the other children to be closed, as it was only Child T who had problems. This seems to have been accepted by the professional network due to the need for parental consent and engagement to continue working with the family.

There were two opportunities for a family focused intervention, the Multi-Systemic Therapy (MST) and family therapy referrals. Both were stood down; the MST, in January 2018, due to Child T being calmer and no longer eligible for Tier 4 CAMHS; the family therapy due to the parents feeling that there were already too many professionals involved. The decision not to implement the family therapy does not seem to have been understood throughout the professional network, had it then this might have enabled further conversations with the parents.

There is an absence of the voices of the siblings in the CiN plan which suggests that the purpose of considering all the children as being in need of support under S17, was not recognised by the whole professional network and, thus, not clarified this with the family.

7.3.4 Interagency collaboration

Between January 2018 and October 2018, there was considerable intervention by various services, with Child T. There were also several occasions of collaboration between agencies.

When Child T was in hospital there were meetings held between education, CAMHS and Children's Social Care. Following discharge CAMHS and Children's Social Care worked together to meet Child T to review the treatment plan. There

was effective two-way communication between CAMHS and the GP. The YOT and Substance Misuse workers liaised and were part of the professional network.

There seemed to be some confusion when Child T was in hospital at the end of January 2018. The hospital staff were extremely concerned that a general ward was inappropriate for a young person displaying such risk-taking behaviour. The CAMHS nurse conceded that it was not appropriate for Child T to remain on the ward overnight. However, the young person was not moved, and the ward staff were advised by the Psychiatrist to utilise zopiclone.

The hospital IMR documented how the ward staff had contacted CAMHS and CSC on several occasions during the admission due to the significant concerns about Child T's safety on the ward, and that of others. CAMHS advised that the police be called as it was not a mental health issue. Meanwhile, the ward staff arranged for the support of a hospital security guard to be with Child T during the stay, a rarity for this paediatric ward. This was arranged in line with the hospital's policy and, therefore, was not discussed with other agencies or the parents. Nevertheless, this accentuated the view that Child T was a risk to others, rather than a young person in emotional distress.

The issue of where to provide a place of safety and recovery for young people who self-harm or attempt suicide is a long-term problem. It has become the practice for them to attend ED and be admitted to a general paediatric ward to await a CAMHS assessment. General Paediatric staff are not fully skilled to care for these young people and there can be a conflict between how staff can care for the young person who might be a risk to self and the other children on the ward. NICE[18] requires that healthcare settings be assessed to ensure that they are safe for young people who have self-harmed.

There can be an expectation that a young person, as in Child T's case, will be transferred to an adolescent mental health ward as soon as there is bed availability. However, the view from the mental health service was that this is not an appropriate setting for young people in an emotional crisis. This is due to the rules required to manage patients within a mental health ward and the damaging impact that admission could have on a young person unless it is in their best interests and for a psychiatric condition that would benefit from admission.

In Child T's case, the dilemma of where to place following the admission at the end of January 2018, led to the professional network displaying its own crisis. On 30 January there were two meetings held which had slightly different outcomes and were led by different Consultants. One meeting was held at the school, the other convened by the ward staff. These two meetings, plus a discharge

[18] NICE Guideline(Quality Standard 34)

discussion held between CAMHS and the ward staff, led to confusion about the plan of care and a perception that the two consultants were of opposing views.

There appeared to be a good professional network within the community, focused around the school. However, this meant that the hospital was left out of this but was expected to deal with the young person's crises and, quite rightly, would push for a multi-agency meeting for discharge planning. Of note, the Hospital IMR highlights a comment from a members of ward staff:

> *"it was difficult to hear that Child T had been discharge home …….seemed what they (young person) was saying was dismissed"*

> *"I feel frustrated that the right care was not provided. I was surprised Child T was discharged when such a high risk"*

NSPCC (2014) [19] noted that children admitted to hospital following suicidal attempts must have a safeguarding assessment prior to discharge. This aligns with NICE (2004) stating that the assessment, following self-harm, should include family, social and child protection needs[20]. This was not undertaken for Child T during the first admission, although referrals were made. Nor was this undertaken for Child T during the second admission, however the referrals succeeded in the Referral and Assessment Team convening a strategy discussion within days of discharge.

Another exclusion within the professional network was that of the GP who was only kept in the loop by CAMHS. Limiting the inclusion of the GP meant that there was a gap in how Child T's needs were met in terms of medication and drug use. The substance misuse worker met Child T at home at undertook education sessions relating to the use of cannabis and benzodiazepines. However, this information does not appear to have been shared with Primary Care and there is evidence that Child T approached GP7 at the extended hours hub to ask for diazepam. This GP would not have had a full understanding of Child T's history but did give advice not to take with zopiclone. A short course was prescribed, as it would not be usual practice to prescribe diazepam to a young person. A few weeks later Child T saw GP1 to ask for a further script due to losing the medication in a hotel room. GP1 agreed to a defined treatment plan of 7 tablets to last a month with a view to titrating down to zero. The GPs both used appropriate caution regarding the prescribing of benzodiazepines and, GP1, liaised with CAMHS so the knowledge of the medication was shared.

[19] NSPCC (2014) *Teenagers: Learning from Serious Case Reviews*. Factsheet

[20] NICE (2004) Clinical Guidance 16. *Self-harm in over 8s: Short-term management and prevention of recurrence.*

In the IMR group, this was discussed, and the substance misuse service agreed that it would be useful to have some liaison with GPs. This would be particularly wise considering the role of GPs in being the main prescribers of medication.

7.4 THEME 4: PATHWAYS FOR SUPPORT FROM SERVICES

This theme focuses on the understanding and agreement regarding thresholds for intervention; listening to the views of others; escalation of concerns; adaptability of services; transition from children to adult services.

7.4.1 Adaptability of services

Some services appeared to focus solely on their individual remit. This meant that there were, at times, numerous workers involved with Child T. The parents reported that this was difficult for the family and young person to cope with and did not resolve their issues.

The question asked of the IMR group was about how the nature of their assessments for intervention. There was good discussion about the need to view a child holistically and to consider which other services are involved. The conclusion was that there might be a skills gap for some workers.

The parents commented that Child T did respond well to some teaching staff and that perhaps a better use of youth workers who can engage with a young person within the context of the young person's interests rather than the 'lanyard in an office' approach. This does seem to make sense as it would enable a service to 'fit' around the young person, rather than require the young person to 'fit' within the service boundaries or be non-compliant.

In primary school, following the ASD diagnosis, work was undertaken to provide support for Child T's transition to secondary school. The child, at that time did not meet the criteria for a Statement of Special Educational Needs but the school put in additional support.

In 2012, post diagnostic support was not available for children and families following an ASD diagnosis. This is a national problem, but the Local Authority is working with the CCG to enable this provision to be available, at the time of need.

The SEN service IMR noted that Child T's difficulties would have qualified as 'predictable needs', i.e. that most schools should have pupils with a similar profile and would have the skills to address these issues. The report goes on to conclude that a statement of SEN or EHCP would not have made a difference to Child T if achieved earlier.

However, this is based on the description of Child T's needs: ASD, dyslexia, sleep difficulties which generalises how a child exhibits their needs. It is also reliant on

the quality of the information submitted by the professionals involved in the SEN assessment.

Child T managed to cope for a while in secondary school but then deteriorated. Although a further application for an EHCP was initiated, it was never completed by the school and, instead, the route taken was for multiple exclusions which became a key part of Child T's identification.

The lead for SEND stated that the schools could have resubmitted an application for a statement (EHCP) at any time but that the expectation is that schools have staff with the skills to deal with ASD and behavioural problems and access to external expertise. The schools involved with the review seemed to concur with this view. Nevertheless, this was a child with complex behavioural, conduct and emotional issues. The school settings seemed to be rigid in their management of pupils or not set up to deal with this type of complexity. The fact that Child T was subject to exclusions, does raise a question about how effective the schools were in managing complex needs. Indeed, schools need to be rigorous in their decision-making regarding exclusions of children with special educational needs.

Finally, an EHCP was accepted in 2016 but there then became a struggle to find the appropriate setting to meet Child T's needs. This was discussed with the Local Authority SEND leads and the IMR group. There seemed to be a frustration from the group that the professional network was not listened to when advising on the need for a residential placement for Child T. However, the SEN lead was quite clear that the legislation requires parental preference being prioritised, and this was for mainstream provision. Nevertheless, the evidence suggests that the parental views were dictated by Child T. There is insufficient professional evidence to demonstrate how the SEND network engaged the parents to fully understand what would be most beneficial for Child T and the family. This led to several unsuitable placements and continued frustration for Child T. Then the parental preference changed to a special school, which was found in the final placement of a college which, according to the parents, was the right place but too late.

In January 2018, a joint Local Area inspection by Ofsted and the Care Quality Commission (CQC) highlighted weaknesses in terms of the implementation of the Children and Family Act 2014[21] and gave rise to a Written Statement of Action. In May 2020, Ofsted and CQC confirmed that the Local Area services had made

[21] Children and Family Act 2014 changed the approach to SEN and established Education, Health and Care Plans. It also set requirements for the Local Authority and Clinical Commissioning Group to work together to ensure effective oversight of plans.

"sufficient progress" in all three areas identified in the SEND inspection and, therefore, Sutton no longer required a Written Statement of Action[22].

The SEN lead did not consider that the weaknesses from the 2018 inspection had an adverse impact on the handling of Child T's case. However, as the weaknesses included poor quality of reports and insufficient health leadership, this does indicate a need to ensure that children with complex behavioural needs are supported to achieve a positive educational experience. This should include listening to the views of professionals as to what will work for the individual young person. In addition, and of critical importance, would be to monitor the relationship between exclusions and special educational needs.

7.4.2 Transition from Child to Adult Services

In March 2019, Child T was still troubled by insomnia. Child T had been referred to the Children's sleep clinic but did not meet the criteria for this service due to being over 16 years of age.

This led to a need for Dr 1 and the GP to make referrals to the adult sleep clinic as there was no direct pathway between the two sleep services.

When the adult sleep clinic offered an appointment, Child T chose not to attend. There were further efforts by the clinic to engage the young person in conducting a sleep actigraphy[23]. However, Child T could not cope with the requirements of wearing an electronic sleep tag or writing a sleep diary. This was due to Child T having a fear of the risk of invasion of privacy posed by electronic devices and the spotlight on the young person's dyslexia if required to show a diary to a professional. Consequently, the clinic closed the case.

Child T was never able to gain any resolution to the insomnia because there was no service or holistic review of what the young person needed to be able to achieve a healthy sleep routine. This is a gap for children with neurodevelopmental disorders are more likely to suffer with sleep problems.[24]

This is an illustration of how there is a gap in the services available to the 16-18-year-old cohort. There seems to be an inequity of access for this group, which is not exclusive to Sutton but, nevertheless, is an important area of risk for young people not able to receive a service that adequately caters for their needs.

[22] Ofsted (2020) Local Area SEND inspection; Sutton

[23] Actigraphy is a home study where a watch type device is worn which records movement and light, with the data subsequently analysed to determine the sleep pattern.

[24] Gregory, A.M. et al (2015) Annual Research Review: Sleep problems in childhood psychiatric disorders-a review of the latest science. *Journal of Child Psychology and Psychiatry*. Vol 57 (3)

7.4.3 Transition from Children to Adult Mental Health Services

In March 2019, CAMHS closed the case as there had been several months without any problems reported for Child T. This seems to have been confirmed by the evidence that Child T had seen the GP and agreed that there was no need for further medication. This would indicate that there was no necessity for any transition to Adult Mental Health services.

Child T appeared to be managing. However, there were still seemingly problems with insomnia which led to a 50% attendance at college. Nevertheless, the college did not consider there to be significant problems for Child T.

When presented with the picture of Child T's life it is easy to question how the young person could have been ready to be discharged. Certainly, it would have seemed pertinent to have presented the family with a clear safety plan to access help, in case of further crises. However, social care had already closed their case and it was clear that Child T no longer wanted CAMHS intervention. There was no legal threshold met to enforce any mental health service upon Child T and the GP could have referred to a service if the need arose.

After March 2019, Child T does not appear to have directly accessed any health service. This does raise a question regarding how the young person managed the insomnia during the months prior to death. The parents reported that the young person enjoyed the college and would have waves of activity followed by feeling flat and utterly exhausted. Before, during and after the October 2019 half-term, Child T self-isolated within a darkened bedroom, not even coming out to eat meals.

The College did not have a full understanding of the emotional crises experienced by Child T, but the young person had opportunities to discuss any problems through a nurturing culture and support to access the timetable around the insomnia. The College have reflected on this within their IMR and are creating a screening process for all holistic assessments, on admission, to be checked by a member of staff who has had mental health training.

8 LEARNING POINTS

Following on from the analysis of practice, it is clear that, although good practice has been highlighted, there are aspects of learning for the Sutton Safeguarding Children Partnership to consider in taking forward to strengthen and improve the outcomes for young people in similar situations to that of Child T.

8.1 COMPLEX NEEDS

Although it has been shown that much work has been done to improve the SEND offer[25] in Sutton, there is more analysis needed of how children, resident in the borough, with complex behavioural and emotional needs are managed within education and the community. The IMR group suggested that Child T was not an unusual young person.

There needs to be a personalised approach to identifying a child's needs and a focus on the following to ensure that children with ASD and conduct disorders are effectively safeguarded within education settings:

- ASD pre and post diagnosis support
- School provision for complex needs
- Professional advice and contribution leading to an EHCP
- Exclusions of children with an EHCP or on edge of SEND
- Use of family therapy in cases of conduct disorder

8.2 SUICIDE ATTEMPTS

The case highlights how the 'reachable moment' can be lost for a young person who has attempted suicide and is admitted to hospital. It is essential that there is coordinated assessment of the young person's mental state but also of what safeguarding support is needed for the young person and any siblings in the household.

NICE (2004) states that there needs to be a full assessment of young people who have been admitted following a suicide attempt, that includes the family, social situation, and child protection factors.[26] This is endorsed by the review of serious cases by the NSPCC[27] indicating that young people should not be discharged from hospital following a suicide attempt without an assessment of their child protection needs. This can then provide a family with a restorative, wrap around support service to enable the young person to reintegrate into a positive life.

When a young person discloses self-harm or suicidal thoughts, professionals must take this seriously and not reverse decision making when there are later retractions.[28]

The practice of admitting a young person who has attempted suicide to a general paediatric ward needs to be reviewed. The NICE guidance specifies that

[25] DFE (2015) Special Educational Needs and Disability Code Of Practice: 0-25 years; Sutton Local Offer www.sutton.gov.uk : accessed 31 May 2020.
[26] NICE (2004) Clinical Guidance 16. *Self-harm in over 8s: Short-term management and prevention of recurrence.*
[27] NSPCC (2014) *Teenagers: Learning from Serious Case Reviews*. Factsheet
[28] *Ibid.*

alternative placements should be considered depending on the young person's age, physical and mental health, and family circumstances.[29] During the Covid-19 pandemic, young people have not been able to be admitted to a paediatric ward for self-harm or suicide attempts. This provides a good opportunity for commissioners and providers to evaluate the emergency provision available for this cohort of young people, as well as the knowledge and skills required to support them effectively. This should be aligned to the LSCP Self-harm Protocol[30].

8.3 Recognition of the family

The most significant gap in the case was that the family therapy was never implemented for the family which meant that there was insufficient understanding about the impact of Child T'

It is crucial that the family is part of any assessment for a young person with complex needs, as set out in the Assessment of a child in need[31]. This can aid the professional network in evaluating the effectiveness of interventions on the whole family, rather than focusing on one child.

8.4 Working Together

On the surface, there was a good professional network in place and effective escalation process,[32] once this had been activated.

There are three key learning points here; firstly, when referrals are submitted to the MASH and the family are already known, there should be questioning of the multi-agency team around the family as to how it has come together to review any change in threshold of concerns for the family; secondly, the escalation process has been shown to work and it would be beneficial to empower frontline services to raise concerns about cases to the case review group, using the referral system already in place for serious cases;[33] thirdly, care must be taken not to exclude key professionals working with a family such as GP and acute services.

Additionally, when a professional network is in place there needs to be clear, written communication which ensures that there is a shared understanding of the child's diagnosis and needs.

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[29] NICE (2004) Clinical guidance 16. *Self-harm in over 8s: Short-term management and prevention of recurrence.*

[30] Sutton LSCP (2018) Self-Harm Protocol

[31] DH (2000) Assessment of Children in Need / London Safeguarding Children Board (2020) Appendix 4: Triangle Chart for Assessment of Children in Need and their Families https://www.londoncp.co.uk/chapters/appendix_4. : accessed 31 May 2020

[32] Sutton LSCP Multi-Agency Escalation Protocol (2015)

[33] Sutton LSCP Guidance on making a referral for review by the case review subgroup

8.5 ASSURANCE OF CHILDREN IN NEED PLANS (CIN)

A gap in this case was when the CiN case was closed without the plan being completed. This demonstrated insufficient rigour in the development of the plan and to achieve agreed outcomes for the family.

There must be a clear lead role and coordination of a CiN plan, with all members of the network understanding, and committing, to completing their actions. The statutory requirements must be maintained, with the plan informed by all children subject to assessment.[34] For a case to close, where actions have not been fully actioned, the professional network must be informed. This will enable each agency to take responsibility for any respective actions remaining, and the opportunity for escalation provided.

8.6 HEARING THE CHILD'S VOICE

In completing this review there remain differing pictures of Child T, a pleasant, intelligent, and inquisitive but troubled young person, known for offending behaviour.

This highlights how crucial it is for services to listen to the child and to question the child's field of perception.

This case also demonstrates how some young people do not 'fit the profile' for services. The narrative must change to ensure that all services challenge themselves to provide flexibility to be able to 'fit' any young person in need of their care and treatment.

The focus of this review has been Child T. However, there were other children in the family. This case shows how a professional network should notice siblings, consider their needs and, assess the extent to which they are acting as young carers. By hearing all the individual voices, professionals can provide clearer support to the whole family and improve outcomes.

9 CONCLUSION

In conclusion, the case of Child T highlights the difficulties for families, professionals, and the young person to navigate a safe path through emotional crises when a young person has history of complex needs.

What it demonstrates is how, even when there is a professional network in place, services can still be working in a siloed approach. This can then have a negative impact on the extent to which a family and young person engage with care and treatment vital to the health and welfare of them all.

[34] HM Govt (2018) Working Together to Safeguard Children

The case shows some good practice in individual agencies. Nonetheless, there is learning for the LSCP to take forward in collaboration with its partners, relevant agencies, and other strategic networks. This will provide assurance to the LSCP of the effectiveness of safeguarding for the children resident in Sutton and enable the joint working in the borough to be strengthened.

10 RECOMMENDATIONS FOR LSCP

Item	Review Finding	Recommendation
Seek assurance		
1.	Individual Management Reviews contributed to the information and analysis for the review.	The LSCP to seek assurance that the Individual Management Reviews are being implemented by agencies.
2.	There is a need for careful support for those with complex needs prior to diagnosis and ASD post diagnostic support to enable children and families to come to terms with the diagnosis	The commissioning partnership from health, social care, and education to review the offers of support for ASD post diagnostic support, including a gaps analysis and clear pathway for referrals and support to report back to the LSCP for further scrutiny.
3.	Children who have SEN, whether with an EHCP or receiving SEN Support, can find it hard to manage within an education setting. When schools exclude rather than address the issues, the problems are then often exacerbated.	The LSCP to seek assurance that for children who are receiving SEN Support, are undergoing an EHC Needs Assessment or have an EHCP, a review by the SEND partnership takes place to address the issues holistically before consideration of an exclusion.
4.	EHCP and safeguarding of those with special educational needs need to be more aligned to ensure that safeguarding issues are not minimised due to SEND.	The LSCP to seek assurance that when a child has an EHCP that the wider professional network such as SEN and relevant health services are included in partnership meeting, subject to consent.

5.	Child Protection, family and social assessment following a suicide attempt can identify care and support needs for the family.	Strategy meetings to be convened following a referral about a suicide attempt.
Independent Scrutiny		
6.	Professional network responsibilities include a shared understanding of the assessment and decision making for child protection or child in need.	The LSCP to seek assurance that strategy meetings always consider if a section 47 investigation is needed, not only in respect of the child who is the subject of the referral but also siblings in the family home.
7.	The emergency provision for young people following a suicide attempt does not aid recovery for the young person or family.	The LSCP to seek assurance from commissioners and providers that the standards set out in the NICE guidance are complied with, including that staff are adequately trained to care for children who are in a mental health crisis.
8.	The professional network around a child is not inclusive of all those working closely with the family (GP)	When health professionals attend a multi-agency professional meeting, they identify which health agency need to be contacted and how they will do that.
9.	When a child or young person has highly complex needs, the focus can be all on the young person without full consideration of the impact of the issues on the whole family.	The LSCP promotes a family-based practice model across the safeguarding partnership that is underpinned by trauma informed, contextual and restorative principles.
10.	Service provision for 16-18-year-old young people does not consistently fit the needs of this cohort.	The LSCP should challenge agencies and partnerships in how they listen to young people for transition to adult services.

11 APPENDICES

11.1 METHODOLOGY

The review focused on a specific period of time (November 2017-November 2019) when Child T came to the attention of the multi-agency network and required professionals to work together.

A rapid review was undertaken by the LSCP and an integrated chronology compiled. This was followed by a request for the key services to undertake Individual Management reviews of their involvement with Child T.

An Independent Author, with extensive safeguarding experience and leadership, was commissioned to bring together the learning from the individual services and to provide an analysis of the multi-agency working and identify themes for the LSCP to take forward in learning for the network.

The authors of the reviews were invited to form a panel to enable the independent author to explore questions arising from the IMRs.

The independent author, along with the Designated Nurse for Safeguarding Children, met with Child T's parents to gain their perspective of how services worked with their child.

The independent author facilitated two workshops with some of the IMR authors and had conversations with key frontline staff and managers to gain more insight into the system within Sutton for supporting young people with special educational needs, emotional and behavioural issues.

The LSCP had already identified four themes within the terms of reference and these were expanded upon by the independent author in the analysis of the case and the learning needed to reduce the likelihood of a similar case in the future.

This methodology was blended with the SCIE 'systems' model to observe how much Child T's case provided a 'window on the system' beyond the specific case[35]. This provided the basis for the learning points but also enabled the acknowledgement of the work already achieved by the agencies in Sutton.

The independent author attended two Case Review Groups chaired by the LSCP Chair, to share and discuss the findings.

The recommendations were suggested by the independent author and then developed in consultation with the Case Review Group to ensure LSCP ownership of the actions to be taken forward from the learning in the case.

[35] Social Care Institute for Excellence (2012) *Learning together to safeguard children: a 'systems' model for case reviews*

11.2 INDIVIDUAL MANAGEMENT REVIEW (IMR) RECOMMENDATIONS

Item	Recommendations
1	Epsom and St Helier NHS Trust
	That all key practitioners directly involved in the internal management review are debriefed and informed of the review findings
	That staff are provided with training on self-harm and suicide /autism
	That the Trust considers developing a temporary / permanent Adolescent ward for older children
	That the Trust considers developing a pool of RMN or alternatives
	That a Discharge Planning Meeting is conducted for all children admitted with self-harm/suicidal and complex health needs
	That the Kitchen door on the ward is permanently locked
	That there is demonstrable SMT support for Safeguarding Supervision, it is accessed by paediatric staff, and highlighted as a Trust priority
2	Primary Care
	The Surgery will introduce a training package with the details of the offer by children's first contact service. This will be alongside training on the LSCP threshold document with the intention of increasing the number of quality referrals into Children's First Contact Service.
3	South West London and St George's Mental Health Trust
	The good practice should be disseminated within the Trust through the regular Learning Events.
	Depending on other agencies investigations there may be opportunities to review the services locally for young people with ASDs and in particular Education provision.
4	Children's Social Care
	Develop staff skills in working with children and young people who have complex presentations (suicidal/self-harm, ASD, substance misuse, avoidant), to include trauma informed approaches.
	Management oversight to be strengthened.
	Review Child in Need planning processes to ensure that schedules of work and interventions remain focussed and are offer a robust service.
	CiN network meetings to take place at the point of closure of a case, to improve effective handover to lead professional and continuation of plan at Early Help/Universal level.
	Multi-professional partners understand the self-harm/suicide protocol which is up to date and reflects current and best practice.
	Learning Event to ensure all staff are aware of the changes to practice and practice guidance.
5	Inspire
	To ensure that we continue to keep the voice of the client (young person) at the forefront of our work Switch will continue to ensure the following best practice is followed. Communication preferences and information

	sharing consents will be completed at the first meeting. To continue current practices of speaking directly to the young person before discharging them from the service. To share good practice and case discussions in team meetings and supervision.
	Ensure all staff are trained in case management, recording, procedures and best practice, with refresher training carried out periodically in line with Cranstoun training schedule.
	Inspire to incorporate staffing levels into the agenda of management meetings to ensure a timely response to shortages
	Switch to develop and implement a Triage assessment to capture more information for brief interventions.
	Effective practice, Lessons Learnt and recommendations to be shared with Cranstoun young people best practice group for further learning at an organisational level.
6	Sutton Health and Care
	Improve the line of communication between the School Nurse and CAMHS which can provide an update of engagement including progress and concerns so that there is clarity about how the young person's mental health.
7	Pupil Referral Unit
	Review the timeliness of the assessment of need and undertake earlier intervention.
	Review how the PRU shares information with post-16 providers.
	Develop further documentation to draw clear attention to vulnerable complex cases.
8	Special Needs College
	Assess holistic assessment document
	Create a screening process for all holistic assessments to be checked by a staff member with mental health training
	Identify a person to complete the holistic assessment with parent / carer and discuss the results
9	Evelina London Children's Hospital and Guys and St Thomas' NHS Trust
	Existing trust wide policy for communication of rejected referrals and notification of those not attending appointments highlighted to clinical staff
10	Metropolitan Police
	Professional development for officers attending incidents involving children to ensure that the voice of the child is recorded in the report.

11.3 SUTTON LSCP ACTION PLAN

CHILD T – LSCP ACTION PLAN

Sutton LSCP
Local Safeguarding Children Partnership

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
1. The LSCP to seek assurance that the Individual Management Reviews are being implemented by agencies.	To oversee that each agency take forward recommendations from their internal reviews.	Relevant agencies to provide assurance to the Child Safeguarding Practice Review subgroup.	Chair of Child Safeguarding Practice Review subgroup.	31 March 2021	Improved systems and practices.
2. The commissioning partnership from health, social care, and education to review the offers of support for ASD post diagnostic support, including a gaps analysis and clear pathway for referrals and support to report back to the LSCP for further scrutiny.	To strengthen post-diagnostic ASD support arrangements to improve outcomes for children.	To review the current offer of ASD post diagnostic support, and submit a report to the LSCP which includes how stakeholders have been listened to.	Chair of the SEND QA subgroup.	31 March 2021	Improved post-diagnostic support to meet the need of children with ASD diagnosis.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
3. The LSCP to seek assurance that for children who are receiving SEN Support, are undergoing an EHC Needs Assessment or have an EHCP, a review by the SEND partnership takes place to address the issues holistically before consideration of an exclusion.	To ensure that SEN needs are fully considered before a child is excluded from school.	To review the process to quality assure multi-agency decision making when a child with SEN needs is excluded from school.	Chair of the SEND QA subgroup.	31 March 2021	Improved partnership working to support children with SEN needs at risk of exclusion.
4. The LSCP to seek assurance that when a child has an EHCP that the wider professional network such as SEN and relevant health services are included in partnership meeting, subject to consent.	To strengthen multi-agency SEND partnership working.	To provide assurance to the LSCP that reviews of EHCPs are multi-agency.	Chair of the SEND QA subgroup.	31 March 2021	Improved partnership working to meet the child needs, as identified in the EHCP.
5. Strategy meetings to be convened following a referral about a suicide attempt.	To fulfil statutory safeguarding responsibilities to keep children safe.	a) Children's social care to review the practice directive for the management of strategy meetings.	Head of QA and Practice, LBS.	1 October 2020	Improved multi-agency risk assessment to safeguard children.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		b) To review the LSCP multi-agency self-harm protocol to include suicide prevention.	Designated Safeguarding Nurse, NHS SWL CCG.	1 November 2020	
6. The LSCP to seek assurance that strategy meetings always consider if a section 47 investigation is needed, not only in respect of the child who is the subject of the referral but also siblings in the family home.	To fulfil statutory safeguarding responsibilities to keep children safe.	To include responses to siblings and outcomes of strategy meetings in the LSCP Children's First Contact Service multi-agency audit.	Head of QA and Practice, LBS.	31 March 2020	Improved multi-agency risk assessment to safeguard children.
7. The LSCP to seek assurance from commissioners and providers that the standards set out in the NICE guidance are complied with, including that staff are adequately trained to care for children who are in a mental health crisis.	To ensure that best practice standards are complied with across the multi-agency partnership to improve the care for children in a mental health crisis.	a) Review and evaluate the emergency provision for young people following a suicide attempt.	CAMHS commissioner, LBS.	31 March 2020	Improved care for children in a mental health crisis.
		b) To engage young people in a meaningful way that assists with informing commissioning intentions and service delivery.	CAMHS commissioner, LBS.		

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		c) Health assurance report to be considered by the LSCP QA subgroup in relation to training to comply with NICE guidance.	Designated Safeguarding Nurse, NHS SWL CCG.		
8. When health professionals attend a multi-agency professional meeting, they identify which health agency need to be contacted and how they will do that.	To strengthen the contribution of health professionals in multi-agency meetings to improve outcomes for children.	a) Letter to be sent to the named health professionals informing them of their responsibilities.	Designated Safeguarding Nurse, NHS SWL CCG.	1 November 2020	Improved health contributions in multi-agency professional meetings.
		b) To explore the continued use of virtual meetings with the GP network to enable contributions to multi-agency meetings.	Designated Safeguarding Nurse, NHS SWL CCG.		
		c) To review the role of the Health navigator in the Children First Contact Service to improve the multi-agency contributions of health providers.	Sutton Health and Social Care.		

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
9. The LSCP promotes a family-based practice model across the safeguarding partnership that is underpinned by trauma informed, contextual and restorative principles.	To strengthen 'think family' approaches in adolescent safeguarding.	To review the current practice model for working with complex needs in the LSCP adolescent safeguarding task & finish group.	Assistant Director, Children's Social Care and Safeguarding, LBS.	31.03.2020	Improved responses to manage children's complex health needs.
10. The LSCP should challenge agencies and partnerships in how they listen to young people for transition to adult services.	To take a young people centred approach in transition planning across children and adults social care.	To review the engagement and participation of young people in transition planning as part of multi-agency transition protocol developments.	Assistant Director, Children's Social Care and Safeguarding, LBS.	31.03.2020	Improved transition planning.