Norfolk Safeguarding Children Partnership

Learning from Safeguarding Practice Reviews

Case AL

Safeguarding Practice Review: Case AJ

This presentation sets out:

- Summary of the case
- Terms of Reference:
  - methodology
  - key research questions
- Family's views
- Areas of Learning & Recommendations
- The NSCP's response
- Learning Activities

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Summary of the Case

- Child AL: middle child with older sister and younger brother
- Good school attendance and achievement up to high school
- *But* suffered from acute social anxiety and became a school refuser. Specialist school place obtained and educated remotely.
- Extensive support from CAMHS for AL between 2015 and summer 2021 and support for his sister between 2018 and 2019, including crisis intervention.

Summary of the Case, cont.

- Parental history of mental health issues. Extent and impact not well understood by professionals as children grew older.
- Mum registered blind with other health issues.
- Father a chronic alcoholic. Lived separately but very present in family, including providing care for mother. His role not well understood.
- Family network included paternal aunt, maternal grandmother and friends.

Summary of the Case, cont.

- Several referrals for Early Help and CAMHS by school; pattern of mother giving/withdrawing consent for support.
- November 2021 mother dies suddenly, AL particularly close to his mother. Significant impact on family and home conditions rapidly deteriorate.
- AL no longer with under 14 CAMHS services. Referred and managed as Family Support Plan. Referrals made for bereavement services and CAMHS but not marked as urgent.

Summary of the Case, cont.

- Father caring for children after Mothers death. Alcoholism concerning but he agrees to stop drinking.
- Wider family unable to provide consistent face to face support due largely to Covid restrictions
- January 2022: AL found hanging and subsequently dies. Inquest to be held in spring 2023.

Terms of Reference: Methodology

- Review group made up of key professionals.
- Identify timescales and key themes – Terms of reference
- Rapid Review and integrated chronology
- National Panel directed NSCP: *to consider the intergenerational context of the family, over the longer term and beyond the time frame suggested [Jan 2019 – Jan 2022], as well as the role of the school and how the wider safeguarding partnership did and did not engage to support the school.*
- 1-2-1 reflective conversations held with practitioners and strategic managers from relevant service providers, e.g. Children's Advice and Duty Service (CADS) and Young Carers.
- Face to face meetings with family members
- Professional learning event
- Documents considered included reports to coroner:
  - Education provider and police reports
  - NSFT Mental Health Provider Serious Incident report

TOR: Key Research Questions

- What can the case tell us about all agency responses to mental health issues, particularly when there is an overlap between mental health interventions and safeguarding?

- What can we learn about the whole family approach, and how we work as a multi-agency safeguarding system, when children and parents present with have a history of mental health concerns, and/or there is bereavement and trauma?

- What does the case tell us about the multi-agency response to the particular experience of older children and young people living with neglect?

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TOR: Key Research Questions

- How well do we recognise and respond to the needs of young carers?

- What can this case tell us about multi-agency practice in terms of risk management, support and effective provision of services, including when young people are placed in specialist educational settings?

- How can the case inform our Covid recovery strategy, as the case was also exacerbated by the pandemic?

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Family's Views

NB. Although still grieving, the family wanted to contribute to prevent other families experiencing such tragic loss. They felt disloyal for sharing their thoughts but believed it was important to support learning and to honour AL. Some of the things they told us:

- Mother self-harmed from adolescence (including suicide attempts) and had no understanding of how it affected family, friends or her children. She drank regularly and hid this from professionals. The family felt she could be very devious and was impossible to confront.

- Mother "put on a good spin" for the mental health professionals. Family felt that they showed no interest in the children's wellbeing or Mother as a Mother.

- After Mother lost her sight, she could not see the mess, so housework was an issue, but she was controlling and prevented the children from having clean clothes.

Family's Views, cont.

- Family believed both parents would lie to social services. Mother said she would take AL to school, but they thought that she did not try.

- Mother blocked professionals. She did not welcome anyone – including family members at times. Mother had to be at the centre of things, needed to "control the narrative." She appeared to encourage AL to stay in his room and not to have a normal life.

- AL thought that Mother's behaviour was normal. "Mother was his world." "He was so dependent on her that he couldn't live a normal life without her." He worried about what he would do if Mother died

Family's Views, cont.

- A Family member said that AL self-harmed a little when he was younger, just scratches. He had seen his Mother do it and thought this was a normal thing to do when you were upset.
- He was withdrawn and uncommunicative. He had unwashed hair and slept in unwashed bed linen.
- He shared some of his feelings with his Sister and was desperately unhappy. He would sometimes go out with her; he enjoyed going out.

"He was a complicated young man. He had a lot to say, he just couldn't say it. He was kind, gentle, sweet…"

Learning: assessing & responding to AL's mental health needs

- **Transition of services -** CAMHS Under 14s Services provided good support to AL for more than three years, but did not transition to youth team and for a few months AL was without additional psychological support. During this time Mother died.

- **Medication** - a key part of the treatment for managing AL's anxiety, especially after his therapy ceased. Dispensing, storing and administering medication not supervised.

Recommendation 1 - Medication supervision

The NSCP should seek assurance from health commissioners and partners that protocols and guidance are in place to ensure the safe management of medication for young people known to have mental health problems, including monitoring use, and advice to carers on storage and administration.

Learning: assessing & responding to AL's mental health needs, cont.

- **Assessing risk of self harm or suicide** – AL mostly seen as low risk but recognised deterioration of mental health following bereavement. Rereferred to CAMHS but heightened risk not noted. *Practice notes re:*
  - *Bereavement as an increased risk*
  - *Mental Health assessments in response to crises*

Recommendation 2 - Referral Pathways for Child Mental Health Services

The learning from this Review should be taken into account in the NSFT Review of referral and care pathways and the development of any associated training package for staff. Referral processes and forms should seek relevant information about family history, any relevant history of trauma and any concerns about current parental mental health or substance misuse. Within the Trust, appropriate checks should be made to see if parents are known to adult mental health services, when children are being referred.

Recommendation 3 - Practice Guidance to Professionals on Children at Risk of Suicide

The NSCP should review this practice guidance to ensure that it is up-to-date and promote it with the dissemination of learning from this Review.

Learning: Child Safeguarding Thresholds

- **Consent and Non-Engagement** – patterns of AL missing therapy with excuses given that he was unwell. When mum was challenged she would consent to interventions and then withdraw consent. *Practice notes re:*
  - *Engaging reluctant families*
  - *Accumulated risk when parents repeatedly don't follow through with consent for intervention*

Recommendation 4 – Recognising the longer term nature of neglect & parental non-cooperation

The NSCP should review its guidance on Thresholds in order to support practitioners' understanding of neglect, the long term and cumulative impact of neglect and how to identify non-cooperation of care givers, as possible evidence of neglect. As well as highlighting examples of single significantly harmful events examples can be provided to help practitioners recognise that neglect includes:

- *not being brought to appointments*
- *repeated refusal of services*
- *not complying with advice or not administering or monitoring a child's medication*.

Learning: Child Safeguarding Thresholds, cont.

- **Neglect/Emotional Abuse and Child Protection Thresholds –** AL's behaviours viewed as self neglect and ascribed to mental health issues. Not seen in context of siblings' MH issues and parental history of MH.

- **Parental alcohol misuse** – No evidence that mother's misuse was observed by professionals although AL's sister witnessed it. Father's chronic alcoholism was known but after mother's death he agreed to stop drinking and this was accepted at face value despite his profound grief and sole parenting responsibility.

Learning: understanding family history and dynamics in assessments and interventions

- **Trauma Informed Practice -** CAMHS held in mind AL's anxiety and behaviours may have been rooted in trauma but unaware of the parents' histories; parents did not share this information voluntarily so puzzle piece was missing. There was **no holistic picture:** mother offered but declined family therapy. Mental Health Services had no way of marrying up the picture, despite the fact that AL's sister was known to a different part of the service. AL's education provider and younger brother's school also unaware and unable to join the dots effectively.

- **Role of Fathers** – Little or no knowledge of the father other than he was involved in family life. Prior to mother's death was apparent that AL struggled with his father.

Recommendation 5 – Understanding the Importance of and Working with Fathers & Father Figures

The NSCP should produce and promote sector specific good practice guides on understanding the importance of fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.

Learning: understanding family history and dynamics, cont.

- **Involvement of wider Family** – prior to mother's death there was little contact with wider family as parents appeared to be co-operating with health and education. Following the death Family Network meetings held and included sister (now adult and living away from home), maternal grandmother and paternal aunt. Think Family is crucial particularly where mental health issues present.

Recommendation 6 –
Understanding Families in their wider context : Think Family

- *The NSCP should seek assurance from Partner Agencies, including those working primarily with adults, that there are processes in place to identify and note when vulnerable adults, including men, have parenting or caring roles.*
- *Services should have systems in place to recognise the importance of seeing a family in its wider context, including assessing key relationships and obtaining a holistic view of any difficulties in the family, and not focusing solely on individual family members.*
- *Systems should ensure that where possible and appropriate family members, including fathers, and other key relatives, should be heard in order to capture important historical information or to understand key dynamics.*

Learning: Multi-Agency Response/Co-ordination & Professional curiosity

- **Education and Mental Health –** Evidence of good joined up work between AL's education provider and CAMHS

- **Professional curiosity and information sharing** – as noted previously, lack of join up meant that patterns of behaviours amongst sibling group not picked up, including emerging signs of distress in younger brother. *Practice note included*

- **Responding in family crisis** – Following mother's death Children's Services Family Support Team became involved and established relationships with AL, his brother and father as well as other services already involved – namely education. Complicating factors included:

  - Rise in Covid and December 2021 lockdown impacting on services, staffing and face to face engagement of wider family
  - Seasonal holidays

Learning: reflective thinking, bereavement support & young carers

- **Joint Agency Group Supervision –** Opportunities to come together to support professional network in their reflective thinking and risk assessments were not sought out following mother's death. *Practice note included*.

Recommendation 7 –
Supporting Reflective Thinking in Complex Work

- *The NSCP should review how the Joint Agency Group Supervision process is working across services, including awareness of it among practitioners and supervisors and further promote it, if necessary.*
- *The Partnership should also review with Commissioners and Providers how psychiatric or psychological consultation can be made available to multi-agency working in cases where there is a mental health component but mental health services are not directly involved.*

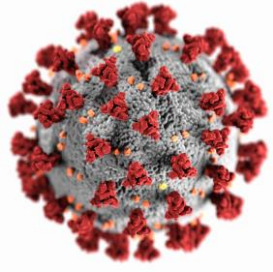
Learning: reflective thinking, bereavement support & young carers

- **Bereavement support** – Referral was made for younger brother to Nelson's Journey was made but AL and his father were required to self refer due to their ages. This was unlikely to happen given their social anxiety and mental health issues.

Carers Matter Norfolk
SUPPORTING YOUNG CARERS & FAMILIES

- **Young carers** – as far back as 2014, Case AL's sister was recognised as a young carer but mother declined services. During the scope of this review her mental health was not recognised as an issue and she appeared to cope with her visual impairment. If anything, she was seen as AL's carer and her own care needs were not assessed as father and maternal grandmother took on any caring roles required. *Practice note included.*

Learning: Impact of Covid



Impact of Covid

- Initially interrupted progress being made in face to face therapy sessions
- Services and contact continued online during first and subsequent lockdowns and home visits made when possible by CAMHS and education mentor

- No additional impact on Case AL's education as his placement was based on online learning

- Younger brother's school recognised him as vulnerable and a place was offered but not taken. As school returned to 'normal' his attendance was an issue which was being addressed.

- Like many children/families with mental health issues the isolation brought about by lockdown did not significantly impact their daily life **BUT**

    - Made it easier for families to dictate terms of engagement and
    - Impacted on agencies' ability to provide services and have eyes and ears on vulnerable children and families
    - Impacted on frontline staff both in terms of capacity as well as personal resilience

NSCP's Response

- Norfolk & Waveney Integrated Care Board's Designated Safeguarding Team will take action to ensure that all health providers, including GPs, are aware of the protocols and guidance to ensure the safe management of medication for young people known to have mental health problems. Other policy documents, including the Threshold Guide, will be reviewed.

- The NSCP has close links with the Children & Young People's Strategic Alliance who are leading on the Mental Health Transformation Agenda, including referral pathways. This report is shared with them alongside a piece of independent scrutiny looking at mental health and safeguarding.

- This review will be shared with the countywide Norfolk Suicide Prevention workstreams that sit under the Health & Wellbeing Board. Specific guidance for children is under review.

- Recommendations from the review will be shared with the NSCP's Neglect Strategy Implementation Group and feed into ongoing work on this priority area.

- The NSCP's three statutory partners have invested in a dedicated project lead to improve the way we work with fathers and men. This will incorporate Think Family approach and build on existing training around Family Networking.

- Learning from this review will be disseminated through SPR roadshows, spring 2023

Learning Activities

- Consider how your team assesses and understand the distinction between mental health and other safeguarding issues such as neglect: how do you address and challenge any ‘grey areas’?

- Develop ways to communicate effectively with parents where their consent is given and then withdrawn, including how to have challenging conversations about safeguarding concerns: how do you build a trusting relationship so they can share their experiences of mental health issues so you can see the family holistically?

- How well do you work with fathers specifically and parents with mental health issues more generally? What are the barriers & opportunities?

- Take up opportunities for Joint Agency Group Supervisions to enable reflective thinking and feedback to your team on how it worked and what perspective it gives you on complex cases

- Ensure your team is up to date with the NSCP guidance on suicide prevention for children and young people – look out for updates!