



Argyll & Bute Child Protection Committee

Learning Review Summary

Child A

Report Prepared by

The Review Group

June 2022

1. Learning Review Criteria

Argyll & Bute Child Protection Committee took the decision to undertake a learning review as it met the criteria set out the national guidance¹ in that

“...a child had died and there was additional learning to be gained from a Review being held that may inform improvements in the protection of children and young people... and the child’s death was by suicide”. (p 5)

The review provided the “...opportunity for in-depth analysis and critical reflection in order to gain greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across agencies”. (p4)

The Review wishes to acknowledge the impact of YP A’s death for his family and for those workers who knew him and who were affected personally by his death.

The Review Group wish to thank all those who participated in the review process.

2. Review Process

A multi agency review group was established comprising of representatives from Social Work, Lead Officer CPC, Health, Education, Police and Justice Services. The review group was chaired by the independent chair of the Child Protection Committee. Overall, the Group met on four occasions between April and November 2021.

The remit of the Group was to review all information and to identify areas for learning and gaps in service provision as well as areas of good practice.

Agency reports and chronologies were requested from all partner agencies and an integrated chronology was prepared. Agency representative critically reviewed their own agency information and provided an analysis of their agency’s involvement with YP A and his family.

A reflective workshop was held on 20 September 2021 with practitioners who were involved with education, health and social work services. The Teams session was facilitated by the CPC Chair and Lead Officer and afforded staff the opportunity to reflect on their involvement with YP A and his family and to explore this within a wider multi agency context. Practitioners were fully engaged in the workshop and through reflection and discussion identified potential areas of learning.

¹ National Guidance for Child Protection Committees Undertaking Learning Reviews, 2021 Scottish Government

3. YP A and the Circumstances that Led to the Learning Review

YP A was born on 10 December 2003 and tragically took his own life on 26 February 2021. YP A went missing from home and was found in the woods nearby having taken his own life. YP A and his family were known to social work services at the time of his death.

The main focus of agency involvement had been with YP A's older sibling who had been known to social work services since 2015. In 2019 YP A was referred to CAMHS due to suicidal thoughts and he was supported by CAMHS over a number of months. When the country went in to COVID lockdown YP A struggled with his mental health and found it difficult to engage with education services and remote learning.

4. Practice & Organisation Learning

This case was managed throughout under S22 as voluntary engagement. This was appropriate due to the level of co-operation by YP A and his family. His older brother subsequently became managed by justice services.

The following areas of future learning were identified by the Review Group and the Practitioners involved in this case -

4.1 YP's Engagement with CAMHS and the Impact of Covid on YP Mental Health & Wellbeing

YP A was referred to CAMHS due to mental health concerns and suicidal ideation. CAMHS responded quickly to this referral and work commenced without delay. CAMHS worked with YP A on safety planning, and this included protective factors that would support and help to manage risk. CAMHS workers indicated that when a YP's protective factors are sufficient then information would not necessarily be shared with a partner agency even when the YP is involved with other services such as Education.

There was limited communication between CAMHS and Education Services. At the point of discharge from the service it would have been appropriate to have convened a Child's Planning meeting to bring all professionals together to review the child's plan and agree any action necessary following the withdrawal of CAMHS. This would have ensured that Education Services were fully aware of YP A's progress with CAMHS and alert to any changes in mood or indicators that may have caused concern.

During Covid we have seen young people struggle with their mental health and nationally demands on CAMHS and other mental health/well-being services have significantly increased. Education staff talked about how fragile YP are in school at present and they are seeing an increase in YP presenting with mental health concerns. This has been a really challenging time for pupils and for staff across the school.

Within Argyll & Bute work has been ongoing via the CPC High Risk Work Group to understand better the impact of Covid on young people and what services are available to meet this need. While not all

children will require formal intervention from CAMHS, many will require supports such as the school counselling service etc.

4.2 Interface between Justice Social Work and Children & Families

When Justice services became involved with YP A's older sibling, he had moved out the family home. There was evidence of information being shared with partners in relation to the sibling but no evidence of information being shared with C&F services. There is no evidence that as part of their assessment consideration was given to the impact of the sibling's behaviour on his younger siblings. There were no joint meetings across adult and children services which could have ensured comprehensive assessment of the needs of all YP in the family home which may have resulted in consideration being given to the use of YPSP or IRD to review concerns and agree actions.

There was no interface between adult protection services and C&F services.

4.3 Chronologies

There was evidence of single agency chronologies within Education but no family multi agency chronology which would have helped both C&F and CJ assess the risk not only to YP A's older sibling but to YP A and his younger brother.

An integrated chronology is a very effective risk tool that provides practitioners with up-to-date information about changes in a child's/family's circumstances and can identify increased risk while also providing evidence of change both when families are doing well and when things are becoming more problematic. The use of chronologies sits within the national practice model and should be used by all professionals to oversee and assess their intervention with a child/YP/family.

4.4 Child Protection Processes

No child protection processes were initiated regarding any of the events involving YP A's older sibling and the potential risk he posed to himself but also to his family when his mental health was poor.

Child protection concerns did not go to IRD but did result in a multi-agency planning meeting held on when C&F SW saw no role for them, and it was agreed that YP A would continue to be supported by the named person (Education).

4.5 GIRFEC Practice Model

During the workshop there was a discussion about thresholds and how and when a meeting should have been convened to consider the needs of YP A and his younger sibling. There is no evidence that a comprehensive assessment was undertaken using the national practice model. The discussion raised the issue of seeing family members in isolation to their wider family network and the need to take into consideration the context of the YP's environment and the impact of other family members on the YP themselves.

While there has been some confusion nationally with regard the role of named person, Argyll and Bute have continued to identify key individuals to provide points of contact for YP. While we await the new national GIRFEC guidance from the Scottish Government, there is an opportunity for the GIRFEC

Working Group to review how the national model is being used to support the assessment of need and risk within Argyll & Bute.

4.6 Transitions

Education spoke about supporting YP in non-Covid times to prepare for leaving school. This can be a stressful time for YP as they think about what the next step will be for them. There is a need to understand the period of transition for autistic YP who may have heightened levels of anxiety about leaving the school environment. During Covid the school were unable to support young people as would have been the normal practice and this led to some YP finding the transition very challenging.

4.7 EEI

YP A's older sibling was referred to EEI on more than one occasion, however, there was no evidence that a whole family approach to assessment of need/risk was considered. While the focus of the EEI referral related to the sibling, it would have been helpful for the group to consider the needs of YP A ensuring that partner agencies were alert to the impact of his older sibling's behaviour and to agree what supports may be necessary.

4.8 C&F Social Work Recording

C&F social work records could have been of a higher standard as it was not always clear who was being referred to in the observations. Copies of the child's plan were not contained in the case file and the review officer was not able to locate relevant assessment information.

5. Effective Practice

5.1 Education Services - Education services relationships between Mum and teaching staff were very good and there was evidence of a close working relationship. Pastoral notes document regular contact between home and school. All education notes relating to YP A were up to date and evidence of action being taken to engage YP A in school work during Covid.

5.2 YP A's Relationship with Teaching Staff

YP A's relationship with teaching staff was positive and his circle of support when in school continued when he was not in school. He had a positive class group of young males who were confident and able to support each other and this group was well supported by one key staff member.

5.3 CAMHS

CAMHS responded immediately to the GP referral and saw YP A quickly. They worked with him to focus on risk and risk management plans were regularly reviewed and updated. It is important to acknowledge that when a YP completes suicide there may not always be indicators that would alert those around them as to what they are planning to do. Sadly, professionals are not always able to accurately predict those YP who may complete suicide.

5.4 Criminal Justice Services with YP A's Older Sibling

Justice Services have been involved with YP A's older sibling and the family for some time and there was evidence of continued support and intervention and engagement with Mum.

5.5 Supports and Processes in School Following YP A's Death

The school management team and central team came together to identify and support a range of opportunities to support YP to grieve and to support staff. Health and wellbeing input for YP was provided by those teachers the YP knew and trusted.

Educational Psychology supported the school during this very difficult period and a safe space was set up in school and this was used by both pupils and teachers. Educational Psychology held an open debrief session for education staff and the school chaplains were in school on a rotational basis.

YP came into school and met in small groups in the cafeteria and while they did not want adult involvement, teaching staff were always available and had oversight on the YP and were able to monitor how the YP were doing.

YP A's peer group was supported directly by a member of staff, and this allowed the young men to talk about how they were feeling and to reflect on YP A's death.

The school arranged for Head Strong to deliver a session supporting parents to know what to look for and importance of linking with the school. There was good involvement with parents and the session was recorded so parents could review after the event.

The school arranged for young people to line the street to show respect as staff and young people were not able to attend the funeral. For many young people this was their first experience of loss/grief and this activity gave pupils and teachers the opportunity to grieve together.

These actions have generated a strong sense of community and family within the school.

6. Learning Outcomes

Learning Outcome 1

The Child Protection Committee may wish to seek an update on the progress of the realignment of the CAMHS service. The newly appointed CAMHS manager should provide the CPC with a response to the findings of this review in order that the CPC can seek assurance that the concerns raised by CAMHS professionals are being addressed and workers are being supported on delivery high quality services to children.

The CPC should request a report on the numbers of YP experiencing mental health difficulties and how many YP are being referred to CAMHS and to other mental health and wellbeing services in order to gain a clear understanding of YP's mental health in Argyll & Bute at this time.

Learning Outcome 2

There is a need to ensure that communication between CAMHS and partner agencies is robust and that the needs of the child/YP are fully understood by all partners involved in the child/YP's care. For those YP at risk the CAMHS manager should consider agreeing a process for a child's planning meeting prior to discharge from the service with partners to ensure information is being shared and plans are being regularly updated to reflect changes in circumstances. It is recognised that such a recommendation would impact on the current capacity of the service.

Learning Outcome 3

The initial work undertaken by both the Child and Adult Protection Committee's in the development of the Young Person Support and Protection Procedures needs to be built upon and discussion between Children and Adult Heads of Service should take place to progress this joint work.

The CPC should request confirmation of the transition pathway for children moving from children to adult services.

Learning Outcome 4

With the imminent publication by the updated GIRFEC practice guidance by the Scottish Government, Argyll & Bute's Gifec Working Group should review and refresh local practice guidance and ensure that practitioners are trained in the model and are confident in its use. This work should be overseen by Argyll & Bute's Strategic Group and the Child Protection Committee should seek reassurance that assessments are of a good standard and that appropriate actions are in place to support and improve practice when identified to be necessary.

Learning Outcome 5

Police Scotland Social Work Services along with health and education partners should review current IRD thresholds and satisfy themselves that professionals understand the IRD threshold and that situations are being appropriately assessed and managed when concerns are raised by any partner.

Learning Outcome 6

C&F Youth Justice Services should review existing EEI guidance with a view to amending practice guidance to include the gathering of information about all children within a family home where there are concerns about the impact of an individual's behaviour on other children within the family home. Within the EEI meeting the question of impact of the subject's offending on other children residing with them should be routinely explored.