Wolverhampton Safeguarding Together

Learning Lessons Briefing – Child H

The Review

This Learning Lessons Briefing is created as the result of a learning review undertaken by the then Wolverhampton Safeguarding Board's Learning Review Committee (LRC) into the experiences of Child H in 2017.

This briefing outlines the key themes identified by the review and identifies learning and questions for professionals to consider in their daily practice with children and young people. We ask that it is shared widely and discussed at team meetings to help professionals to understand how to apply the learning in the context of their roles.

Background Summary:

Child H lived at home with her mother and younger sibling. Her parents were separated however she maintained regular contact with her father.

Her mother had significant health issues following an accident that occurred several years previously and as a result of these issues it is believed that Child H was likely to have been a Young Carer.

In early 2016 Child H was referred to Child and Adolescent Mental Health Services (CAMHS) for support due to concerns about self-harm, depression and suicidal ideation. Appointments were offered but Child H was not bought for these and she was discharged from the service.

From January 2017, Child H was prescribed anti-depressant medication from her GP. An assessment within CAMHS occurred in Febraury 2017 where Child H was discharged and advised to self-refer to the voluntary sector for emotional well-being support. This self-referral did not occur.

In March 2018 Child H commenced school counselling at her request. Child H expressed a wish for this to continue throughout exam leave.

The day before her death Child H, was seen by her GP and expressed an improvement in her mood and said that she was accessing counselling in school.

The following day Child H had a cardiac arrest at home and tragically died as short time later. She had taken an overdose.

Key learning themes arising from the review

Theme 1: Early Help

Throughout the review it was recognised that there were numerous opportunities for an Early Help assessment to occur. This could have resulted in 'Team around the Family' meetings to be in place, and most importantly in this case, the identification of a lead professional who would have had an oversight of the issues and concerns for this family. An Early Help assessment could have enabled multi-agency, co-ordinated and shared assessments and planning to occur. Support for Child H was being provided by education and health but she received single agency support without a joined up approach.

It was highlighted in the review that there was a misconception by professionals around Early Help as it was seen as a tool to refer to Strengthening Families. Early Help training was also described as poor, which may have contributed to the misunderstanding of Early Help as a whole.

What does this mean for your professional practice?

In all cases where single agency early help support is occurring **STOP and think the following questions:**

1: Within my agency and role am I able to fully address and meet the needs of this child and young person?

2: Do I need to complete and early help assessment for this child and family to fully understand their needs?

3: Is there another agency or service that is involved in providing support, or could provide support for this child or young person

If **Yes:**

- Complete an Early Help Assessment
- Consider commencing **multi-agency** early help support as per Thresholds of Need and Support in Wolverhampton (https://www.wolverhamptonsafeguarding.org.uk/images/safeguarding-children/Thresholds-of-Need-and-Support-in-Wolverhampton-Dec-2017.pdf)
- Identify a lead professional to co-ordinate the case
- Consider holding a 'Team around the family' meeting, including the child and family wherever possible
- Contact the Strengthening Families Hub for advice and support

Theme 2: Information Sharing

Ongoing support was being provided to Child H by the GP and education, while targeted assessments and support was provided by CAMHS. It was evident from the review that silo-working within each service was occurring; information sharing in regards to the different agencies support for Child H did not happen.

At the level of Early Help, consent is needed to share information unless there are clear safeguarding concerns. This can be viewed as a barrier to information sharing and may have had an impact in this case. It is not demonstrated or recorded by services that seeking consent from Child H or her mother was considered.

What does this mean for your professional practice?

- **Silo working can be dangerous.**
- When commencing work with a child, young person and their carer discuss information sharing and gain their consent to share information when needed
- If consent is gained, clearly document the consent within your records following your agencies record keeping guidelines
- When supporting a child, young person and their family consider other services and agencies that may be involved and whether sharing of information will provide more robust support and join up information.
- Record information sharing decisions
- Where approporate, revisit consent when sharing information to encourage an open and honest relationship with all children, young people and their carers

Theme 3: Referral Processes

At key points in this case direct referrals in to services did not occur;

1 – The family were advised to self-refer to the voluntary sector rather than CAMHS completing the referral. This resulted in the self-referral not being undertaken and it would have been advisable for the professional to complete the referral to ensure that this was actioned.

2 – Education signposted the family to the GP rather than completing a direct referral in to CAMHS. This was due to the school being unaware that they were able to complete referrals directly.

What does this mean for your professional practice?

When completing referrals to other agencies and services consider:

1. Am I aware of how to carry out a referral to this agency / service? If no, contact the service to determine the process and share this with your colleages.

2. If I am unable to refer to this service, is there another professional that is able to do so? If there is, consider contacting that professional to discuss the referral.

3. Is the service self-referral only? If yes, follow up with the child, young person and carer whether it has occurred. Consider whether another service is necessary and more appropriate.

    - If you are a service where you receive referrals from others, review your referral process to ensure that all other agencies and services are fully aware of how to access your support.

    - If you only accept self-referrals, is this the safest way to ensure that children, young people and their carers are receiving the right support at the right time.

Theme 4: Awareness and Training about Young Carers

Throughout the review of the case it became apparent that the role of Child H as a Young Carer was not recognised by professionals and therefore the associated impact of this on her emotional health and well-being, and the support that she may have needed, was not considered in assessments and contact with her.

What does this mean for your professional practice?

- Do you need to access training to be aware of the signs and symptoms to look out for and questions to ask to determine whether a child or young person is a young carer?

- Do you know how to access support for a child or young person who you feel is a young carer?